SOPHIE E. K. FENTON BSc Hons, MSc

THE POSITION OF PERINATAL SERVICES TO SUPPORT PARENTS AND DETECT PARENTAL DISTRESS

Section A:

Help-seeking for parental psychological distress during the perinatal period and child's early years: A systematic review

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Section B:

Fathers' and health professionals' perceptions and experiences of paternal perinatal support and their views on improving services: A Delphi study

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A thesis submitted in partial fulfilment of the requirements of
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Doctorate in Clinical Psychology (D.Clin.Psychol.)

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Summary of the Major Research Project

Section A

This review explored mothers' and fathers' help-seeking behaviours, barriers, and facilitators for their own psychological distress during pregnancy and child's early years. A systematic search yielded 19 studies. The papers presented mixed help-seeking rates, although results suggested that mothers and fathers may turn to social networks more than professionals. Help-seeking barriers for both parents were related to stigma, interpersonal relationships, and issues with services. Facilitators included positive influences of others, and a desire for reduced stigma. Fathers' specifically indicated wanting better father-inclusion by perinatal services.

Section B

A three-round Delphi methodology was used to explore fathers' perinatal experiences, and support from professionals (midwives and health visitors); professionals' experiences and understanding of fathers; both groups' ideas for paternal perinatal support; and areas of between-group agreement and disagreement. Overall, 27 fathers and 24 professionals participated. Results reflect the change in culture, whereby fathers are increasingly acknowledged for their involvement and importance to mother- and child-wellbeing, yet do not receive adequate support from services in their transition to parenthood. Findings associated with fathers' experiences and inclusion were proposed to span various ecological levels. Participants agreed that services should be more family-centred, and should support parents around relational and psychological aspects of parenthood.

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Abstract

Children with parents experiencing psychological distress during their early development are more vulnerable to social, emotional, cognitive and psychological problems. Acknowledging the importance of parental mental health and early intervention, the UK government has included perinatal services in their mental health five year forward view. However, for parents to access psychological services, increased understanding of parental help-seeking during the early years is needed. Two previous reviews have focused on parental psychological help-seeking, identifying several barriers, but missing important studies between them: quantitative studies, studies on psychological distress beyond depression, and studies on fathers. The current review sought to synthesise Western research reporting where mothers *and* fathers go for help, and the main help-seeking barriers and facilitators. Nineteen studies were identified by electronic searches of seven databases and hand-searching. Reported help-seeking rates varied widely. It could tentatively be concluded from the literature that both parents tend to help-seek more from social networks than from professionals. Barriers included stigma, interpersonal relationships, and healthcare provider issues. Facilitators included positive influences of others, and desires for services to reduce stigma. Fathers' specifically desired improved father-inclusion and engagement by perinatal services. Methodological issues across studies, and research and clinical implications are discussed.

Keywords: Help-seek, parental psychological distress, perinatal.

1. Introduction

Becoming a parent is a challenging life transition (Huston & Holmes, 2004). Expectant and new parents are required to restructure their lives to accommodate the demanding responsibility of raising a child, while roles and relationships are realigned and new ones developed (Cowan & Cowan, 1995). Couples welcoming their first child experience identity-shifts from partner to parent and must adapt to a triadic relationship (Genesoni & Tallandini, 2009). Women undergo the physical ordeal of producing a baby (McGovern et al., 2006), and both mothers and fathers can experience hormonal changes, sleep deprivation, and weight-gain (Berg & Wynne-Edwards, 2001; Condon, Corkindale, & Boyce, 2004; Gunderson et al., 2008; Hendrick, Altshuler, & Suri, 1998).

As overwhelming as this transition can be, many parents report feeling complete love for their child, amazement, satisfaction, enjoyment and pride, and a mutual togetherness with their partners (Nystrom & Ohrling, 2004). However, for some couples, a baby's arrival can place strain on their relationship (Doss, Rhoades, Stanley, & Markman, 2009). Mothers have reported a loss of sense-of-self, social support (Mercer & Ferketich, 1995), and partner support (McBridge & Shore, 2001). Fathers have reported feeling useless and anxious during labour and birth (Chandler & Field, 1997), less skilled and confident in parenting than mothers (Henderson & Brouse, 1991), and difficulties in balancing their wish to be an involved parent with pressures to provide materially (Henwood & Proctor, 2003). Overall, parents can feel loss, isolation, reduced freedom, role-strain, inadequacy, powerlessness, exhaustion, disappointment, or guilt (Nystrom & Ohrling, 2004).

A minority of parents understandably experience psychological distress. This is more likely for those with difficult past and current experiences. Parents with no positive role-models can find

the psychological reorganisation particularly challenging (Henwood & Proctor, 2003). For those who experienced childhood abuse and trauma, difficult unresolved feelings or 'ghosts in the nursery', can be stirred-up by the new parent-infant relationship (Fraiberg, Adelson, & Shapiro, 1975; Fonagy, Steele, & Steele, 1991). Additionally, low social support, poverty, life-stressors, relationship problems, single parenthood, and being from an immigrant or black and minority ethnic (BAME) background are associated with increased vulnerability to psychological distress during the perinatal period[1] (Kurtz-Landy, Sword, & Valaitis, 2009; Onozawa, Kumar, Adams, Dore, & Glover, 2003; Robertson, Grace, Wallington, & Stewart, 2004).

Parental psychological distress during pregnancy and the child's early years

Psychological distress has been defined as: "the unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person" (p. 539, Ridner, 2004). Table 1 presents descriptions and rates of some forms of psychological distress sometimes experienced by parents. These are categorised under psychiatric diagnoses because the literature presents it this way. Diagnostic categories can be a spurious way of defining psychological distress as people with similar underlying psychological issues (e.g. childhood trauma) may experience different 'symptoms' (e.g. one person may appear depressed, and another as anxious). People's presentations depend on many psychosocial factors, requiring consideration within each individual's formulation.

[1] The 'perinatal period' is defined in mental health fields as spanning pregnancy and the first postnatal year (Sharp, 2009).

Table 1. Descriptions and estimated prevalence of some forms of psychological distress that can be experienced by parents in the perinatal period.

Mental health experience	Maternal prevalence estimates	Paternal prevalence estimates
Depression and anxiety: Postpartum depression (PPD)[2] is associated with persistent sadness, anhedonia, fatigue difficulties functioning, and possible difficulties forming and maintaining relationships (Dunn, 2016, Hirschfeld et al., 2000). Research suggesting biological causes is limited (Beck, 2008). Psychosocial factors are consistently associated with PPD, including limited social support, marital dissatisfaction, childhood trauma, and past depression (Dennis & Creedy, 2007; Matthey, Barnett, Ungerer, & Waters, 2000). Anxiety, often concurrently present with PPD, can involve restlessness, sleep difficulties, rumination, nervousness, feelings of dread, and can manifest with obsessive compulsions involving repetitive intrusive thoughts and urges (Dunn, 2016; Matthey, Barnett, Howie, & Kavanagh, 2003).	20640 women (30/1000 maternities) experience severe depression in England annually, and 86020 women (100-150/1000 maternities) experience mild-to-moderate depression and anxiety in England annually (Hogg, 2013).	Depression reported in 10.4% of new fathers (Paulson & Bazemore, 2010), and 24-50% of fathers with partners with PPD (Goodman, 2004). Anxiety reported in 4.1-18% of fathers (Leach et al., 2016).
Trauma: Childbirth can be traumatic, particularly in cases with a difficult labour, haemorrhage, or emergency treatment. This can result in post-traumatic stress disorder (PTSD), involving intrusive recollections, flashbacks, panic, physical sensations, irritability, sleep difficulties, nightmares, and possible avoidance of the infant (Beck, 2004; Dunn, 2016). The transition to parenthood can also exacerbate complex feelings from past traumas in people with experiences of childhood abuse (Fonagy et al., 1991).	20640 women (30/1000 maternities) develop PTSD in England annually (Hogg, 2013).	5% of fathers are estimated to develop PTSD (Ayres, Wright, & Wells, 2007).
Psychosis: Postpartum psychosis involves a rapid onset of symptoms such as delusions, hallucinations, confusion, paranoia, and mood symptoms of mania or depression (Hogg, 2013). Postpartum psychosis is associated with higher rates of suicide than any other perinatal mental health problem (Sit, Rothschild, & Wisner, 2006).	1380 women (2/1000 maternities) experience postpartum psychosis in England annually (Hogg, 2013).	Not enough research (see Bradley & Slade, 2011, [p.37-38], for synthesis regarding potential psychosis risk for fathers).

[2] Postpartum depression (PPD) has been expanded to include the onset of a major depressive episode during pregnancy as well as postpartum (American Psychiatric Association, 2013). This review will use 'PPD' to describe depression occurring in fathers and mothers during this period.

Importance of parental mental health

The term 'good-enough mother', originally coined by Winnicott (1953), and later expanded to 'good-enough parent' (Bettelheim, 1987) is used by psychoanalytic theorists to define parenting that meets the child's emotional and physical needs. Research agrees that secure attachment is important for children's healthy emotional development (Carlson & Sroufe, 1995). Bowlby's (1969; 1973; 1980) attachment theory describes how a child seeks proximity to their main caregiver – a 'secure base' from where they can safely explore their environment (Ainsworth, 1969). Many infants are likely to become distressed by separation from their parent(s) (Lamb, 1977), but with sensitive responses to their child following a threatened or actual separation, the child's emotional security and secure attachment develops. Compared to individuals with insecure attachments, those with secure attachments to either or both parents are observed to fair better throughout life – cognitively, socially, emotionally, and psychologically (Belsky & Cassidy, 1994; Bretherton, 2010; Lamb, 2002).

Psychological distress may limit a parent's ability to meet their child's needs. Pregnant women experiencing psychological distress more often have poor physical health, obstetric complications, and misuse substances, with increased risk to the baby's development and survival (Kelly, Zatzick, & Anders, 2001; King-Hele et al., 2007). Either parent experiencing psychological distress can demonstrate less engagement, responsivity, play, vocal synchronisation, and affection with their infants, and more negative interactions, irritability, and hostility (Paulson, Dauber, & Leiferman, 2006; Wilson & Durbin, 2010; Zlochower & Cohn, 1996). Effects of psychological distress such as these, are associated with impaired parent-child attachment (Moehler, Brunner, Wiebel, Reck, & Resch, 2006), and impaired cognitive, social, emotional, and psychological child development (Kane & Garber, 2004; Kingston, Tough, & Whitfield, 2012; Kingston, McDonald, Austin, & Tough, 2015;

Ramchandani, Stein, Evans, & O'Connor, 2005; Ramchandani et al., 2008), which can persist into adulthood (Peisah, Brodaty, Luscombe, & Anstey, 2004).

It must be noted that not all children of parents experiencing psychological distress are at risk of harm or impaired physical or emotional outcomes (Tunnard, 2004). However, acknowledging the increased risk and value of early intervention, the National Institute for Health and Clinical Excellence (NICE) recommends "*healthcare professionals should be aware of signs and symptoms of maternal mental health problems*", and at each postnatal contact "*women should be asked about their emotional wellbeing*" (2006). The focus is on the mothers, and even so, many experiencing distress do not receive treatment (Russell, Ashley, Chan, Gibson, Jones, 2017). This suggests that parents – particularly fathers – need to actively help-seek to improve the likelihood of early intervention support.

Help-seeking

With regards to mental health, this review defines help-seeking as: "*an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern*" (Rickwood & Thomas, 2012, p. 180). Help can be sought from informal (e.g. friends, family, partners, internet/helplines) and formal sources (e.g. professionals with recognised roles to provide help, such as healthcare/mental health professionals, teachers), with 'help-seeking' encompassing all stages from initiating, to engaging with, care (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Numerous help-seeking theories and models exist. Dominant models include Rosenstock's (1966) health belief model – whereby a person's behaviour depends on their appraisal of perceived threats, barriers, and benefits of the behaviour; Andersen's (1968) healthcare

utilisation model – whereby a person's behaviour depends on predisposing factors, enabling factors, and need; and Ajzen's (1991) theory of planned behaviour – whereby attitudes, norms, and perceived behaviour-control influence intentions and behaviour. All three have been applied to mental health help-seeking in the general population (Goodwin & Andersen, 2002; Henshaw & Freedman-Doan, 2009; Smith, Tran, & Thompson, 2008a), but are criticised as linear and static (Biddle, Donovan, Sharp, & Gunnell, 2007).

Pescosolido's (1992) network episode model (NEM) dynamically elaborates on how a person's interactions with their culture and social networks influences help-seeking, rather than being an individualistic choice. The NEM suggests a person's formal and/or informal networks' beliefs, attitudes, values, and responses regarding "illness", are instrumental to help-seeking (Perry & Pescolido, 2015). For example, networks can convey support or discrimination – either facilitating or inhibiting a person's help-seeking. Indeed, anti-stigma campaigns have been found to facilitate formal and informal mental health help-seeking (Henderson, Robinson, Evans-Lacko, & Thornicroft, 2017). Help-seeking *efficacy* from family and friends appears to depend on their support, empathy, and relevant knowledge and expertise (Griffiths, Crisp, Barney, & Reid, 2011).

The theories described above concern men and women. However, men tend to help-seek less than women (Galdas, Cheater, & Marshall, 2005), despite their threefold risk of substance misuse and suicide (Mental Health Foundation, 2016; Office for National Statistics, 2017). One way to understand this difference is by considering the concept of 'gender'. Pleck's (1981, 1995) gender-role strain paradigm suggests that 'masculinity' and 'femininity' are socially constructed dynamic ideas based on gender stereotypes that are internalised by individuals, and enacted via interpersonal interactions. Socialisation to masculine gender norms (e.g.

competition, restricted emotionality, restricted affection, and self-reliance) is argued to create problems for men (and women and families; O'Neil, 1981; Pleck, 1995). Men's conformity to masculine norms has been associated with increased stress, conflict, aggression, and depression (Levant, 1996; Rice, Fallon, & Bambling, 2011), limited problem-awareness (Mackenzie, Knox, Gekoski, & Macaulay, 2004), greater perceived barriers to psychological help-seeking (Addis & Mahalik, 2003), higher self-stigma, self-reliance, and emotional control (Mahalik, Good, & Englar-Carlson, 2003; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Masculine gender norm endorsement and help-seeking reportedly differs according to race/ethnicity, social class, sexual orientation, and social context (Levant, 1996; Levant & Majors, 1997; Levant et al., 2003; Levant & Richmond, 2007). However, beyond gender differences, help-seeking has been observed as less likely in men and women from BAME, lower socioeconomic status (SES) backgrounds, compared to people from white, higher SES backgrounds (Alvidrez, 1999; Lane & Addis, 2005).

Previous reviews on mental health help-seeking in parents

Six reviews exist on women's help-seeking for perinatal psychological distress. Two focused exclusively on help-seeking (Button, Thornton, Lee, Shakespeare, & Ayers, 2017; Dennis & Chung-Lee, 2006), and four included help-seeking within the wider review (Liberto, 2012; O'Mahony & Donnelly, 2010; Schmied, Black, Naidoo, Dahlen, & Liamputtong, 2017; Wittkowski, Patel, & Fox, 2017). One included quantitative and qualitative data (Liberto, 2012), with the remaining including qualitative studies. One focused on a range of psychological distress (Button et al., 2017), with the remaining only including PPD. None of these reviews included research on men.

Help-seeking barriers reported across reviews included poor knowledge and recognition of PPD and the help available, shame and stigma, a preference to deal with symptoms independently, practical barriers, and unhelpful input from healthcare professionals (HCPs) or informal networks (Button et al., 2017; Dennis & Chung-Lee, 2006; Liberto, 2012; Wittkowski et al., 2017). Help-seeking influences specific to reviews with immigrant populations included cultural factors, gender roles, and language barriers (O'Mahony & Donnelly, 2010; Schmied et al., 2017; Wittkowski et al., 2017).

Of the two reviews focused on help-seeking, Dennis and Chung-Lee (2006) identified 40 papers reporting barriers including poor recognition or knowledge of PPD and the help available, symptom denial and minimisation, fear of losing the baby, hesitancy of mental health services, practical barriers, shame, and stigma. Help-seeking facilitators included education and stigma-reducing discussions, good relationships with HCPs, and practical facilitators (e.g. childcare facilities). From 24 qualitative UK articles, Button et al. (2017) identified three factors affecting women's help-seeking for perinatal psychological distress: (1) identifying the problem: recognising and articulating distress, with identification by others potentially helpful; (2) healthcare expectations and experiences: including structural/practical factors (e.g. waiting-lists), experiences with professionals, limited knowledge of professionals' roles, medication averseness, and continuity of care; and (3) stigma: self-judgement, minimising symptoms, worrying about others' judgements and consequences (e.g. children being taken into care). Button et al. (2017) recommended further research further explores help-seeking for psychological distress beyond PPD, and whether help-seeking likelihood varies during the perinatal period.

Rationale and aims for the current review

Among the six reviews described above, most focused on qualitative data with eligibility criteria limited to depression and certain populations (e.g. UK samples, immigrant samples, women). In doing so, important data may have been missed from quantitative studies, qualitative studies of wider western populations, studies on psychological distress beyond depression, and all reviews missed research including men. Acknowledging the gaps in existing reviews, and evidence highlighting the importance of both parents, lower rates of male help-seeking, and the range of parental psychological distress, this paper aims to provide a comprehensive systematic review of both qualitative and quantitative research on help-seeking for psychological distress (including but not limited to depression) in mothers *and* fathers from western populations. Specifically, this review aims to answer the following questions:

1) Where or to whom do parents turn for help?
2) What are the main help-seeking barriers?
3) What are the main help-seeking facilitators?
4) Do help-seeking issues differ between men and women?

2. Methodology

Seven online databases were searched for relevant peer-reviewed articles published in the English language up until October 2017, using the search matrix detailed in Table 2. Databases, search terms, and search locations (e.g. title or abstract) were selected through an iterative process involving several trial searches to achieve sufficient specificity and sensitivity (Tacconelli, 2010). To maximise the likelihood of detecting all relevant literature, no date restrictions were applied.

Table 2. Search matrix

Search Terms	Boolean operator	Search location
parent* OR paternal* OR father* OR dad* OR maternal* OR mother* OR mum* OR perinatal* OR postpartum* OR postnatal* OR antenatal* OR prenatal*	AND	Title
mental* OR psycholog* OR distress* OR stress* OR trauma* OR psychiatr* OR mood OR exp "mental disorders" (term exploded) OR "anxiety disorders" (term exploded) OR "affective disorders" (term exploded)	AND	Abstract
"help seek*" OR help-seek* OR "health seek*"	AND	Abstract

Following removal of most duplicates via a database function, relevant articles were identified through screening titles, then abstracts, and then full-texts according to inclusion criteria detailed in Table 3. The process of screening and inclusion of articles for this review is demonstrated in Figure 1. Reference lists of relevant articles were hand-searched to identify research missed through database searches. The online literature search identified 635 articles, with a further 14 identified through hand-searching. Of these 649 articles, 19 were selected for review.

Table 3. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Published in a peer-reviewed journal • Available in the English language • Study researching parents' help-seeking for psychological distress in themselves or their co-parent from pregnancy to five years postpartum • Mothers and/or fathers are the primary informants of their experiences • Research on samples living in western or high-income countries • Studies not already reviewed on the topic of help-seeking for psychological distress	• Non-peer reviewed journals, book reviews, opinion articles, unpublished theses, or literature reviews • Not available in the English language • Not focusing on parents' help-seeking for psychological distress in themselves or their co-parent during pregnancy to five years postpartum • Parents are not the primary informants of their experiences • Participants' described as having children with serious emotional, behavioural or physical problems • Samples living in non-western or low-income countries • Studies that have been included in previous reviews with a similar focus to the current review

A systematic review type was selected to "*systematically search for, appraise, and synthesise research evidence…draw together all known knowledge on a topic area*" (pg.95, Grant & Booth, 2009), and make recommendations for future research and practice. Articles' quality was assessed using the 'Appraisal Tool for Cross-Sectional Studies' (AXIS; Downes, Brennan, Williams, & Dean, 2016; Appendix A), and 'Critical Appraisal Skills Programme (CASP) Cohort Study Checklist' (2013; Appendix B). Numerical quality ratings were not applied due to being subjective and potentially misleading (Booth, Papaioannou, & Sutton, 2012), nor were papers excluded according to quality. However, appraisal tools were used to critically analyse articles to allow for a more balanced view of the overall findings' robustness.

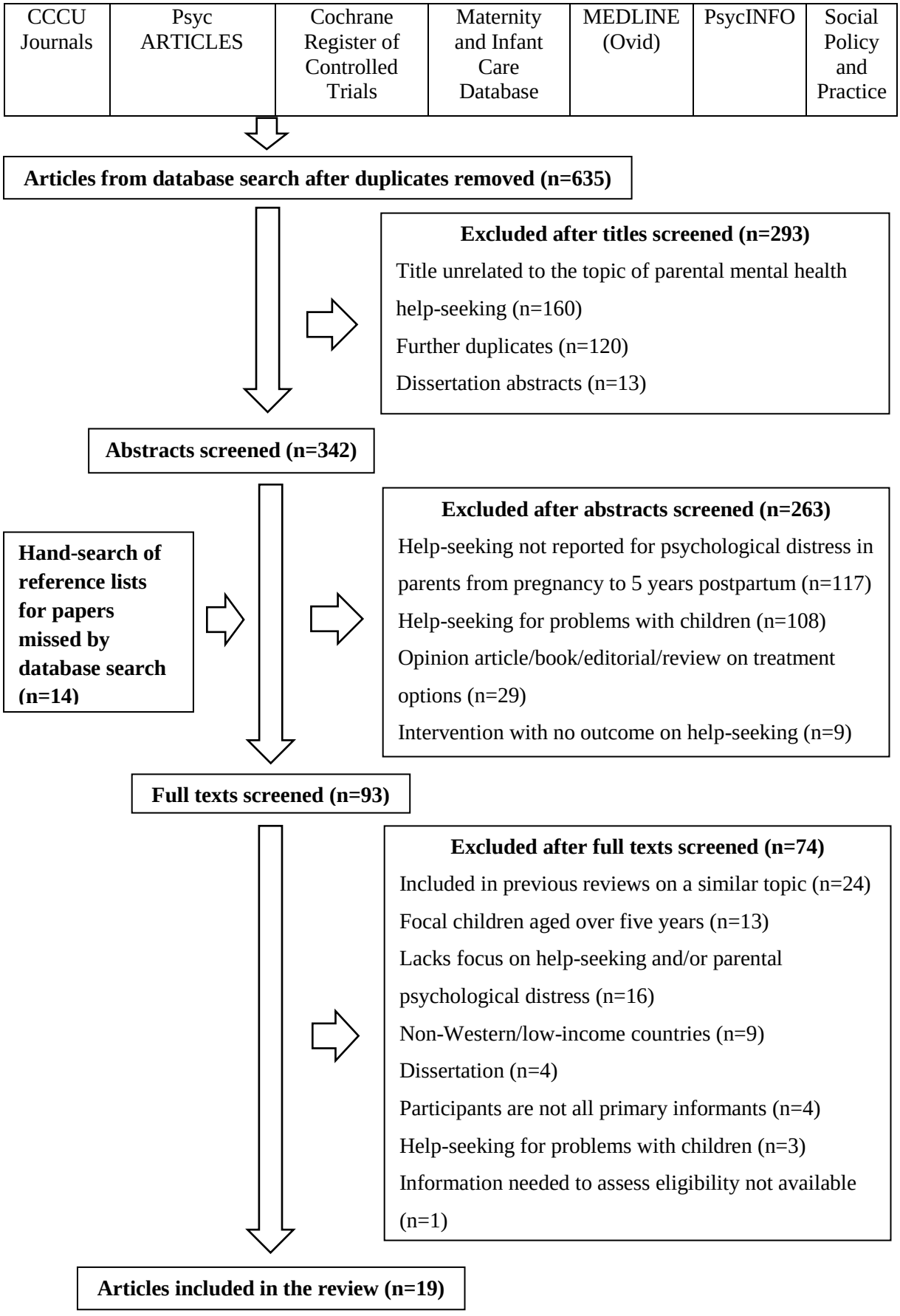

Figure 1. PRISMA flowchart of the systematic literature search (Liberati et al., 2009).

3. Review

Overview of studies and review structure

The literature search identified 19 eligible papers, published between 2007 and 2017, from America (n=9), Canada (n=5), Portugal (n=2), and the UK (n=1). Three used mixed methodologies (Ahmed, Bowen, & Feng, 2017; Colquhoun & Elkins, 2015; TaPark, Goyal, Nguyen, Lien, & Rosidi, 2015), six employed qualitative methodologies (Bilszta, Ericksen, Buist, & Milgrom, 2010; Byatt, Biebel, Friedman, Debordes-Jackson, & Ziedonis, 2013; Foulkes, 2011; Guy, Sterling, Walker, & Harrison, 2014; Rominov, Giallo, Pilkington, & Whelan, 2017; Sword, Busser, Ganann, McMillan, & Swinton, 2008), and the remaining ten used quantitative methodologies.

Relevant findings are critically discussed and summarised according to mothers' and fathers' psychological help-seeking behaviours, barriers, and facilitators during the perinatal period and child's early years. A subsequent methodological critique of the studies allows the reader to consider the findings according to their strengths and limitations. Where several studies report similar results, detail is provided for the study appraised as most robust. Key characteristics and results of all included articles are summarised in Table 4.

Table 4. Summary of articles included in the review

Authors, date	Relevant aims	Participants and recruitment	Design, measures, and analysis	Findings relevant to the current review
Ahmed et al. (2017). Canada	Understand influences on refugee women's help-seeking behaviours and barriers.	**Participants**: 12 Syrian refugee perinatal women. Mean age 27.2 years (range 20-37 years). All married, Arabic-speaking, mostly unemployed and educated up to high school. **Recruitment**: Purposeful sampling from outreach programs, religious organisations, resettlement agencies, doctors', and maternity wards.	**Design**: Qualitative and quantitative cross-sectional design. **Measures**: socio-demographics, Edinburgh Postnatal Depression Scale (EPDS)[1], Primary Care PTSD screen[2]. **Analysis**: Thematic analysis of focus group data. Descriptive statistics of questionnaire data.	**7 women had psychological distress symptoms** (depression, anxiety, and/or PTSD symptoms). **Help-seeking barriers**: mental health stigma; privacy concerns; potential for husbands to stop women help-seeking (although denied this regarding their own husbands)
Bilszta et al. (2010). Australia	Explore how PPD influences women's help-seeking beliefs, attitudes and behaviours	**Participants**: 40 women with PPD. Mean age: 34 years (range 27-47 years). 81% were married or partnered. 78.3% had a $40,000+ income. **Recruitment**: recruited from outpatient depression treatment programs and community support programs	**Design**: Qualitative cross-sectional design. **Measures**: socio-demographics, perceived level of support, reason for seeking help, EPDS. **Analysis:** Interpretative phenomenological analysis of focus group data	**Help-seeking prevalence**: 89.1% sought professional help. **Help-seeking barriers:** 'keeping up appearances'; stigma; denial of emotional problems; difficulty recognising depression; difficulty accessing support; poor continuity of care; depression symptoms; negative family help-seeking attitudes; poor sleep; difficulties thinking clearly; unhelpful responses to disclosures from HCPs. **Desired facilitators from professionals:** validation, kindness, empathy, availability, knowledge of help available, active assistance, and continuity of care.

Byatt et al. (2013). USA	Identify help-seeking barriers and facilitators to detecting PPD in paediatric settings	**Participants**: 27 white women self-reporting perinatal anxiety, depression, or emotional difficulties. 48% aged 35+, 85% in relationship. **Recruitment**: from a perinatal education and advocacy community organisation	**Design**: Preliminary qualitative cross-sectional study. **Measures**: socio-demographics. **Analysis:** Grounded theory analysis of focus group data	**Help-seeking barriers:** concerns about stigma and losing parental rights; ambivalence about the role of paediatricians' screening; perception of paediatricians as not trained to screen or discuss PPD. **Help-seeking facilitators:** For HCPs to address mental health as well as medical care needs of mother and baby; for HCPs to have a de-stigmatising and therapeutic approach to screening.
Colquhoun & Elkins (2015). Australia	Understand fathers' experiences of distress, and barriers and facilitators to help-seeking	**Participants:** Men in 12 focus groups, 1531 online survey participants, 23 online forum participants. Men were divided into 3 segments: **expecting first child (10%):** 61% aged 18-34, 53% living with partner, household income ≤$100K (64%); **one child ≤1 year (12%)**: 63% aged 18-34, 93% living with family; **child aged 1-4 (78%):** 31% aged 40-54, 91% living with family, 24% with income over $120K. **Recruitment**: Not reported.	**Design**: Multi-stage, multi-method qualitative and quantitative approach **Measures**: Kessler Psychological Distress Scale[3], Brief Resilience Scale[4] , questions designed for study. **Analysis**: Factor analysis and cluster analysis to identify segments in the project's entire cohort of fathers (expectant fathers, new fathers with child under 1, and experienced fathers with children aged 1-4). Structural equation modelling.	**Psychological distress:** High risk of psychological distress in 33% of expectant fathers, 39% of fathers of a child ≤1 year, and 21% of fathers of children aged 1-4. **Barriers for expectant fathers:** 21% lacked time; 20% would not know where to start, 19% would feel uncomfortable. **Barriers for fathers of children ≤1**: 27% would not know where to start, 26% concerned about financial cost, 23% unavailable locally, 22% felt they would not fit in. **Barriers for fathers of children aged 1-4:** 32% prefer to spend time with baby/family, 31% lacked time, 23% would feel uncomfortable. **Quantitively (n=1531):** 35% sought professional help. 47% expectant and new fathers preferred not to admit not coping. 49% would not want to 'bother' their partner. **Qualitatively**: Fathers felt they should persevere, hesitant to seek help, and lacked opportunity to ask for help. **Overall barriers**: internalised pressure to cope; poor understanding of PPD and who it can affect; negative attitudes towards identifying problems as psychological distress; lack of father-specific support or engagement by professionals.

Dunford & Granger (2017). UK	Explore whether women's guilt and shame are associated with PND symptoms and help-seeking attitudes.	**Participants:** 183 mothers of infants aged 4 weeks to 1 year. Mean age: 31 years, mostly white British (84%), married (72%), with higher education qualifications (63%). **Recruitment**: Recruited from UK-based parenting and PPD websites.	**Design**: Quantitative cross-sectional, correlational. **Measures**: EPDS, Inventory of Attitudes Towards Seeking Mental Health Services[5] ; Test of Self-Conscious Affect-3[6] ; Event-Related Shame and Guilt Scales[7] ; Social Support Questionnaire 6[8] . **Analysis**: Descriptive, correlations, regressions.	**Psychological distress:** 25% of the sample presented with significant depressive symptoms on the EPDS (38% of whom were currently accessing support for low-mood). **Influences on help-seeking attitudes:** Shame-proneness significantly predicted negative attitudes toward help-seeking for depressive symptoms when social support and demographics were accounted for. Guilt-proneness was not significantly associated with help-seeking attitudes. Shame proneness also significantly predicted fear of stigma, and depression symptoms.
Fonseca, Gorayeb, & Canvarro (2015). Portugal	Explore help-seeking behaviours of women with PPD, barriers to help-seeking, and socio-demographic and clinical correlates to help-seeking behaviours and barriers.	**Participants:** 656 perinatal women, mean age: 31.13 years. Mostly achieved higher education (73%), were married or living together (90.7%), employed (74.7%), with a monthly household income between €1000-3500 (66.6%). **Recruitment**: non-probability sampling via advertisements in pamphlets, social media, websites, online forums focused on pregnancy and childbirth.	**Design**: Quantitative cross-sectional survey **Measures**: socio-demographics, clinical data, questions on help-seeking behaviours and barriers, EPDS (Portuguese version) [9] . **Analysis**: Descriptive statistics, X^2 tests and phi coefficients, logistic regressions, and Friedman tests with Bonferroni corrections ($p<.02$).	**Psychological distress:** 30.2% (n=198) had scores above the clinical cut off for PPD on the EPDS. **Help-seeking behaviours:** 35.9% of women with PPD disclosed psychological difficulties to their social network, 38.4% expressed willingness to help-seek, but only 13.6% sought professional help. Least likely to help-seek were pregnant, currently married women with no history of psychological problems. 44% of women with PPD symptoms did not recognise a problem or engage in any help-seeking. **Help-seeking barriers:** Women most frequently identified barriers related to poor knowledge (not knowing if their problems were a reason to seek help, and not

				knowing the treatment options), and practical barriers (i.e. lack of time or money to have treatment).
Fonseca & Canvarro (2017). Portugal	Examine the relationship between women's intention to seek informal and formal help, and effects of perceived encourage-ment from partners to formally help-seek.	**Participants:** 231 perinatal women, mean age: 29.99 years. Mostly married/living with partner (83.1%), had completed higher education (62.3%), were employed (73.5%), with a monthly household income between €500-2000 (72.3%). **Recruitment**: non-probability sampling via advertisements in pamphlets, social media, websites, and online forums on pregnancy and childbirth.	**Design**: Quantitative cross-sectional online survey. **Measures**: socio-demographics, EPDS (Portuguese version), Hospital Anxiety and Depression Scale (Portuguese version) [10] , General Help-Seeking Questionnaire[11], and perceived encouragement from partner to seek help. **Analysis**: Descriptive statistics, paired samples t-test, Pearson bivariate correlations, independent-samples t-tests, moderated mediation analyses.	**Psychological distress:** 38.5% had high distress levels, 55% of whom had clinically significant depression and anxiety. **Help-seeking preference:** Women had significantly higher intention to seek help from partners than professionals, despite perceiving high encouragement from partners to seek professional help for emotional difficulties. This trend was stronger for employed women with higher incomes. **Help-seeking barriers:** Women with higher perinatal distress were significantly less likely to seek help from partners, and perceived significantly less encouragement from partners to seek professional help, compared to women with lower perinatal distress. **Help-seeking facilitators:** Intention to help-seek from partners was significantly positively associated with formal help-seeking intentions. Perceived encouragement from partners was significantly positively associated with intentions to seek help from partners and professionals.
Foulkes (2011). Canada	To explore barriers and enablers to help-seeking for Postpartum Mood	**Participants:** 10 Caucasian women with PPMD. Mean age: 32.6 years. All married, well-educated, middle-class. **Recruitment**: Purposeful, theoretical, and snowball sampling. Posters and flyers	**Design**: Qualitative cross-sectional study. **Measures**: Demographics, and semi-structured interview. **Analysis:** Grounded theory.	**Help-seeking actions:** 80% sought professional help, while the remaining 20% sought help from lay or others. **Help-seeking barriers**: Stigma and shame; issues with healthcare providers. **Help-seeking facilitator:** comprehensive maternal-child care (to reduce stigma, give equal priority to mental health

	Disorder (PPMD).	distributed in baby clinics, centres, and a PPD group.		as to physical healthcare, and help women to feel as equally valued as the baby).
Guy et al. (2014). USA	Understand lower income women's mental health literacy and experiences recognising symptoms and seeking help.	**Participants:** 25 perinatal women, 15 of whom had depressive symptoms. Women were Anglo (n=6), Hispanic (n=10), and African American (n=9), mean age 24.3 years, 52% were married, 10 had completed high school, and all were receiving prenatal care for low income women. **Recruitment**: Not stated.	**Design**: Secondary analysis of qualitative data from a longitudinal study. **Measures**: Socio-demographics, Centre for Epidemiologic Study-Depression (CES-D) Scale[12], and focus group data **Analysis:** Qualitative thematic analysis	**Recognition of symptoms**: Via their own or others' appraisals, women could recognise mental health changes. **Help-seeking preferences:** Women expressed a preference for obstetricians, they voiced positive views of counsellors, and ambivalence about medication. **Help-seeking barriers:** Negative past experiences, frustration regarding lack of easy access to care within a reasonable time, and fear (of losing custody of their child, of being institutionalised without consent, or of their confidential information being shared with the community such as child's school).
Henshaw, Sabourin, & Warning (2013). USA	Explore help-seeking and treatment preferences of women at risk of perinatal depression or anxiety, and the responses from social support.	**Participants:** 36 perinatal women reporting clinically significant depression or anxiety symptoms (50% in the low symptom range). Mean age: 28.4 years, 61.1% white, 38.9% black, 69.4% married or living with partner, 55.6% achieved undergraduate degree or higher, 50% with a household income over $40,000. **Recruitment**: Of 220 women screened for perinatal anxiety	**Design**: Quantitative cross-sectional descriptive design with 6-week follow-up. **Measures**: Socio-demographics, EPDS, Brief Measure of Worry Severity[13], questions on help-seeking, treatment preferences, referral and beliefs about depression. **Analysis:** Descriptive statistics.	**Treatment preferences:** Most women expressed a preference for counselling, psychologist or social worker (58.3%), and at an outpatient mental health clinic for location (41.7%) **Help-seeking behaviours:** 83.3% asked friends of family if they thought they might have depression/anxiety; and regarding depression/anxiety, 69.4% considered their need for treatment; 50% sought information; 50% asked their obstetrician about depression/anxiety; 44.4% got a medication prescription; 30.6% took medication; 33.3% attended a mental HCP appointment; 16.7% attended a postpartum support group; 13.9% rang a support line.

		and depression, those with symptoms were interviewed.		
Huang, Wong, Ronzio, & Yu (2007). USA	To present estimates and correlates of maternal depression prevalence, and to examine the relationship of mental health help-seeking by nativity, race or ethnicity.	**Participants:** 7676 mothers with a child <1-year-old, 40.9% mothers with mild to severe depression symptoms, 61.6% white, 20.3% Hispanic, 14.1% black, 3.1% Asian, 0.6% Native American. Mostly US-born (81.2%), aged 20-35 (79%), living with partner (80.4%). Various household incomes and SES status'. **Recruitment**: Sampled from birth records with the use of incentives. No further information provided.	**Design**: Quantitative analysis of baseline data from the Longitudinal Survey-Birth Cohort (Nine-Month data) **Measures**: Socio-demographics, race/ethnicity and nativity questions, modified version of the CES-D, two yes/no help-seeking questions. **Analysis:** Chi-square statistics and logistic regression analyses.	**Psychological distress:** 1392 (18%) mothers had moderate to severe depressive symptoms. **Help-seeking:** 58.7% of women with depressive symptoms did not feel they needed emotional/psychological help, and 74.2% did not talk to a HCP regarding emotional or psychological problems. **Help-seeking likelihood:** Foreign-born mothers, and mothers from racial/ethnic minorities (Asian, black and Hispanic) were least likely to feel the need to seek help, and least likely to talk to a professional about emotional or psychological problems, compared to US-born and white mothers who were more likely to feel the need for help and talk to a professional.
Isacco, Hofscher, & Molloy (2015). USA	Explore fathers' help-seeking behaviours, and whether greater stress is associated with less help-seeking.	**Participants:** 1989 fathers with a child approximately 3-years-old. Mean age: 31 years, mean income: $46,156. 50% were African American, 29% white, 13% other/mixed, 4% American Indian, 3% Asian American, 0.1% Hispanic. 68% had reached High School Diploma or less.	**Design**: Quantitative correlational analysis of longitudinal cohort data. **Measures**: Socio-demographics, parenting stress, Composite International Diagnostic Interview-Short Form[14] , yes/no question about seeking counselling	**Help-seeking behaviours:** Only 3.2% of fathers sought therapy or counselling for mental health. **Help-seeking barriers:** Increases in depression symptoms were significantly associated with decreased likelihood to help-seek.

		Recruitment: From hospitals across approximately 20 cities.	**Analysis:** Descriptive statistics, logistic regression.	
Mickelson, Biehle, Chong, & Gordon (2017). USA	Explore the role of perceived stigma on PPD symptoms and help-seeking, and whether this differs for mothers and fathers.	**Participants:** 92 married or cohabiting couples, 1-4 months postpartum. Most with income >$60K (72.8%). Mean age: 28.1 years (mothers), 29.8 years (fathers). Participants were mostly white (mothers 89.4%; fathers; 88.1%), college educated or higher (mothers 76.6%; fathers 65.2%), and in full-time employment (mothers 69.1%; fathers 89.2%). **Recruitment**: Recruited from local birthing classes and online.	**Design**: Quantitative cross-sectional study. **Measures**: Socio-demographics, CES-D, Postpartum Depression Screening Scale[15] , Self-Efficacy for Parenting Tasks[16] , questions on stigma and support seeking **Analysis**: Descriptive statistics, mediation models, chi-square analyses, MANOVAs	**Psychological distress:** 23% mothers and 9.9% fathers had possible clinical depression. From 1-4 months, PPD symptoms significantly decreased in mothers and fathers. **Help-seeking behaviours:** indirect help-seeking significantly decreased for fathers (not mothers) from 1-4 months. **Help-seeking barriers:** Greater indirect (thus less effective) informal help-seeking was significantly associated with greater internalised and externalised stigma, and with increased depression symptoms for mothers and fathers. **Predictors**: For mothers at 1-month postpartum, internalised stigma significantly predicted less parenting efficacy, more indirect help-seeking, and more PPD symptoms. For fathers at 1-month postpartum, experienced stigma significantly predicted less parenting efficacy and more PPD symptoms.
Prevatt & Desmarais (2017). USA	Explore barriers and facilitators to disclosure of Postpartum Mood Disorder (PPMD)	**Participants:** 211 women within 3 years postpartum. Mean age: 32.99 years (range 22-45 years). Mostly white (91%), in a partnered relationship (98%), university educated (87%), employed	**Design**: Quantitative cross-sectional community-based participatory research. **Measures**: Socio-demographics, Perceived Barriers to Psychological Treatment[17] ; Depression,	**Psychological distress:** 51% reported disrupted postpartum mood, 49% of whom had a diagnosis. The sample's mean stress subscale score was moderate (M=13.83). **Help-seeking**: 21% did not disclose postpartum mood disorder symptoms to a HCP. Those who did, most frequently disclosed to their OB-GYN (53%), then

	symptoms to professionals	(61%), and over 75% had a household income >$70K. **Recruitment**: Convenience and snowball sampling by adverts placed in services and online.	Anxiety, and Stress Scales (DASS-21) [18] , Maternity Social Support Scale[19] . **Analysis:** Descriptive statistics, correlations, linear and logistic regressions.	paediatrician (37%), and were least likely to disclose to primary care staff (2%). **Help-seeking barriers:** 46% of women reported at least one barrier, and one third reported multiple, with stigma (19%), time constraints (18%), and low motivation (16%) most frequently reported. Higher self-identification of postpartum symptoms and stress were associated with greater perceived barriers to treatment.
Reilly et al. (2014). Australia	Explore whether past or current mental health assessment with or without referral for additional support is associated with perinatal help-seeking.	**Participants:** Women reporting significant emotional distress during pregnancy (N=398) or 12 months postpartum (N=380). Mean age: 34.8, majority living with partner (93.7%), completed a university degree (56.4%), English-speaking background (94.2%), living in urban locations (55.4%). **Recruitment**: Not described.	**Design**: Quantitative design using data from a longitudinal cohort, and sub-surveys mailed to participants for this study. **Measures**: socio-demographics, questions on help-seeking, assessments and referrals, emotional distress and prior treatment. **Analysis:** Descriptive analyses, logistic regressions.	**Help-seeking barrier/facilitator:** Women not assessed for mental health were significantly less likely to seek formal help (93% less likely prenatally; 90% less likely postnatally) compared to women assessed and referred for mental health support. Women assessed but not referred for mental health support were significantly less likely to seek formal help, compared to women assessed and referred. **Informal help-seeking**: Most women sought help from partner/family/social networks (85.7% prenatally; 90.3% postnatally). No significant differences were found in women who were assessed/referred or not. **Formal help-seeking:** Women most often sought help from GPs (27.4% prenatally; 42.6% postnatally), midwives (24.1% prenatally) and child health nurses (31.6% postnatally).
Rominov et al. (2017). Australia	Explore men's help-seeking experiences	**Participants:** 20 fathers expecting or parenting an infant <2 years old. Mean age: 33.9 years, all with their	**Design**: Descriptive qualitative cross-sectional study.	**Help-seeking preferences:** Fathers expressed a preference for seeking support from social networks, particularly friends who were fathers.

	for perinatal mental health and parenting, support needs, and help-seeking barriers and facilitators.	partners, in paid employment, mostly living in urban areas (80%) and educated to undergraduate degree or higher (65%). **Recruitment**: Non-probability snowball sampling via word-of-mouth and advertising online and in parenting groups.	**Measures**: Socio-demographics, and face-to-face or telephone semi-structured interviews. **Analysis:** Thematic content analysis.	**Help-seeking barriers:** Stigma, not wanting to draw attention away from partner and baby, lack of awareness of support available (assumed resources for mother and baby), inflexible work arrangements (perinatal services open during business hours, limited paternal leave from work, workplace lacking acknowledgement of fathers as co-parents). **Desired help-seeking facilitators:** For perinatal services to include and actively engage fathers, recognise the father role, give father-specific information, make language in parenting resources more father inclusive, and improve father awareness of support available.
Stone et al. (2015). USA	Evaluate associations between perinatal stressors, postpartum depressive symptoms, and help-seeking	**Participants:** 5395 postpartum mothers. 806 had PPD symptoms. Mean age: 28 years; 52.9% completed some/all college; 50% married; 37% had a family income ≥$50K; 34.7% had ≤$15K; 56% white, 20% Hispanic, 11.7% black, 10.5% Asian. **Recruitment**: Surveys mailed to mothers randomly selected from state birth certificate information.	**Design**: Quantitative cross-sectional study. **Measures**: Socio-demographics, questions on stressful events, mood, help-seeking, covariates associated with stressful events and depression. **Analysis:** Regression analyses.	**Help-seeking behaviours/barriers:** Only 38.8% of mothers with perinatal depressive symptoms and any category of stressor sought help from a healthcare provider, and mothers with depressive symptoms and no stressor were even less likely to seek help from a healthcare provider (27.2%). Of mothers with perinatal depressive symptoms, 49.6% had partner-related stressors, and 48.6% had financial-related stressors.
Sword et al. (2008). Canada	To explore women's help-seeking	**Participants:** 18 mothers, average 8 weeks postpartum; mean age: 29.4 years; 72.3%	**Design:** Qualitative approach with cross-sectional design.	**Help-seeking barriers:** Individual level (normalising, limited understanding, waiting to improve, discomfort discussing psychological distress, fear); social network

	experiences following referral for PPD	married/living with partner; wide range of household income and education levels. **Recruitment**: Women with probable PPD receiving early intervention were recruited by the public health nurse.	**Measures**: Socio-demographics, EPDS. **Analysis**: Content analysis	(normalising, low understanding); healthcare (normalising, unacceptable intervention offers, disconnected care pathways). **Help-seeking facilitators:** individual level (symptom awareness, feeling unlike self); social network (encouragement, expressions of worry and concern); health system (established, supportive relationships, validation of PPD, follow-up, outreach, timely care).
TaPark, Goyal, & Rosidi (2015). USA	Explore Vietnamese American mothers' perceptions and experiences of PPD and mental health help-seeking	**Participants:** 15 married Vietnamese-American mothers, 1 year postpartum, who had been living in the USA an average of 18 years (range 5-35 years). 14 were born in Vietnam, 8 employed full-time, 6 on maternity leave, 1 unemployed, 12 educated to college level, and 2 completed university education. **Recruitment**: Convenience and snowball sampling via flyers posted in community, and word-of-mouth.	**Design**: Mixed-method qualitative and quantitative cross-sectional pilot study. **Measures**: Socio-demographics, mental health service use experience, EPDS, semi-structured interview. **Analysis:** Descriptive statistics, and content analysis.	**Prevalence:** 5 scored ≥10 on the EPDS, indicating possible PPD. Qualitatively, 8 mothers reported "sadness". **Likeliness to help-seek:** 8 mothers did not feel it was severe enough. 5 said they would not seek professional help. Most (n=14) said they would if they really needed it, and family would play a large role. 1 mother reported receiving psychological help, 2 accessed spiritual help. **Help-seeking preferences:** preference for help from social networks (n=13), alternative medicines (n=2), religious/spiritual help (n=2), or distraction activities (n=11) over professional help-seeking. **Help-seeking barriers:** Lack of culturally appropriate care (n=14), stigma (n=13), shame/embarrassment (n=6), financial difficulties (n=5), lack of knowledge of help available, medication fear (n=3), hopelessness (n=2), denial (n=2).

[1]EPDS (Cox, Holden, & Sagovsky, 1987); [2]Primary Care PTSD screen (Prins et al., 2004); [3]Kessler Psychological Distress Scale (Kessler et al., 2002); [4] Brief Resilience Scale (Smith et al., 2008b); [5] Inventory of Attitudes Towards Seeking Mental Health Services (Mackenzie et al., 2004); [6] Test of Self-Conscious Affect-3 (Tangney, Dearing, Wagner, & Gramzow, 2000); [7] Event-Related Shame and Guilt Scales (Orth, Berking, & Burkhardt, 2006); [8] Social Support Questionnaire 6 (Sarason, Sarason, & Shearin., 1987); [9] EPDS (Portuguese version; Areias, Kumar, & Figueiredo, 1996); [10] Hospital Anxiety and Depression Scale (Portuguese version; Pais-Ribeiro et al., 2007); [11]General Help-Seeking Questionnaire (Rickwood et al., 2005); [12]Centre for Epidemiologic Study-Depression Scale (CES-D; Radloff, 1977); [13]Brief Measure of Worry

Severity (Gladstone et al., 2005); [14] Composite International Diagnostic Interview-Short Form (Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998); [15] Postpartum Depression Screening Scale (Beck & Gable, 2000); [16] Self-Efficacy for Parenting Tasks (Coleman & Karraker, 2003); [17] Perceived Barriers to Psychological Treatment (Mohr et al., 2010); [18] Depression, Anxiety, and Stress Scales (DASS-21; Lovibond & Lovibond, 1995); [19] Maternity Social Support Scale (Webster et al., 2000).

Who do mothers turn to for help?

Informal sources

Quantitively, two studies found most women help-seek from family, friends, or partners for emotional distress (85.7% prenatally, 90.3% postnatally, Reilly et al., 2014), depression and anxiety (83.3%, Henshaw et al., 2013). Less frequently sought were helplines or internet support (13.9%, Henshaw et al., 2013; 10.8% prenatally, 17.9% postnatally, Reilly et al., 2014). Among Portuguese women, few sought help for PPD from social networks (35.9%, Fonseca et al., 2015). Another Portuguese sample nevertheless expressed significantly higher help-seeking intentions from partners than from professionals, despite perceiving high encouragement from partners to seek professional help (Fonseca & Canavarro, 2017). Only one of these studies reported race/ethnicity demographics (61.1% white participants, Henshaw et al., 2013), one did not describe sampling procedures (Reilly et al., 2014), while the rest used convenience sampling, making these findings vulnerable to selection bias and generalisability difficulties.

Qualitatively, 13 of 15 Vietnamese-American mothers said they would seek informal help for PPD, and their families would largely influence professional help-seeking decisions – suggesting family are approached first (TaPark et al., 2015). Syrian refugees said family would be most helpful, and were strongly against medication (Ahmed et al., 2017). Ahmed and colleagues' (2017) findings may have limited generalisability to other refugees due to purposeful sampling and few participants (n=12), yet it is important to consider research with this vulnerable population, with whom UK services have increased likelihood of working.

Formal sources

Two large American studies using registered births as sampling frames, observed formal help-seeking by 25.8% and 38.8% of women with depressive symptoms (Huang et al., 2007; Stone

et al., 2015). Help-seeking rates increased with more trauma, financial or emotional-related stressors (Stone et al., 2015), and decreased among black (16.8%), Asian (12.6%), and foreign-born (11.7%) mothers (Huang et al., 2007). Both studies satisfied many quality appraisal criteria, for instance by having large, clearly defined samples, and clearly described data analysis procedures. Stone et al. (2015) is the only paper in this review reporting random sampling, and one of the few assessing confounders. However, as with most studies in this review, the cross-sectional nature of these findings only allows correlational relationships to be observed.

Three studies with smaller convenience samples (n=36-211) observed formal help-seeking by 13.6% of women with PPD symptoms, despite 38.4% expressing willingness to help-seek (Fonseca et al., 2015); 16.7%-50% of women with depression and anxiety, despite 60.4% considering help-seeking (Henshaw et al., 2013); and 79.3% of women with PPMD[3] (Prevatt & Desmarais, 2017). These studies had self-selecting participants, possibly over-representing women more likely to recognise psychological distress and the need to help-seek, which could also explain the unusually high prevalence of women reporting PPMD (51%) in Prevatt and Desmarais' (2017) sample.

Women reporting significant emotional distress most frequently sought formal help from GPs (27.4% prenatally, 42.6% postnatally), child health nurses (31.6% postnatally), and midwives (24.1% prenatally), although figures changed significantly based on whether women received mental health assessments and referrals (Reilly et al., 2014). Reilly et al. (2014) clearly described data analysis procedures, but not sampling methods or race/ethnicity demographics.

[3] Postpartum mood disorder encompasses 'baby blues', postpartum depression, and psychosis (Seyfried & Marcus, 2003).

Nor did they use validated outcomes measures – calling into question the validity and representativeness of their findings.

Two qualitative studies reported formal help-seeking. One Vietnamese-American woman reported receiving professional help for psychological distress, while the remaining 14 expressed not wanting professional help (TaPark et al., 2015). However, when asked again, most said they would formally help-seek if necessary. Similarly, Syrian refugee women said they would overcome barriers to formally help-seek if they really needed to (Ahmed et al., 2017).

> *"What is important to me, is to treat myself so I can live comfortably with my family."*
>
> (participant in Ahmed et al., 2017).

Who do fathers turn to for help?

Informal sources

Qualitatively, fathers reported a preference to help-seek from social networks, particularly friends who were fathers, which increased their likelihood to access other support (Rominov et al., 2017). Quantitively, 49% of fathers reported not wanting to 'bother' their partner, although the same study reported most fathers spoke with partners (91%), family (76%), and friends (71%) to cope with stress (Colquhoun & Elkins, 2015).

Rominov et al. (2017) used non-probability sampling, but provided clear descriptions of study procedures and analyses. Colquhoun and Elkins (2015) did not describe sampling or clearly describe study and analyses procedures. Neither study reported race/ethnicity demographics. Research on fathers' informal help-seeking therefore lacks quality and quantity.

Formal sources

Quantitatively, Isacco et al. (2015) found 3.2% of fathers of three-year-old children accessed talking therapies, whereas Colquhoun and Elkins (2015) observed 35% of expectant/new fathers sought professional psychological help. However, Isacco et al. (2015) asked participants one specific question about receiving counselling in the past year – missing other formal help-seeking, or help-seeking during the perinatal period. Colquhoun and Elkins (2015) asked participants more broadly whether they sought professional help.

Qualitatively, Colquhoun and Elkins (2015) found some men reported formal help-seeking for alcohol-use or depression. Rominov et al. (2017) did not report whether participants accessed formal help, despite asking them.

What are the main help-seeking barriers?

Poor recognition, understanding, or knowledge of the need for help and the options available

Mothers

Women with depression symptoms reported difficulties recognising their distress and need for help, in qualitative (Sword et al., 2008; TaPark et al., 2015) and quantitative studies (44%, Fonseca et al., 2015; 58.7%, Huang et al., 2007), with foreign-born and BAME women less likely to recognise difficulties than white women (Huang et al., 2007).

Qualitatively, women reported difficulty differentiating between depression and normal mood changes (Bilszta et al., 2010; Sword et al., 2008), denying their sadness/depression, not

knowing the treatment available (TaPark et al., 2015; Bilszta et al., 2010), whether they had enough reason to help-seek, and waiting for symptom improvements (Sword et al., 2008). Of these studies, Sword et al. (2008) most clearly described their methodology, sampling procedures, data collection and analysis.

Quantitively, women reported poor awareness of needing help (76%) or treatment options available (70.2%), and women who perceived knowledge as important to help-seeking tended to be younger, unemployed, with no psychiatric history (Fonseca et al., 2015).

Fathers

Fathers quantitively indicated not knowing where to start with help-seeking (20% prenatally; 27% postnatally), and qualitatively and quantitatively (27%) reported incomplete understanding of perinatal depression and anxiety, assuming it is only experienced by women (Colquhoun & Elkins, 2015). Rominov et al. (2017), also found fathers reported limited knowledge about support, and assumed resources were for mother and baby.

> *"Depression is all about the mother, nothing for the father – everything is for the mother and child."*
>
> (father in Colquhoun & Elkins, 2015).

Stigma, shame, and feared disapproval

Mothers

Mental health stigma was widely cited as a help-seeking barrier across American (Byatt et al., 2013; Prevatt & Desmarais, 2017), Vietnamese-American (TaPark et al., 2015), Syrian

(Ahmed et al., 2017), Canadian (Foulkes, 2011; Sword et al., 2008), Australian (Bilszta et al., 2010), and British samples (Dunford & Granger, 2017).

Stigma of being perceived as a 'bad mother' (Sword et al., 2008) sometimes led to symptom-denial (Bilszta et al., 2010). One woman worried employers would not hire her (Sword et al., 2008). Women described feeling hurt by significant others invalidating their difficulties (Foulkes, 2011), feeling pressure not to fail, and guilt about not coping (Bilszta et al., 2010; Foulkes, 2011). However, Dunford and Granger (2017) found guilt-proneness was not significantly associated with help-seeking attitudes.

> *"I was worried that he would look at me as "Oh she's not doing a very good job" and my in-laws too, "…she's not doing a very good job as a mother"."*
>
> (woman in Foulkes, 2011).

Related to stigma, was shame – voiced by six Vietnamese-American women (TaPark et al., 2015). Fonseca et al. (2015) observed more attitudinal barriers (e.g. shame or embarrassment) for younger, less educated, unemployed women. A cross-sectional study with 183 UK mothers found shame-proneness significantly predicted fear of stigma and negative help-seeking attitudes when controlling for social support and demographics (Dunford & Granger, 2017). This study used validated measures, clearly reported data analysis, controlled for confounders, and reported a completion rate (77%), finding no significant differences to non-completers.

Another quantitative study found women's internalised stigma significantly mediated the relationship between more indirect[4] (thus less effective) informal help-seeking and more PPD symptoms at 1-month postpartum (Mickelson et al., 2017). The authors presented their findings as though some variables predicted others, but later mention cross-sectional findings do not allow causal ordering of variables.

Fathers

Mickleson and colleagues' (2017) model of stigma mediating indirect help-seeking and PPD was not significant for fathers. However, the authors observed significant positive correlations between stigma and indirect help-seeking in fathers. Qualitatively, fathers reported internalised pressure to cope and persevere, negative attitudes towards PPD or anxiety (Colquhoun & Elkins, 2015), hesitancy to help-seek, and considered depression as 'weakness' – with comments reflecting mental health stigma (Colquhoun & Elkins, 2015; Rominov et al., 2017).

> *"If someone told me to see a psych, I'd feel insulted. I'd think what do they think of me?"*
>
> (father in Colquhoun & Elkins, 2015).

Quantitively, 77% of fathers indicated: "When I'm stressed or down about being a dad I 'suck it up and just get on with it'", 47% of expectant/new fathers expressed not wanting to admit coping difficulties, and 31% of new fathers indicated believing "postnatal depression and anxiety in men is a sign of weakness" (Colquhoun & Elkins, 2015).

[4] Indirect help-seeking is described as passive, unclear, and subtle, for example by appearing to others as sad, without saying why or giving details (Barbee & Cunningham, 1995).

Interpersonal barriers and the need for privacy

Mothers

Women reported their social networks had limited knowledge or understanding of PPD and normalised symptoms (Sword et al., 2008). Vietnamese-American women reported insufficient spousal support (TaPark et al., 2015), and Syrian refugees suggested husbands could stop women help-seeking, although denied this regarding their husbands (Ahmed et al., 2017). Family emerged as important to help-seeking (TaPark et al., 2015; Bilszta et al., 2010).

> *"[My dad] didn't want me painting this impression to everyone that things weren't right with me."*
>
> (mother from Bilszta et al., 2010).

Some women expressed concerns about information being shared among the community, such as their child's school (Guy et al., 2014). Specific to non-English speakers, were privacy concerns regarding interpreters from the same cultural community (Ahmed et al., 2017).

Fathers

'I would be betraying my partner if I shared our problems outside of the family' was agreed with by 40% of fathers, yet 49% also indicated not wanting to 'bother' their partner (Colquhoun & Elkins, 2015). Fathers reported not wanting to draw attention away from their partner and baby by help-seeking (Rominov et al., 2017). This suggests fathers may feel responsible for prioritising mother and baby's wellbeing above their own. Fathers also expressed privacy concerns among the community (Rominov et al., 2017).

Level of psychological distress

Mothers

Quantitively, increased depression was significantly associated with decreased help-seeking (Huang et al., 2007). Higher self-identification of PPD, anxiety, and stress were significantly associated with greater perceived treatment barriers (Prevatt & Desmarais, 2017). Higher perinatal distress was significantly associated with lower help-seeking from partners, and significantly lower perceived encouragement from partners to seek professional help, compared to women with less distress (Fonseca & Canavarro, 2017). Mickelson et al. (2017) observed a significant correlation between increased PPD symptoms and more indirect (i.e. passive) informal help-seeking. These results suggest that women with greater psychological need are less likely to actively help-seek. Qualitative studies also cited psychological distress symptoms as barriers, such as hopelessness (n=2; TaPark et al., 2015), poor motivation, and difficulties thinking clearly (Bilszta et al., 2010).

Fathers

As with mothers, Mickelson et al. (2017) found fathers' *indirect* informal help-seeking increased with PDD symptoms, suggesting that fathers may help-seek less assertively when depressed.

Discomfort and fear of help

Mothers

Mothers discussed initial discomfort discussing psychological distress with HCPs (Sword et al., 2008), and fear of medication (Foulkes, 2011; Guy et al., 2014), side-effects (n=3; TaPark

et al., 2015), hospitalisation (Guy et al., 2014), and losing parental rights of their children (Byatt et al., 2013; Guy et al., 2014; Foulkes, 2011; Sword et al., 2008).

> *"I always had in the back of my mind that if something ever happened between my husband and I that he would get the kids cause I'm just not doing a good job."*
>
> (mother in Foulkes, 2011).

Guy and colleagues' (2014) findings are from secondary analysis of existing qualitative data, so must be considered with caution. The data were collected for different (unreported) research questions, 88% of the sample were overweight, not all had psychological distress, and results were not separated accordingly. Additionally, secondary researchers can be unaware of nuances from data collection processes relevant to interpreting the results (Cheng & Phillips, 2014).

Fathers

Fathers indicated expecting discomfort when first arriving for professional help (19%-23% of expectant/new fathers), and 22% of new fathers felt they would not fit in (Colquhoun & Elkins, 2015). Fathers expressed discomfort qualitatively too:

> *"A guy isn't supposed to hang out with his mates and start crying. It isn't easy for guys to share their problems."*
>
> (father in Colquhoun & Elkins, 2015).

Practical and physical barriers

Mothers

Quantitively and qualitatively, women reported limited finances (63.8%, Fonseca et al., 2015; 33.3%, TaPark et al., 2015), limited time (50.8%, Fonseca et al., 2015; 18%, Prevatt & Desmarais, 2017), potential negative consequences from missing work for appointments (38.6%), and lacking travel means (19.3%, Fonseca et al., 2015). Physical barriers were less prominent, with one study citing poor sleep and physical discomfort from delivery (Bilszta et al., 2010). Younger, less educated, unemployed women with lower household incomes most often named practical barriers (Fonseca et al., 2015).

Fathers

Quantitively, fathers reported limited time (21% prenatally, 31% 1-4 years postnatally), money (26% <1 year postnatally), locally available support (23% <1 year postnatally), and limited energy after work (24% of fathers) as barriers (Colquhoun and Elkins, 2015). Qualitatively, Rominov et al. (2017) observed work prevented men's help-seeking via limited paternal leave, poor workplace acknowledgement of fathers as co-parents, and services' opening hours.

Healthcare provider issues

Mothers

Women raised healthcare provider issues, such as negative past experiences, limited quick and easy access to care (Guy et al., 2014), difficulties finding and accessing appropriate support, poor continuity of care, lack of culturally appropriate care (TaPark et al., 2015), ambivalence about HCPs' role to attend to mothers and psychological distress, and the lack of a single discipline responsible for maternal mental health (Byatt et al., 2013; Foulkes, 2011).

> *"there's just nothing that's done to help you with the emotional side of becoming a mum and childbirth. One maternal nurse just told me to suck it up. Babies scream. That was helpful!"*
>
> (mother in Bilszta et al., 2010).

Women who did help-seek experienced long waiting-lists, disappointment with services, poor continuity of care (Bilszta et al., 2010; Sword et al., 2008), and dislike of medication (Foulkes, 2011; Sword et al., 2008). Following disclosure, responses from professionals involving normalisation and reassurance rather than active treatment left some women feeling invalidated, unable to cope, and silenced (Bilszta et al., 2010; Sword et al., 2008).

Fathers

Fathers qualitatively reported feeling marginalised by services' poor acknowledgement of fathers as co-parents, limited father-specific support, HCPs' attitudes (Rominov et al., 2017), engagement, few opportunities to help-seek as most attention is on mothers, and ineffective responses from HCPs following help-seeking attempts (Colquhoun & Elkins, 2015).

> *"I started to tell her [nurse] about my own stress and anxiety and she said 'I can't really help'."*
>
> (father in Colquhoun & Elkins, 2015).

> *"a nurse came in and she was talking like I was a ghost in the room – it's all about the mums… I had a meltdown that I was a nobody."*
>
> (father in Colquhoun & Elkins, 2015).

What are the main help-seeking facilitators?

Desire for services to reduce stigma

Mothers

Across two studies, women voiced desires for services to reduce stigma via addressing mental health as well as physical health (Byatt et al., 2013; Foulkes, 2011), and for comprehensive maternal-child care whereby mothers and babies are equally valued (Foulkes, 2011), and HCPs have a de-stigmatising, therapeutic approach to screening (Byatt et al., 2013).

Fathers

Fathers suggested services make help-seeking less stigmatising by reframing it:

> *"reframing the whole thing as, getting help for yourself is a way of helping your baby".*
>
> (father in Rominov et al., 2017).

Others' influence

Mothers

Informal figures in women's lives have been associated with greater help-seeking. Fonseca & Canavarro (2017) found women's intentions to help-seek from partners was significantly positively correlated with formal help-seeking intentions. Additionally, perceived encouragement from partners was significantly positively associated with women's intentions to help-seek from partners and professionals. Qualitatively, women highlighted how significant others' encouragement and concern facilitated formal help-seeking (Sword et al., 2008), and some women said family were influential to help-seeking decisions (TaPark et al., 2015).

Regarding professionals' potential to facilitate help-seeking, Reilly et al. (2014) found women not assessed for mental health were significantly less likely to help-seek from midwives, GPs, or mental HCPs (93% less likely prenatally, 90% less likely postnatally) compared to women assessed and referred for mental health support. Those assessed but not referred were also significantly less likely to formally help-seek, compared to when assessed and referred. This also has the potential to become a barrier under 'healthcare provider issues'. The authors found informal help-seeking was not significantly associated with assessments and/or referrals.

Women recalled supportive HCP relationships, validation of PPD, timely care, outreach care, and follow-up as important (Sword et al., 2008). Some women named services' and professionals' attributes as facilitating help-seeking, including validation, kindness, empathy, availability, knowledge, active assistance, and continuity of care (Bilszta et al., 2010).

Fathers

Fathers who sought formal help for anxiety and depression qualitatively reported more partner-support, and quantitatively reported strong partner relationships and supportive workplaces (Colquhoun and Elkins, 2015). A disruptive pathway was observed in fathers with partner strain help-seeking more, which Colquhoun and Elkins (2015) supposed was from desperation.

Personal factors

Mothers

Women reported symptom-awareness and not feeling themselves facilitated help-seeking (Sword et al., 2008).

Fathers

Quantitively, Colquhoun and Elkins (2015) observed increased formal help-seeking in fathers whose coping strategies involved family and friends. A disruptive pathway to increased formal help-seeking observed in this study involved greater internal pressure and depression, which again the authors supposed led to last-minute help-seeking from desperation.

Fathers' desire for father-specific support

Qualitatively, fathers voiced wanting perinatal services to actively include and engage fathers, recognise their role, provide father-specific information, use father-inclusive language, and improve fathers' awareness of support available (Rominov et al., 2017). Fathers spoke about the importance of the timing of support, whereby face-to-face contact with HCPs would provide good opportunities to offer support regarding fathers' emotions or role (Colquhoun and Elkins, 2015). The idea for fathers' groups received positive support.

> *"I really like the idea of dad's groups. Being able to discuss problems, milestones etc. with other guys".*
>
> (father in Colquhoun & Elkins, 2015)

Quantitively, 63% of fathers indicated interest in information about managing parenting stress and receiving fathering information during pregnancy scans, 42% expressed interest in a course for fathers and partners to learn about new parenthood and managing relationship changes, and 38% of fathers expressed interest in father-child education groups (Colquhoun & Elkins, 2015).

Table 5. Strengths and limitations of included studies

Authors, and date	Design and sample	Strengths	Limitations
Ahmed, Bowen, & Xin Feng (2017)	Qualitative cross-sectional design[1] with quantitative data with 12 Syrian refugee women in Canada	• Study aims and sample were clearly defined. • Validated tools were used to measure mental health symptoms, and the focus group procedure was described reasonably well. • Data analysis described well. • Ethical approval and oral participant consent obtained. • Limitations considered in the discussion. • No competing interests declared by the authors.	• Preliminary study with a small sample of Syrian refugee women in one Canadian city limits how far findings can be generalised to other refugees. • Purposeful sampling of volunteers – potential for selection bias. • Non-responders were not reported. • Meanings may have got lost in translation from Arabic to English. • Group setting and Arabic translator may have restricted what women shared on the sensitive topic.
Bilszta et al. (2010)	Qualitative cross-sectional design with 40 women in Australia.	• Study aims were clearly defined. • Focus group discussion guide is provided • Qualitative data collection appropriate for the aims • Ethical approval and oral participant consent obtained. • Limitation considered in the discussion (although only one limitation)	• Non-probability sampling, increasing chance of selection bias. • Non-responders were not reported. • Most participants were in a structured PND treatment programme, and a minority were in a community or mutual support group, limiting the extent to which findings can be applied to women not accessing support. • Participant ethnicity, education, or employment not described. • Funding sources or potential conflicts of interest not described.

Byatt, Biebel, & Friedman (2013)	Preliminary qualitative cross-sectional study with 27 white women in the USA.	• Study aims and sample clearly defined. • Limitations considered in the discussion. • Inclusion of women with psychological distress beyond just depression improves generalisability. • Inter-rater agreement (≥90%) reported for coding. • Funding sources described.	• Participants self-identified as having mental health symptoms, but these were not measured with validated tools. • Participants purposefully sampled from a community organisation providing advocacy and education to perinatal women, may bias the sample. • 100% white sample limits generalisability • No reporting of non-responders.
Colquhoun & Elkins (2015)	Multi-method qualitative and quantitative Australian study with fathers.	• Study aims and objectives clearly outlined. • Tools used were validated and appropriate to the aims. • Basic data was well-described and illustrated. • Limitations were discussed.	• Methods, data analyses, and sample information (e.g. no race demographics) not clearly described. • No information on recruitment procedures or sampling frame. • No information on non-responders. • Ethical approval, consent, or conflicts of interest not reported.
Dunford & Granger (2017)	Quantitative cross-sectional correlational design with 183 mothers of infants aged 4 weeks to 1 year in the UK.	• Study aims clearly defined. • Validated and appropriate measures. • Response rate provided. • Data analysis procedures and measures of statistical significance were clearly reported. • Basic data well-described and presented. • Limitations considered in the discussion. • Informed consent was obtained from participants. • Authors reported no conflict of interest.	• Sample partially described, in that majority demographics are provided, but not the range of different demographics. • Sample may have an over-representation of women with PPD symptoms who are also help-seeking as they were recruited from websites focused on PPD. • Characteristics of non-responders not reported. • Ethical approval was not reported. • Study design does not allow for causality to be determined.

Fonseca, Gorayeb, & Canvarro (2015)	Quantitative cross-sectional online survey with 656 women in Portugal	• Study aims clearly defined. • Validated tool used to measure depression symptoms. • Study procedures, data analysis procedures, and measures of statistical significance were clearly reported. • Ethical approval, participant informed consent, and funding arrangements reported. • Basic data well-described and presented • Limitations considered in the discussion.	• Potential selection bias via participants volunteering for an internet survey, who may be more likely to recognise their psychological problems and the need to seek help than non-volunteers. Also, those without internet are not represented. • Non-responders not measured. • Participant ethnicity not described, limiting our knowledge of what ethnic backgrounds results can be generalised to. • Questions to measure help-seeking were not piloted, and only had dichotomous yes/no response options.
Fonseca & Canvarro (2017)	Quantitative cross-sectional online survey with 231 women in Portugal	• Study aims and sample clearly defined. • Measures used were validated and appropriate to the study's aims. • Study procedures, data analysis procedures, and measures of statistical significance clearly reported. • Potential confounders were accounted for. • Limitations considered in the discussion. • Ethical approval, participant informed consent, and funding arrangements reported.	• Potential selection bias via participants volunteering for an internet survey, who may be more likely to recognise their psychological problems and the need to seek help than non-volunteers. Also, those without internet are not represented. • Non-responders not measured. • Participant ethnicity not described, limiting our knowledge of what ethnic backgrounds results can be generalised to.
Foulkes (2011)	Qualitative interviews with 10 women in Canada	• Study aim broad but clearly defined. • Sample clearly defined. • Study procedures, and data analysis procedures clearly reported. • Ethical approval and participant informed consent reported.	• Small sample size. • Non-probability sampling – increasing likelihood of selection bias and reducing generalisability. • Findings only generalisable to well-educated, middle-class, married white women.

		• Limitations considered in the discussion.	• Funding arrangements and conflict of interest not reported. • Some participants self-identified as having PPD symptoms, but these were not measured with validated tools.
Guy et al. (2014)	Secondary qualitative analysis of data from a longitudinal study of 25 women in the USA.	• Aims of secondary analysis clearly defined. • Sample characteristics clearly described. • Secondary data analysis clearly described. • Validated and appropriate tool used to measure depression. • Limitations considered in the discussion.	• Aims of primary study not reported. • Sample recruited to meet different aims, meaning that 88% of the sample have a BMI ≥25, making the sample not fully representative of the general population. • Recruitment methods or sampling frame not reported. • Participants self-selected, increasing the likelihood of selection bias and limited generalisability. • Ethics, consent procedures, or conflicts of interest not reported.
Henshaw, Sabourin, & Warning (2013)	Prospective descriptive quantitative design with 36 women in the USA	• Sample characteristics clearly described. • Depression and anxiety were measured with validated tools. • Ethical approval and written informed consent was obtained. • No funding relationships or conflicts of interest. • Limitations considered in the discussion.	• Characteristics of non-responders not reported. • Participants sampled from a private hospital, limiting the generalisability to women who can access private healthcare. • Help-seeking actions were measured using non-validated items developed by the first author, with yes/no responses. • Potential confounders not accounted for. • 6-week follow-up data not separated from initial data.
Huang et al. (2007)	Quantitative, Longitudinal[2] Survey-Birth Cohort Nine-	• Study addresses a clearly focused issue. • Appropriate sampling frame using registered births.	• Sampling procedures only partially described, without detail of whether random sampling was used. • Characteristics of non-responders not reported. • Help-seeking assessed without a validated tool.

	Month data of 7676 mothers in the USA.	• The large sample size and over-sampling for ethnic minorities allows for greater generalisability. • Sample clearly defined, and response rate reported. • Depression symptoms measured with validated tool. • Data analysis procedures clearly described. • Limitations considered in the discussion. • Funding sources reported.	• This study used data collected at a single timepoint from a longitudinal cohort, so it will have the same disadvantages as cross-sectional study designs and lack the benefits of prospective longitudinal designs.
Isacco, Hofscher, & Molloy (2015)	Quantitative correlational analysis of data from a longitudinal study of 1989 fathers in the USA.	• Large sample size allows for greater generalisability. • Sample size justified. • Sample clearly defined. • Psychological distress measured via diagnostic criteria. • Data analysis procedures clearly described. • Limitations considered thoroughly in the discussion. • Funding sources and the absence of conflicting interests reported.	• Hypotheses given without study's aims/objectives clearly stated. • Sampling procedures only partially described, without detail of whether random sampling was used. • Characteristics of non-responders not reported. • Ethical approval and informed consent not reported. • Potential confounders not accounted for. • Mental health help-seeking measured via one 'yes/no' item, which potentially restricts the information it can obtain.
Mickelson et al. (2017)	Quantitative prospective cohort with 92 married/	• Study objectives clearly defined. • Depression and help-seeking measured either with validated tool or with good demonstrated internal consistencies. • Data analysis procedures and measure of statistical significance clearly described	• Non-probability sampling – increases likelihood of selection bias. • Low representation of ethnic minorities in the sample. • Ethical approval and informed consent not reported. • Measures of stigma and parenting efficacy have questionable internal consistencies.

	cohabiting couples in the USA	(including statistical procedures to account for power). • Change measured over time. • Characteristics of non-completers compared to completers (no significant differences). • Limitations considered in the discussion. • Funding arrangements reported.	• Cohort was only from 1-4 months postpartum, and mediators and outcomes were measured at the same wave. • The cross-sectional mediation model is suggestive of causal ordering and direction of relationships, when the nature of the data does not allow this to be inferred.
Prevatt & Desmarais (2017)	Quantitative, community-based cross-sectional participatory research study with 211 women in the USA.	• Study aims clearly defined. • Recruitment procedures described • Appropriate sampling frame. • Response rate of 73% reported. • Outcomes measured with validated tools. • Data analysis procedures clearly described in accordance with the study aims. • Limitations considered in the discussion. • Compliance with ethical standards, consent, and absence of conflicts of interest reported.	• Convenience and snowball sampling used, with self-selecting participants, which increases the likelihood of selection bias. • Homogenous sample limits generalisability. • Cross-sectional study design does not allow causality to be inferred.
Reilly et al. (2014)	Quantitative cross-sectional study with data from the Australian Longitudinal Study on Women's Health.	• Study aims clearly defined. • Data analysis procedures, and measure of statistical significance clearly described. • Confounders controlled for (but not told what the potential confounders are). • Limitations considered in the discussion. • Funding relationships reported.	• Sampling method by original study not described. • Outcome measures were not validated. • Demographics only presented for participants reporting significant emotional distress, rather than entire sample. • Differences between groups not described. • Racial demographics not reported on the sample, limiting the readers' ability to generalise the findings. • Controlled for confounders not described. • Ethical approval and informed consent not reported.

Rominov et al. (2017)	Descriptive qualitative cross-sectional study with 20 fathers in Australia	• Study objectives clearly defined. • Study procedures (including interview questions) and data analysis clearly described. • Limitations considered in the discussion. • Ethical approval and informed consent reported. • Funding relationships reported.	• Non-probability sampling, increasing likelihood of selection bias. • Racial demographics not reported on the sample, limiting the readers' ability to generalise the findings.
Stone et al. (2015)	Quantitative population cohort of 5395 mothers in the USA	• Study aims clearly defined. • Covariates associated with exposure and outcomes assessed as potential confounders. • Large, clearly described sample obtained via random sampling. • Study procedures and data analysis procedures clearly reported. • Limitations considered in the discussion. • Absence of conflict of interest reported.	• Characteristics of non-responders not measured. • Exposures and outcomes not measured with well-validated tools. • Informed consent not described.
Sword et al. (2008)	Qualitative cross-sectional study with 18 mothers in Canada	• Study aims clearly defined. • Study and data analysis procedures clearly reported. • Validated tool used to measure depression. • Limitations briefly discussed. • Ethical approval and informed consent reported. • Funding relationship reported.	• Small sample size. • Non-responders not reported. • Racial demographics not reported on the sample, limiting the readers' ability to generalise the findings. • Presence or absence of conflict of interest not reported.

TaPark, Goyal, Nguyen, Lien, & Rosidi (2015)	Mixed-method qualitative and quantitative cross-sectional US study of 15 Vietnamese-American mothers	• Study aims clearly defined. • Validated tool used to measure depression. • University approval and informed consent reported. • Sample, study procedures, and data analysis clearly described. • Funding relationship and absence of conflict of interest reported.	• Small sample size. • Self-selecting sample may increase selection bias. • Findings not separated between mothers who presented with probably PPD (n=5) on the EPDS and those who did not (n=10). • One limitation considered in the discussion (small sample size) – missing consideration of other limitations.

[1]Cross-sectional designs appraised using the Appraisal Tool for Cross-Sectional Studies (AXIS; Downes, Brennan, Williams, & Dean, 2016).
[2]Cohort designs appraised using the Critical Appraisal Skills Programme (CASP) Cohort Study Checklist' (2013).

Methodological considerations

While offering important considerations relevant to the psychological wellbeing of expectant and new parents, the reviewed articles have strengths and limitations (see Table 5). Most studies clearly described their objectives, methods, samples, and analyses. However, there were issues with study designs, samples, and variable assessment across studies.

Study designs and samples

Ten quantitative, six qualitative, and three mixed-method studies were reviewed. Quantitative studies had larger samples (mean participants per study: 1724.7 [range 36-7676]) – good for generalisability. However, just one quantitative study justified their sample size (Isacco et al., 2015). Quantitative measures do not provide deep understanding of underlying processes involved in psychological help-seeking. Qualitative studies allow participants freedom in their responses, consequently providing deeper and richer understanding. However, qualitative analysis is vulnerable to subjectivity and biases, and smaller samples reduce generalisability (mean participants per study: 23.2 [range 10-40]). Mixed-method studies possess advantages of quantitative and qualitative studies (e.g. Colquhoun & Elkins, 2015).

Qualitative and quantitative data were collected via 13 cross-sectional designs, one prospective study presenting baseline and follow-up data merged together (Henshaw et al., 2013), one longitudinal cohort sub-study (Reilly et al., 2014), two studies analysing data collected at single timepoints of longitudinal cohorts (Huang et al., 2007; Isacco et al., 2015), one secondary analysis of data from one timepoint of a longitudinal study (Guy et al., 2014), and one longitudinal prospective cohort (Mickelson et al., 2017). Cross-sectional studies are advantageous for identifying correlational relationships and assessing many variables at once, with no loss to follow-up – a common issue with longitudinal designs (Levin, 2003; 2006).

However, inferences of direction or causality cannot be drawn. By measuring change over time, prospective longitudinal studies allow for this (Caruana, Roman, Hernandez-Sanchez, & Solli, 2015). Yet, five of six studies associated with prospective designs either presented data collected at one timepoint, or presented results as though collected at one timepoint, thus losing prospective cohort benefits. This meant one study reported change over time in this review (Mickelson et al., 2017).

All designs are prone to non-response and selection bias if non-responders differ on important characteristics to responders, and samples do not represent the wider population (Levin, 2003; 2006). One study reported random sampling (Stone et al., 2015). Seven reported completion-rates, with just one reporting analyses of non-completer characteristics. When interpreting findings in this review, non-response and selection biases regarding samples' motivations and representativeness should be considered, as people volunteering for psychological help-seeking research may be more likely to recognise their symptoms and need for help.

While this review's results are generalisable to western countries, most findings represent countries where people require health insurance, and services may be further afield in rural locations. This is unlike the UK, represented by one study. Males were highly unrepresented, with 15 studies involving all-female samples. Seven papers did not report race/ethnicity. Those that did, represented populations from black, white, Asian, Hispanic, Syrian, and other backgrounds. The widespread poor reporting of race/ethnicity and limited data on men must be considered when generalising findings.

Assessment of variables

Studies defined psychological distress differently, with some using self-reports of 'sadness', for example, and others using clinical cut-off scores – occasionally inconsistently between studies (e.g. using EPDS cut-offs of 10 [Henshaw et al., 2013] or 12 [Sword et al., 2015]). Findings in this review suggest psychological distress levels are associated with help-seeking behaviours and attitudes. Proportions of participants with psychological distress varies across samples. By several studies including responses from people without psychological distress in their overall findings, the representativeness of parental help-seeking is potentially diluted.

Help-seeking is measured differently across studies, possibly explaining the wide-ranging help-seeking rates, with some studies asking narrow, specific questions (e.g. Isacco et al., 2015), and others asking broad questions, open to participants' interpretation (e.g. Fonseca et al., 2015). Lastly, all key findings were assessed using self-reports – reliant on participants' memory, honesty, understanding, and introspective ability (Hoskin, 2012).

4. Discussion

Summary of review findings

This review synthesised and appraised research exploring help-seeking for parental psychological distress over pregnancy and the child's first five years. The systematic search yielded 19 eligible papers, providing a mixture of quantitative and qualitative data. Quantitative studies provided descriptive and statistical data from large samples. Participant quotes from qualitative studies valuably deepened understanding of parents' help-seeking experiences. However, varied methodologies and samples across studies made synthesising the findings difficult. The findings themselves are vulnerable to selection bias and reduced validity due to limitations realised from the quality appraisals. Qualitative studies had small samples, and like quantitative studies, had self-selecting, and self-reporting participants – potentially biasing the data and limiting generalisability. Quantitative studies could only demonstrate correlations, so causality or direction of relationships are unknown. The more robust studies are drawn on in greater depth throughout the synthesis, but all findings must be considered with their weaknesses (Table 5).

Quantitative studies presented parents' help-seeking rates from formal (13.6%-79.3% in women; 3.2%-35% in men) and informal sources (35.9%-90.3% in women; 71%-91% in men). Figures varied widely, perhaps due to heterogenous procedures, sampling methods, and outcome measures used across studies. Men and women nevertheless appear to help-seek more frequently from informal, than formal, sources. It can tentatively be suggested that men formally help-seek less than women – reflecting previous research on male psychological help-seeking (Galdas et al., 2005). Pleck's (1981, 1995) gender-role strain paradigm could explain this trend as men having reduced likelihood to formally help-seek due to endorsing socially constructed masculine gender roles.

Higher informal (than formal) help-seeking rates were observed in this review. Social networks can provide emotional and informational support, and encourage formal help-seeking, yet there is a risk that family and friends could hold stigmatising mental health attitudes, or provide inappropriate, uninformed, or unhelpful support (Griffiths et al., 2011). This is supported by findings in this review that social networks can facilitate formal help-seeking (e.g. Fonseca & Canavarro, 2017; Sword et al., 2008), yet poor knowledge and unhelpful responses can deter people from accessing professional support (e.g. Sword et al., 2008). Overall, this review's findings suggest expectant and new parents experiencing psychological distress may encounter several barriers on their help-seeking journey (Figure 2).

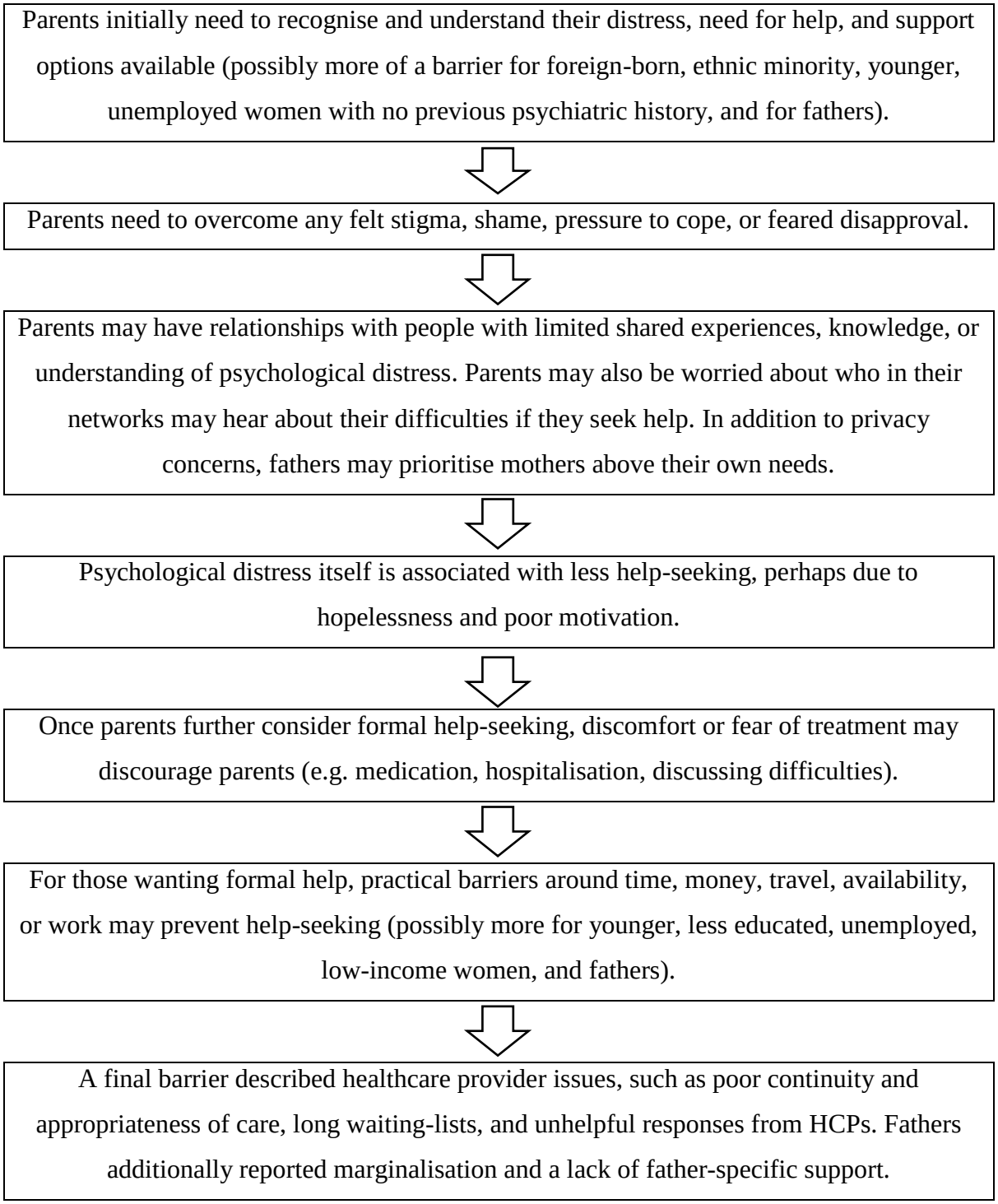

Figure 2. Barriers that mothers and fathers may encounter on their help-seeking journey.

In line with Pescosolido's (1992) network episode model (NEM), these barriers highlight the importance of a person's interactions with their culture and formal/informal networks in influencing help-seeking. Additional experiences specific to men support the theory that

socially constructed masculine gender roles can hinder fathers' help-seeking via how much men endorse these roles, and potentially via how much their networks endorse these roles (O'Neil, 1981; Pleck, 1981; 1995).

Of the fewer findings regarding help-seeking facilitators, parents reported others' influence, personal factors, and wanting services to reduce stigma. Fathers expressed wanting services to provide more father-specific information, support, and inclusion. Limited findings on personal factors, and extensive findings on the influence of others, supports Pescosolido's (1992) NEM. Women were observed to formally help-seek more following mental health assessments and referrals, and both men and women with supportive partner relationships were observed to help-seek more – although neither of these associations can be assumed to be cause-effect. Women described the importance of significant others and supportive relationships with HCPs who had empathic, knowledgeable and validating responses while offering timely, continuous, outreach, and follow-up care. For fathers, increased help-seeking was associated with supportive and flexible workplaces, and concerningly, with a strained partner relationship, which perhaps leads to help-seeking as a last resort.

Button et al. (2017) recommended future research explores psychological distress beyond PPD, and how help-seeking changes over the perinatal period. Their eligibility criteria meant they missed Reilly et al. (2014) and Fonseca et al. (2015) who observed higher help-seeking rates in postnatal, than prenatal women. Colquhoun and Elkins (2015) divided findings between expectant, new, and experienced fathers, and Mickleson et al. (2017) measured change in indirect help-seeking over time. Although there was a dominance of literature on PPD, eight of 19 studies included participants with anxiety, PPMD, emotional distress, and PTSD symptoms.

Implications for Clinical Practice

Services need to be aware of more than only PPD in women. This review highlights the variety of psychological distress fathers and mothers can experience during the perinatal period and child's early years. Help-seeking rates were low, particularly formal help-seeking, despite the possibility for selection bias creating an overrepresentation of people more likely to recognise their distress and need for help. A concerning consideration is that UK services may not have capacity for more help-seeking due to stretched NHS resources (Gilburt, 2015). However, it is increasingly appreciated that early intervention has long-term reductions in cost to the country's economy, and to parents' and children's health and wellbeing (Bate, et al., 2017; Bauer, Parsonage, Knapp, Iemmi, & Adelaja., 2014). Acknowledging this, increased funding and attention has been directed at perinatal services as part of the UK government's five-year forward view for mental health (NHS England, 2017).

If frontline staff (e.g. midwives, health visitors, GPs) increase the prominence of de-stigmatising and informative mental health discussions during appointments and classes, with both parents, then awareness within individuals, couples, and the general public may improve. This could increase the likelihood of social networks providing beneficial support, and could increase formal help-seeking. However, staff are likely to be over-stretched and time-pressured (Royal College of Midwives, 2016), with limited time to spend on mental health, or limited control over continuity of care, for example. Therefore, based on this review's findings, suggestions to increase formal help-seeking are presented below according to the different levels where change could be helpful (to be considered tentatively with the methodological issues discussed above).

Front line staff

A warm, non-judgemental, de-stigmatising, and open approach is recommended, with regular initiation of informative, supportive discussions with parents on psychological distress, how to recognise distress, how to seek help, the support available, and processes involved (e.g. confidentiality, treatment options). This should be father-inclusive and adapted appropriately for people from different cultures and backgrounds.

Perinatal services

Practical and physical barriers could be reduced by evening clinics, sign-posting to out-of-hours resources, internet support, and home visits. Staff training on father-engagement, cultural, and mental health awareness (e.g. educating parents, recognising distress, and responding to disclosures) could be valuable. Greater continuity of care would facilitate staff and parents' rapport-building, which may facilitate detection or disclosure of distress.

Mental health services

Once clients reach mental health services, engagement may improve via focusing on shame and stigma reduction, and collaborative consideration with clients regarding their preferred treatment options, according to NICE guidelines. A systemic approach, involving significant others chosen by the client may improve informal support, and increase the likelihood of continued engagement with help. Psychologists could work in partnership with perinatal services, providing consultation, training, and supervision to HCPs who work with parents.

Public health

Clinical psychologists could lead anti-stigma campaigns on parental mental health to reduce this major barrier. Psychologists' involvement with policy and funding decisions regarding

perinatal services may improve frontline staffs' capacity to increase parity between mental and physical healthcare, and between mothers and fathers.

Implications for Research

This review improved our understanding by including research on fathers and psychological distress more broadly, however the literature on fathers is limited. Despite evidence emphasising the importance of fathers (e.g. Bretherton, 2010), there is a surprising lack of robust research to inform our clinical practice with this important other parent. Additionally, the literature predominantly focuses on PPD above other forms of psychological distress. Different forms of psychological distress often occur together, such as depression and anxiety (Matthey et al., 2003). More research is necessary on help-seeking for anxiety, trauma, psychosis and stress given the varying ways these experiences can affect individuals (see Table 1).

This review, like previous related reviews, is of research *describing* help-seeking barriers and facilitators for parents experiencing psychological distress. A move from descriptive to more experimental research evaluating whether various tactics, practices, interventions or training can influence parents' access to help for psychological distress is needed. Additionally, the research is skewed towards help-seeking barriers more than facilitators. More research on help-seeking facilitators and effective practice is needed to inform experimental studies.

The literature has a balance of quantitative and qualitative data – good for breadth and depth of understanding. However, selection bias was a frequent concern across the reviewed studies. Further research with either methodology should employ more rigorous sampling techniques (e.g. random sampling) where possible, report non-responders/completers, and provide

detailed participant demographic descriptions. Longitudinal studies would indicate directionality and potentially causality of relationships. The use of validated tools is recommended. Failing that, researchers should be careful in designing questions to be sure not to miss potentially important information (e.g. avoid narrow yes/no questions).

Finally, for services to improve the likelihood that children will benefit from positively involved fathers and have a higher chance of at least one secure attachment, more research with fathers is needed. This could involve combining the voices of both fathers and perinatal services, so that experiences and ideas from these important stakeholders can be used to collaboratively inform service delivery to reduce barriers to father engagement.

5. Conclusion

Psychological distress is highly understandable given the biopsychosocial stresses parenthood can bring. Some parents may also be trying to cope with additional pressures and difficulties, from past and present. No parent is expected or required to manage perfectly. Rather, as Winnicott and Bettelheim affirmed, children will benefit from their parents being 'good-enough' (Winnicott, 1953; Bettelheim, 1987). To understand how 'good enough' parenting can be better facilitated, this review aimed to explore help-seeking behaviours, barriers, and facilitators for parents experiencing psychological distress during the perinatal period and child's early years. The 19 reviewed papers provided a varied picture regarding help-seeking rates, reflecting the varied methodologies, and differential strengths and weaknesses across studies. Nevertheless, some important findings emerged regarding the positions that health services, friends, family, partners and communities are in to provide support and influence help-seeking for parents experiencing psychological distress during the perinatal period and child's early years. This review provides a timely summary of the most up-to-date research on

parents' help-seeking for psychological distress, as parenting culture has been rapidly changing, for instance with the introduction of shared parental leave in the UK (Department for Business, Energy, and Industrial Strategy, 2018), which may be associated with changes to people's experiences.

Awareness of help-seeking barriers that parents may face can inform approaches adopted by formal and informal sources of support. However, more research is needed, involving more rigorous designs and sampling procedures, greater focus on psychological distress beyond PPD, and greater inclusion of fathers. Additionally, a focus on more active experimental studies testing intervention efficacy in increasing parental psychological help-seeking could have greater impact on improvements for services having contact with families during pregnancy and the first five years of life – a challenging time for parents, and concurrently critical time for the developing child.

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*, 5–14. doi:10.1037/0003-066x.58.1.5

Ahmed, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: a preliminary study. *BMC Pregnancy and Childbirth, 1*, 1-11. doi:10.1186/s12884-017-1433-2

Ainsworth, M. D. S. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development, 40*, 969. doi:10.2307/1127008

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*, 179–211. doi:10.1016/0749-5978(91)90020-t

Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low income African American, Latina, and European American young women. *Community Mental Health Journal, 35,* 515–530.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Andersen, R. (1968*). A behavioral model of families' use of health services*. Chicago: Centre for Health and Administration Studies, University of Chicago Press.

Areias, M., Kumar, R., Barros, H., & Figueiredo, E. (1996). Comparative incidence of depression in women and men, during pregnancy and after childbirth: validation of the Edinburgh Postnatal Depression Scale in Portuguese mothers. *British Journal of Psychiatry, 169,* 30–35. doi:10.1192/bjp.169.1.30.

Ayres, S., Wright, D., & Wells, N. (2007). Symptoms of post-traumatic stress disorder in couples after birth: association with the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology, 25,* 40-50. doi:0.1080/02646830601117175.

Barbee, A. & Cunningham, M. (1995). An experimental approach to social support communications: Interactive coping in close relationships. In B. R. Burleson (Ed.). *Communication yearbooks* (pp. 381-413). Thousand Oaks: Sage.

Bate, A., Barber, S., Powell, T., Parkin, E., Long, R., Bolton, P., … & Mackley, A. (2017). *Briefing paper: Early intervention.* London: House of Commons Library.

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. London: Centre for Mental Health. Retrieved from: http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

Beck, C. T. (2008). State of the science on postpartum depression. *MCN, The American Journal of Maternal/Child Nursing, 33,* 151–156. doi:10.1097/01.nmc.0000318349.70364.1c

Beck, C. T. (2004). Post-Traumatic Stress Disorder due to childbirth. *Nursing Research, 53*, 216–224. doi:10.1097/00006199-200407000-00004

Beck, C. T., & Gable, R. K. (2000). Postpartum Depression Screening Scale: Development and psychometric testing. *Nursing Research, 49*, 272–282. doi:10.1097/00006199-200009000-00006.

Belsky, J., & Cassidy, J. (1994). Attachment: Theory and evidence. In Rutter, M., & Hay, D. (Eds.). *Development through life: A handbook for clinicians*. Oxford: Blackwell.

Berg, S. J., & Wynne-Edwards, K. E. (2001). Changes in testosterone, cortisol, and estradiol levels in men becoming fathers. *Mayo Clinic Proceedings, 76*, 582–592. doi:10.4065/76.6.582

Bettelheim, B. (1987). *A good enough parent: A book on child-rearing*. New York, US: Vintage Books.

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour. *Sociology of Health & Illness, 29*, 983–1002. doi:10.1111/j.1467-9566.2007.01030.x

Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). Women's experience of postnatal depression – Beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing, 27,* 44-54.

Booth, A., Papaioannou, D., & Sutton, A. (2012). *Systematic Approaches to a successful literature review*. England: SAGE Publications Ltd.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. London: Hogarth Press.

Bowlby, J. (1973). *Attachment and loss: Vol.2. Separation: Anxiety and anger*. London: Hogarth Press.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. London: Hogarth Press.

Bradley, R., & Slade, P. (2011). A review of mental health problems in fathers following the birth of a child. *Journal of Reproductive and Infant Psychology, 29*, 19–42. doi:10.1080/02646838.2010.513047

Bretherton, I. (2010). Fathers in attachment theory and research: A review. *Early Child Development and Care, 180*, 9-23. Doi: 10.1080/03004430903414661.

Button, S., Thornton, A., Lee, S., Shakespeare, J., & Ayers, S. (2017). Seeking help for perinatal psychological distress: a meta-synthesis of women's experiences. *British Journal of General Practice, 67*, e692–e699. doi:10.3399/bjgp17x692549

Byatt, N., Biebel, K., Friedman, L., Debordes-Jackson, G., & Ziedonis, D. (2013). Women's perspectives on postpartum depression screening in pediatric settings: a preliminary study. *Archives of Women's Mental Health, 16,* 429–432. doi:10.1007/s00737-013-0369-4

Carlson, E. A., & Sroufe, L. A. (1995). Contribution of attachment theory to developmental psychopathology. In Cicchetti, D., & Cohen, D. J. *Developmental psychopathology, Vol. 1: Theory and methods.* Oxford, England: John Wiley & Sons.

Caruana, E., Roman, M., Hernandez-Sanchez, J., & Solli, P. (2015). Longitudinal studies. *Journal of Thoracic Disease, 7*, 537-540. Doi: 10.3978/j.issn.2072-1439.2015.10.63.

Chandler, S., & Field, P. A. (1997). Becoming a father: First-time fathers' experience of labor and delivery. *Journal of Nurse-Midwifery, 42,* 17–24. doi.org/10.1016/S0091-2182(96)00067-5

Cheng, H., & Phillips, M. (2014). Secondary analysis of existing data: opportunities and implementation. *Shanghai Archives of Psychiatry, 26*, 371-375. doi:10.11919/j.issn.1002-0829.214171.

Coleman, P. K. & Karraker, K. H. (2003). Maternal self-efficacy beliefs, competence in parenting, and toddlers' behavior and developmental status. *Infant Mental Health Journal, 24,* 126–148. doi:10.1002/imhj.10048.

Colquhoun, G., & Elkins, N. (2015). *Healthy Dads? The challenge of being a new father.* Australia: Hall & Partners | Open Mind. Retrieved from: https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0313-beyondblue-healthy-dads-full-report.pdf?sfvrsn=6f0243ea_0

Condon, J. T., Corkindale, C. J., & Boyce, P. (2004). The First-Time Fathers Study: A prospective study of the mental health and wellbeing of men during the transition to parenthood. *Australian & New Zealand Journal of Psychiatry, 38,* 56–64. doi:10.1177/000486740403800102

Cowan, C., & Cowan, P. (1995). Interventions to ease the transition to parenthood: Why they are needed and what they can do. *Family Relations, 44*, 412–423. doi:10.2307/584997

Cox, J., Holden, J., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh postnatal depression scale. *British Journal of Psychiatry, 150*, 782-786.

Critical Appraisal Skills Programme (2013). *CASP Cohort Study Checklist*. Retrieved from http://docs.wixstatic.com/ugd/dded87_5ad0ece77a3f4fc9bcd3665a7d1fa91f.pdf

Dennis, C. L. & Creedy, D. (2007). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Systematic Reviews, 4*, CD001134. doi:10.1002/14651858.CD001134.

Dennis, C.-L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33*, 323–331. doi:10.1111/j.1523-536x.2006.00130.x

Department for Business, Energy, and Industrial Strategy (2018). *Parents' guide to shared parental leave and pay*. Crown copyright: London. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679664/Parents__Guide_to_Shared_Parental_Leave_and_Pay_FINAL.pdf

Doss, B. D., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2009). The effect of the transition to parenthood on relationship quality: An 8-year prospective study. *Journal of Personality and Social Psychology, 96*, 601–619. doi:10.1037/a0013969.

Downes, M., Brennan, M., Williams, H., & Dean, R. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ, 6,* e011458. doi:10.1136/bmjopen-2016-011458.

Dunford, E., & Granger, C. (2017). Maternal guilt and shame: Relationship to postnatal depression and attitudes towards help-seeking. *Journal of Child and Family Studies, 26,* 1692–1701. doi:10.1007/s10826-017-0690-z

Dunn, K. (2016). *Understanding postnatal depression and perinatal mental health.* London: Mind. Retrieved from: https://www.mind.org.uk/media/4852718/understanding-postnatal-depression-2016.pdf

Fonagy, P., Steele, H., & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development, 62*, 891. doi:10.2307/1131141

Fonseca, A., Gorayeb, R., & Canavarro, M. C. (2015). Women′s help-seeking behaviours for depressive symptoms during the perinatal period: Socio-demographic and clinical correlates and perceived barriers to seeking professional help. *Midwifery, 31,* 1177–1185. doi:10.1016/j.midw.2015.09.002

Fonseca, A., & Canavarro, M. (2017). Women's intentions of informal and formal help-seeking for mental health problems during the perinatal period: The role of perceived encouragement from the partner. *Midwifery, 50,* 78-85. doi.org/10.1016/j.midw.2017.04.001

Foulkes, M. (2011). Enablers and barriers to seeking help for a postpartum mood disorder. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 40,* 450–457. doi:10.1111/j.1552-6909.2011.01264.x

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 13,* 387-421. doi: 10.1016/S0002-7138(09)61442-4.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing, 49,* 616–623. doi:10.1111/j.1365-2648.2004.03331.x

Genesoni, l., & Tallandini, M. (2009). Men's psychological transition to fatherhood: an analysis of the literature, 1989–2008. *Birth, 36,* 305–17. doi:10.1111/j.1523-536X.2009.00358.x

Gilburt, H. (2015). *Briefing: Mental health under pressure.* The King's Fund, London. Retrieved from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf

Gladstone, G. L., Parker, G. B., Mitchell, P. B., Malhi, G. S., Wilhelm, K. A., & Austin, M.-P. (2005). A Brief Measure of Worry Severity (BMWS): Personality and clinical correlates of severe worriers. *Journal of Anxiety Disorders, 19,* 877–892. doi:10.1016/j.janxdis.2004.11.003

Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing, 45*, 26–35. doi:10.1046/j.1365-2648.2003.02857.x

Goodwin, R., & Andersen, R. M. (2002). Use of the Behavioral Model of Health Care Use to identify correlates of use of treatment for panic attacks in the community. *Social Psychiatry and Psychiatric Epidemiology, 37*, 212–219. doi:10.1007/s00127-002-0543-x

Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal, 26,* 91–108. doi:10.1111/j.1471-1842.2009.00848.x

Griffiths, K. M., Crisp, D. A., Barney, L., & Reid, R. (2011). Seeking help for depression from family and friends: A qualitative analysis of perceived advantages and disadvantages. *BMC Psychiatry, 11*, 196. doi:10.1186/1471-244x-11-196.

Gunderson, E. P., Rifas-Shiman, S. L., Oken, E., Rich-Edwards, J. W., Kleinman, K. P., Taveras, E. M., & Gillman, M. W. (2008). Association of fewer hours of sleep at 6 months postpartum with substantial weight retention at 1 year postpartum. *Obstetrical & Gynecological Survey, 63*, 358–359. doi:10.1097/01.ogx.0000316303.62825.14.

Guy, S., Sterling, B. S., Walker, L. O., & Harrison, T. C. (2014). Mental health literacy and postpartum depression: A qualitative description of views of lower income women. *Archives of Psychiatric Nursing, 28,* 256–262. doi:10.1016/j.apnu.2014.04.001

Henderson, A. D., & Brouse, A. J. (1991). The experiences of new fathers during the first 3 weeks of life. *Journal of Advanced Nursing, 16,* 293–298. doi:10.1111/j.1365-2648.1991.tb01652.x

Henderson, C., Robinson, E., Evans-Lacko, S., & Thornicroft, G. (2017). Relationships between anti-stigma programme awareness, disclosure comfort and intended help-seeking regarding a mental health problem. *British Journal of Psychiatry, 211,* 316–322. doi:10.1192/bjp.bp.116.195867.

Hendrick, V., Altshuler, L. L., & Suri, R. (1998). Hormonal changes in the postpartum and implications for postpartum depression. *Psychosomatics, 39,* 93–101. doi:10.1016/s0033-3182(98)71355-6.

Henshaw, E. J., & Freedman-Doan, C. R. (2009). Conceptualizing mental health care utilization using the health belief model. *Clinical Psychology: Science and Practice, 16,* 420–439. doi:10.1111/j.1468-2850.2009.01181.x

Henshaw, E., Sabourin, B., & Warning, M. (2013). Treatment- seeking behaviors and attitudes survey among women at risk for perinatal depression or anxiety. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 42,* 168–177. doi:10.1111/1552-6909.12014

Henwood, K., & Procter, J. (2003). The "good father": Reading men's accounts of paternal involvement during the transition to first-time fatherhood. *British Journal of Social Psychology, 42,* 337–355. doi.org/10.1348/014466603322438198

Hirschfeld, R. M. A., Montgomery, S. A., Keller, M. B., Kasper, S., Schatzberg, A. F., Moller, H.-J., … Bourgeois, M. (2000). Social functioning in depression. *The Journal of Clinical Psychiatry, 61,* 268–275. doi:10.4088/jcp.v61n0405.

Hogg, S. (2013). *All babies count: spotlight on perinatal mental health – prevention in mind.* London: NSPCC. Retrieved from: https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf

Hoskin, R. (2012). *The dangers of self-report.* Blogs, Brain and Behaviour, Cognitive Psychology. Science Brainwaves. Retrieved from: http://www.sciencebrainwaves.com/the-dangers-of-self-report/

Huang, Z. J., Wong, F. Y., Ronzio, C. R., & Yu, S. M. (2006). Depressive symptomatology and mental health help-seeking patterns of U.S.- and foreign-born mothers. *Maternal and Child Health Journal, 11,* 257–267. doi:10.1007/s10995-006-0168-x

Huston, T., & Holmes, E. K. (2004). Becoming parents. In A. Vangelisti (Ed.), *Handbook of family communication* (pp. 105 – 133). Hillsdale, NJ: Erlbaum.

Isacco, A., Hofscher, R., & Molloy, S. (2016). An examination of fathers' mental health help seeking. *American Journal of Men's Health, 10,* NP33–NP38. doi:10.1177/1557988315581395

Kane, P. & Garber, J. (2004) The relations among depression in fathers, children's psychopathology, and father–child conflict: a meta-analysis. *Clinical Psychology Review, 24,* 339–360. doi.org/10.1016/j.cpr.2004.03.004

Kelly, R. H., Zatzick, D. F., & Anders, T. F. (2001). The detection and treatment of psychiatric disorders and substance use among pregnant women cared for in obstetrics. *American Journal of Psychiatry, 158*, 213–219. doi:10.1176/appi.ajp.158.2.213

Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S.-L. T., … Zaslavsky, A. M. (2002). Kessler Psychological Distress Scale. *PsycTESTS Dataset.* doi:10.1037/t22929-000

Kessler, R. C., Andrews, G., Mroczek, D., Ustun, B., & Wittchen, H.-U. (1998). The World Health Organization Composite International Diagnostic Interview short-form (CIDI-SF). *International Journal of Methods in Psychiatric Research, 7*, 171–185. doi:10.1002/mpr.47

King-Hele, S. A., Abel, K. M., Webb, R. T., Mortensen, P. B., Appleby, L., & Pickles, A. R. (2007). Risk of sudden infant death syndrome with parental mental illness. *Archives of General Psychiatry, 64*, 1323. doi:10.1001/archpsyc.64.11.1323

Kingston, D., Tough, S., & Whitfield, H. (2012). Prenatal and postpartum maternal psychological distress and infant development: a systematic review. *Child Psychiatry and Human Development, 43*, 683–714. Doi: 10.1007/ s10578-012-0291-4.

Kingston, D., McDonald, S., Austin, M., & Tough, S. (2015). Association between prenatal and postnatal psychological distress and toddler cognitive development: a systematic review. *Plos One, 10*, 1–16. Doi: 10.1371/journal.pone.0126929.

Kurtz-Landy, C., Sword, W., & Valaitis, R. (2008). The experiences of socioeconomically disadvantaged postpartum women in the first 4 weeks at home. *Qualitative Health Research, 19*, 194–206. doi:10.1177/1049732308329310.

Lamb, M. E. (1977). Father-infant and mother-infant interaction in the first year of life. *Child Development, 48,* 167. doi:10.2307/1128896

Lamb, M. E. (2002). Infant-father attachments and their impact on child development. In: C. Tamis-Le Monda, & N. Cabrera (Eds.). *Handbook of father involvement: Multidisciplinary perspectives* (pp. 93–117). Mahwah, NJ: Erlbaum.

Lane, J. M., & Addis, M. E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. *Psychology of Men & Masculinity, 6,* 155–168. doi:10.1037/1524-9220.6.3.155

Leach, L. S., Poyser, C., Cooklin, A. R., & Giallo, R. (2016). Prevalence and course of anxiety disorders (and symptom levels) in men across the perinatal period: A systematic review. *Journal of Affective Disorders, 190,* 675–686. doi:10.1016/j.jad.2015.09.063

Levant, R. F. (1996). The new psychology of men. *Professional Psychology: Research and Practice, 27*, 259–265. doi:10.1037/0735-7028.27.3.259

Levant, R. F., & Majors, R. G. (1997). An investigation into variations in the construction of the male gender role among young African American and European American women and men. *Journal of Gender, Culture, and Health, 2,* 33–43.

Levant, R. F., Richmond, K., Majors, R. G., Inclan, J. E., Rossello, J. M., Heesacker, M., . . . Sellars, A. (2003). A multicultural investigation of masculinity ideology and alexithymia. *Psychology of Men & Masculinity, 4,* 91–99. doi:10.1037/1524-9220.4.2.91

Levant, R., & Richmond, K. (2007). A review of research on masculinity ideologies using the Male Role Norms Inventory. *The Journal of Men's Studies, 15,* 130–146. doi:10.3149/jms.1502.130

Levin, K. A. (2003). Study design IV: Cohort studies. *Evidence-Based Dentistry, 7,* 51-52. doi:10.1038/sj.ebd.6400407.

Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry, 7,* 24-25. doi:10.1038/sj.ebd.6400375.

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J., … Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: Explanation and elaboration. *PLoS Medicine, 6,* e1000100. doi:10.1371/journal.pmed.1000100.

Liberto, T. L. (2012). Screening for depression and help-seeking in postpartum women during Well-Baby pediatric visits: An Integrated Review. *Journal of Pediatric Health Care, 26,* 109–117. doi:10.1016/j.pedhc.2010.06.012

Lovibond, S. H., & Lovibond, P. F. (1995). Depression Anxiety Stress Scales. *PsycTESTS Dataset*. doi:10.1037/t01004-000

Mackenzie, C. S., Knox, V. J., Gekoski, W. L. & Macaulay, H. L. (2004). An adaptation and extension of the Attitudes Toward Seeking Professional Psychological Help Scale. *Journal of Applied Social Psychology, 34*, 2410–2433. doi:10.1111/j.1559-1816.2004.tb01984.

Mahalik, J. R., Good, G. E., & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help-seeking: Implications for practice and training. *Professional Psychology: Research and Practice, 34*, 123-131.

Matthey, S., Barnett, B., Ungerer, J., & Waters, B. (2000). Paternal and maternal depressed mood during the transition to parenthood. *Journal of Affective Disorders, 60*, 75–85. doi:10.1016/s0165-0327(99)00159-7

Matthey, S., Barnett, B., Howie, P., & Kavanagh, D. J. (2003). Diagnosing postpartum depression in mothers and fathers: whatever happened to anxiety? *Journal of Affective Disorders, 74*, 139–147. doi:10.1016/s0165-0327(02)00012-5.

McBride, A. B. & Shore, C. P. (2001). Women as mothers and grandmothers. In J. Fitzpatrick & N. Woods (Eds.), *Annual review of nursing research: Women's health research, vol. 19* (pp. 63–85). New York: Springer Publishing Company.

McGovern, P., Dowd, B., Gjerdingen, D., Gross, C., Kenney, S., Ukestad, L., … Lundberg, U. (2006). Postpartum health of employed mothers 5 weeks after childbirth. *Annals of Family Medicine, 4*, 159–167. doi:10.1370/afm.519

Mental Health Foundation. (2016). *Fundamental facts about mental health 2016.* London: Mental Health Foundation.

Mercer, R. T., & Ferketich, S. L. (1995). Experienced and inexperienced mothers' maternal competence during infancy. *Research in Nursing and Health 18,* 333–343. doi:10.1002/nur.4770180407

Mickelson, K. D., Biehle, S. N., Chong, A., & Gordon, A. (2017). Perceived stigma of postpartum depression symptoms in low-risk first-time parents: Gender differences in a dual-pathway model. *Sex Roles, 76,* 306–318. doi:10.1007/s11199-016-0603-4

Moehler, E., Brunner, R., Wiebel, A., Reck, C., & Resch, F. (2006). Maternal depressive symptoms in the postnatal period are associated with long-term impairment of mother–child bonding. *Archives of Women's Mental Health, 9,* 273–278. doi:10.1007/s00737-006-0149-5

Mohr, D. C., Ho, J., Duffecy, J., Baron, K. G., Lehman, K. A., Jin, L., & Reifler, D. (2010). Perceived barriers to psychological treatment measure. *PsycTESTS Dataset.* doi:10.1037/t30550-000

National Institute for Clinical Excellence (2006). *Postnatal care up to 8 weeks after birth.* Clinical guideline (CG37). Retrieved from: https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#maternal-health

NHS England (2017). *Five year forward view for mental health: One year on.* London: NHS England. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf

Nystrom, K., & Ohrling, K. (2004). Parenthood experiences during the child's first year: literature review. *Journal of Advanced Nursing, 46,* 319-330. doi:10.1111/j.1365-2648.2004.02991.

Office for National Statistics. (2017). *Suicides in the United Kingdom: 2016 Registrations.* Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations

O'Mahony, J., & Donnelly, T. (2010). Immigrant and refugee women's post-partum depression help-seeking experiences and access to care: a review and analysis of the literature. *Journal of Psychiatric and Mental Health Nursing, 17,* 917-928. doi:10.1111/j.1365-2850.2010.01625.x

O'Neil, J. M. (1981). Male sex role conflicts, sexism, and masculinity: Psychological implications for men, women, and the counseling psychologist. *The Counseling Psychologist, 9,* 61–80. doi:10.1177/001100008100900213

Onozawa, K., Kumar, R. C., Adams, D., Dore, C., & Glover, V. (2003). High EPDS scores in women from ethnic minorities living in London. *Archives of Women's Mental Health, 6,* s51–s55. doi:10.1007/s00737-003-0006-8

Orth, U., Berking, M., & Burkhardt, S. (2006). Self-conscious emotions and depression: rumination explains why shame but not guilt is maladaptive. *Personality and Social Psychology Bulletin, 32,* 1608–1619. doi:10.1177/0146167206292958.

Pais-Ribeiro, J., Silva, I., Ferreira, T., Martins, A., Meneses, R., & Baltar, M. (2007). Validation study of a Portuguese version of the Hospital Anxiety and Depression Scale. *Psychology, Health & Medicine, 12*, 225–237. Doi: 10.1080/13548500500524088.

Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression. *JAMA, 303,* 1961-1969. doi:10.1001/jama.2010.605

Paulson, J. F., Dauber, S., & Leiferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. *PEDIATRICS, 118*, 659–668. doi:10.1542/peds.2005-2948

Peisah, C., Brodaty, H., Luscombe, G., & Anstey, K. (2004). Children of a cohort of depressed patients 25 years later: Psychopathology and relationships. *Journal of Affective Disorders, 82,* 385–394. doi.org/10.1016/j.jad.2004.03.002

Pescosolido, B. A. (1992). Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology, 97*, 1096–1138. doi:10.1086/229863

Perry, B. L., & Pescosolido, B. A. (2015). Social network activation: The role of health discussion partners in recovery from mental illness. *Social Science & Medicine, 125*, 116–128. doi: 10.1016/j.socscimed.2013.12.033.

Pleck, J. H. (1981). *The myth of masculinity*. Cambridge, MA: MIT Press.

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

Prevatt, B., & Desmarais, S. L. (2017). Facilitators and barriers to disclosure of postpartum mood disorder symptoms to a healthcare provider. *Maternal and Child Health Journal, 22,* 120–129. doi:10.1007/s10995-017-2361-5

Prins, A., Ouimette, P., Kimerling, R., Camerond, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., … Sheikh, J. I. (2004). The primary care PTSD screen (PC–PTSD): development and operating characteristics. *Primary Care Psychiatry, 9,* 9–14. doi:10.1185/135525703125002360

Radloff, L. S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurements, 1,* 385-401. doi:10.1177/014662167700100306

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. G. (2005). Paternal depression in the postnatal period and child development: a prospective population study. *The Lancet, 365,* 2201–2205. doi:10.1016/s0140-6736(05)66778-5

Ramchandani, P. G., Stein, A., O'Connor, T. G., Heron, J., Murray, L., & Evans, J. (2008). Depression in men in the postnatal period and later child psychopathology: A population cohort study. *Journal of the American Academy of Child & Adolescent Psychiatry, 47,* 390–398. doi:10.1097/chi.0b013e31816429c2

Reilly, N., Harris, S., Loxton, D., Chojenta, C., Forder, P., & Austin, M. (2014). The impact of routine assessment of past or current mental health on help-seeking in the perinatal period. *Women and Birth, 27,* e20–e27. doi:10.1016/j.wombi.2014.07.003

Rice, S., Fallon, B., & Bambling, M. (2011). Men and Depression: The impact of masculine role norms throughout the lifespan. *The Australian Educational and Developmental Psychologist, 28,* 133–144. doi:10.1375/aedp.28.2.133

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4,* 218–251. doi:10.5172/jamh.4.3.218

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research Behaviour management, 5,* 173-183. doi: 10.2147/PRBM.S38707.

Ridner, S. H. (2004). Psychological distress: concept analysis. *Journal of Advanced Nursing, 45,* 536–545. doi:10.1046/j.1365-2648.2003.02938.

Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General Hospital Psychiatry, 26,* 289–295. doi:10.1016/j.genhosppsych.2004.02.006

Rominov, H., Giallo, R., Pilkington, P. D., & Whelan, T. A. (2017). "Getting help for yourself is a way of helping your baby:" Fathers' experiences of support for mental health and parenting in

the perinatal period. *Psychology of Men & Masculinity.* Advanced online publication. doi:10.1037/men0000103

Rosenstock, I. M. (1966). Why people use health services. *The Milbank Memorial Fund Quarterly, 44,* 94. doi:10.2307/3348967

Royal College of Midwives. (2016). *State of maternity services report 2016*. Retrieved from: https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf

Russell, K., Ashley, A., Chan, G., Gibson, S., & Jones, R. (2017). *Maternal mental health – Women's voices.* London: Royal College of Obstetricians and Gynaecologists. Retrieved from: https://www.rcog.org.uk/globalassets/documents/patients/information/maternalmental-healthwomens-voices.pdf

Sarason, I. G., Sarason, B. R., Shearin, E. N., & Pierce, G. R. (1987). A Brief Measure of Social Support: Practical and theoretical implications. *Journal of Social and Personal Relationships, 4,* 497–510. doi:10.1177/0265407587044007.

Schmied, V., Black, E., Naidoo, N., Dahlen, H. G., & Liamputtong, P. (2017). Migrant women's experiences, meanings and ways of dealing with postnatal depression: A meta-ethnographic study. *PLOS ONE, 12,* e0172385. doi:10.1371/journal.pone.0172385

Seyfried, L. S., & Marcus, S. M. (2003). Postpartum mood disorders. *International Review of Psychiatry, 15,* 231–242. doi:10.1080/09540260305196.

Sharp, D. (2009). Perinatal Mental Health. In L. Gask & H. Lester, T. Kendrick & R. Peveler (Eds.), *Primary Mental Health Care* (pp. 198-210). London: Royal Collage of Psychiatrist Publications.

Sit, D., Rothschild, A. J., & Wisner, K. L. (2006). A review of postpartum psychosis. *Journal of Women's Health, 15,* 352–368. doi:10.1089/jwh.2006.15.352

Smith, J., Tran, G., & Thompson, R. (2008a). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men and Masculinity, 9,* 179–192. doi:10.1037/a0012158

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008b). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15,* 194–200. doi:10.1080/10705500802222972.

Stone, S. L., Diop, H., Declercq, E., Cabral, H. J., Fox, M. P., & Wise, L. A. (2015). Stressful events during pregnancy and postpartum depressive symptoms. *Journal of Women's Health, 24,* 384–393. doi:10.1089/jwh.2014.4857

Sword, W., Busser, D., Ganann, R., McMillan, T., & Swinton, M. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qualitative Health Research, 18,* 1161-1173. doi: 10.1177/1049732308321736.

Tacconelli, E. (2010). Systematic reviews: CRD's guidance for undertaking reviews in health care. *The Lancet, 10,* 226. doi.org/10.1016/S1473-3099(10)70065-7

Tangney, J. P., Dearing, R. L., Wagner, P. E., & Gramzow, R. (2000). Test of Self-Conscious Affect–3. *PsycTESTS Dataset*. doi:10.1037/t06464-000.

TaPark, V. M., Goyal, D., Nguyen, T., Lien, H., & Rosidi, D. (2015). Postpartum traditions, mental health, and help-seeking considerations among Vietnamese American women: a mixed-methods pilot study. *The Journal of Behavioral Health Services & Research, 44*, 428–441. doi:10.1007/s11414-015-9476-5

Tunnard, J. (2004). *Parental mental health problems: messages from research, policy and practice.* England: Research in Practice. Retrieved from: http://lx.iriss.org.uk/sites/default/files/resources/Parental%20mental%20health.pdf

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": An examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes of men from diverse backgrounds. *Journal of Counseling Psychology, 58,* 368-382. doi: 10.1037/a0023688.

Webster, J., Linnane, J. W. J., Dibley, L. M., Hinson, J. K., Starrenburg, S. E., & Roberts, J. A. (2000). Measuring Social Support in Pregnancy: Can It Be Simple and Meaningful? *Birth, 27*, 97–101. doi: 10.1046/j.1523-536x.2000.00097.

Wilson, S., & Durbin, E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review, 30,* 167-180. doi:10.1016/j.cpr.2009.10.007.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena; a study of the first not-me possession. *The International Journal of Psychoanalysis, 34,* 89-97.

Wittkowski, A., Patel, S., & Fox, J. R. (2017). The experience of postnatal depression in immigrant mothers living in Western countries: A meta-synthesis. *Clinical Psychology & Psychotherapy, 24,* 411–427. doi:10.1002/cpp.2010

Zlochower, A. J., & Cohn, J. F. (1996). Vocal timing in face-to-face interaction of clinically depressed and nondepressed mothers and their 4-month-old infants. *Infant Behavior and Development, 19,* 371–374. doi:10.1016/s0163-6383(96)90035-1

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Section B:

Fathers' and health professionals' perceptions and experiences of paternal perinatal support and their views on improving services: A Delphi study

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A thesis submitted in partial fulfilment of the requirements of
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Abstract

Background: Positive father involvement has important implications for fathers, mothers, and children. Perinatal services are well-positioned to detect difficulties in fathers. However, fathers report marginalisation, while staff report limited resources for father-inclusion.

Objectives: To explore fathers' perinatal experiences, and support from professionals (midwives and health visitors); professionals' experiences and understanding of fathers; both groups' ideas for paternal perinatal support; and areas of between-group agreement and disagreement.

Method: A three-round Delphi method was employed. Thematic analysis of first-round focus groups informed the development of a second-round quantitative online survey – completed by 24 fathers and 22 healthcare professionals. A third-round survey finalised within- and between-group consensus.

Results: Both groups strongly agreed on the importance of fathers. Participants endorsed service improvement ideas, such as being more family-centred, and supporting mothers and fathers with relational and psychological changes that can occur. Groups disagreed on whether fathers should receive 10-minutes alone with healthcare professionals to discuss their own coping or concerns.

Discussion: The findings support the rationale for perinatal services to include fathers and focus on the family system. This could be facilitated by greater partnership working with clinical psychology, and the provision of necessary resources by wider organisational structures. Limitations include low participant diversity and possible selection bias. Implications for further research are discussed.

Keywords: Father involvement, paternal, perinatal services

1. Introduction

Social constructions of fatherhood have changed throughout cultures over the last several decades (Lamb, 2000; Selin, 2014). In the UK, fathers are more involved as nurturing co-parents than ever before – present at antenatal classes and birth, and sharing with their partner the responsibilities involved with child-rearing, domestic duties, and maintaining family life (Henwood & Proctor, 2003; Pleck & Pleck, 1997). In recognition of fathers as primary carers, the UK government has implemented a shared parental leave policy (Department for Business, Energy, and Industrial Strategy, 2018), and the national institute for clinical excellence (NICE) recommend that for children's social and emotional wellbeing, practitioners should "focus on developing the father-child relationship as part of an approach that involves the whole family" (NICE, 2012).

Importance of father involvement

Since being termed "the forgotten contributors to child development" (Lamb, 1975, pg.245), research has increasingly recognised the positive contributions of father-involvement to children's psychological, behavioural, and cognitive development (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008; Wilson & Prior, 2011). Often reported as more prevalent in father-child than mother-child relationships, is competitive and physical play, which a recent meta-analysis suggests has positive associations with children's emotional development, self-regulation, and social competence (StGeorge & Freeman, 2017). Children require a secure caregiver attachment for their sense of security and healthy development (Bowlby, 1979), which fathers can offer (Pleck, 2007). Children with secure attachments to *both* parents exhibit better personal, social, and cognitive development (Beardshaw, 2001; Lieberman, Doyle, & Markiewicz, 1999).

Positive father involvement can also be protective for the mother's wellbeing (Whisman, Davila, & Goodman, 2011). Fathers are often first to notice psychological distress in the mother, sometimes before the mother herself (Russell et al., 2013). Women hospitalised for postpartum depression (PPD) tend to have shorter stays if they have a supportive partner (Grube, 2004). Whereas women reporting lower partner support have greater risk of PPD (Dennis & Ross, 2006). Additionally, when mothers experience psychological distress, fathers who are 'well' can buffer against potentially negative consequences for the child (Mezulis, Hyde, & Clark, 2004).

Fathers' vulnerabilities to psychological distress

As with mothers, the emotional upheaval of parenthood can increase vulnerability to psychological distress in fathers, rates of which are not dissimilar from those reported for mothers (Giallo et al., 2012; Paulson & Bazemore, 2010; Bradley & Slade, 2011), and are consistent with psychosocial rather than biological explanations for perinatal distress (Condon, 2006; Giallo et al., 2013).

Research highlights difficult experiences encountered by new fathers including sleep deprivation, psychological reorganisation of the self, and relationship changes with their partner, social networks, and baby (Darwin et al., 2017; Genesoni & Tallandini, 2009). Fathers have reported feeling unprepared and unconfident when transitioning to parenthood having not learned suitable parenting skills from their own fathers (Condon, Boyce, & Corkindale, 2004). Lower parenting confidence is suggested to delay father-infant bonding (Fletcher, 2011). Financial burdens that babies bring may increase pressure on fathers to earn money, resulting in greater likelihood of isolation from mother and baby (Kim & Swain, 2007). Difficulties balancing personal and work-related pressures with the new parental role can be highly

stressful (Genesoni & Tallandini, 2009). Additionally, with mothers increasingly returning to work following maternity leave, and fathers expected to be more involved in childcare, fathers may feel conflicted between sociocultural roles and expectations of what it means to be a 'father' and a 'man' (McBride et al., 2005; O'Brien, 2005; Wee et al., 2013).

These stressors may be perpetuated by 'hegemonic masculinity' – a term used to describe dynamic hierarchically-ordered social practices, or 'masculinities', which lead to the subjugation of those not representing dominant masculine ideals (Connell, 1987). Although masculine ideals vary according to time and place, dominant western ideals have traditionally assumed men are stoic, self-reliant, providers and protectors (Hunter, Riggs, & Augoustinos, 2017). Societal pressures for men to conform to hegemonic masculinity is suggested to contribute to psychological distress and increased suicidal behaviours in males (Cleary, 2012; Emslie, Ridge, Ziebland, & Hunt, 2006). In fathers, masculine norms have been associated with reluctance to seek psychological help due to feeling they should "suck it up and get on with it", appear strong, and prioritise the mothers' psychological needs (Colquhoun & Elkins, 2015; Rominov, Giallo, Pilkington, & Whelan., 2017; Williams, 2007).

Paternal mental health and the family

Although not always the case, research suggests that fathers experiencing psychological problems can demonstrate impaired parenting behaviours and interactions with their infants, such as under-stimulation, insensitivity, emotional and physical unavailability, and in rare cases, child maltreatment (Cleaver, Unell, & Aldgate, 2011; Giallo et al., 2015; Sethna et al., 2015; 2018; Wilson & Durbin, 2010). Disengaged father-child interactions and paternal depression is associated with increased likelihood of poor father-infant attachment (Buist, Morse, & Durkin, 2003), and behavioural and emotional problems in children (Kane & Garber,

2004; Kvalevaag et al., 2013; Ramchandani et al., 2005, 2008, 2013; Ramchandani & Psychogiou, 2009).

In line with family systems theory, which highlights the emotional interconnectedness of family members (Bowen, 1978), paternal psychological distress has been associated with maternal depression and partner conflict (Goodman, 2004; Ramchandani et al., 2011). Having two depressed parents increases children's risks of negative outcomes (Goodman, 2004; Ramchandani et al., 2008), and children exposed to parental conflict have increased likelihood of internalising and externalising problems (McHale, 2007).

Do fathers get appropriate support?

UK policies are responding to the increasing focus on 'involved fatherhood' by advocating for the inclusion of fathers throughout the perinatal period[5] (Royal College of Midwives, 2011). NICE guidelines recommend perinatal services "offer fathers information and support in adjusting to their new role and responsibilities within the family unit" (NICE, 2006).

However, fathers have reported lacking support from NHS perinatal staff when they needed it most (Machin, 2015). UK research suggests that fathers are keen to be equally involved, but often feel pushed into traditional roles by societal norms, policies, structures, and healthcare professionals' (HCPs') attitudes – leaving them feeling like a 'secondary' parent (Deave & Johnson, 2008; Machin, 2015; Steen et al., 2012). NICE guidance to "address the needs of partners…that might affect a woman" (2014) reflects how fathers are often regarded for their ability to support the mother, rather than their experience being considered a worthy focus itself

[5] The 'perinatal period' is used to refer to the period encompassing pregnancy, labour, birth, and the first postnatal year.

(May & Fletcher, 2013). Perinatal services tend to be mother-centred, and lack father-specific support, which can deter fathers from help-seeking (Colquhoun & Elkins, 2015; Rominov et al., 2017). This pattern is echoed in the literature, whereby parenting and perinatal mental health research is predominantly mother-focused, with fathers comparatively under-represented (Macfadyen, Swallow, Santacroce, & Lambert, 2011). Overall, these findings suggest that traditional social attitudes persist, whereby fathers may feel "relegated to the position of providing support for the mother, rather than having their own role to play" (Barrows, 1999, p.334).

An ecological perspective

To bring together theory and research regarding fathers' experiences, it may be helpful to take an ecological perspective. The Social Ecological Model (SEM; McLeroy, Steckler, & Bibeau, 1988) outlines five levels of influence, extending from intrapersonal to policy level, as shown in Figure 1 (adapted by broadening the previously termed 'policy level' to 'socio-political level'). Ecological models encourage non-individualistic understandings of systems by focusing on dynamic interactions between people *and* systems, rather than looking at people *or* systems independently (Kelly, 2006).

Although the NHS endeavours to provide "a comprehensive service, available to all", with "a wider social duty to promote equality through the services it provides" (NHS, 2015), research suggests that beyond the mothers' medical care needs, parents' access and experiences of perinatal services differs according to their sex (Whitelock, 2016). Factors reported to affect father-inclusion by HCPs include austerity measures contributing to busy workloads, mother-focused workplace traditions, and a lack of father-specific staff training (Whitelock, 2016).

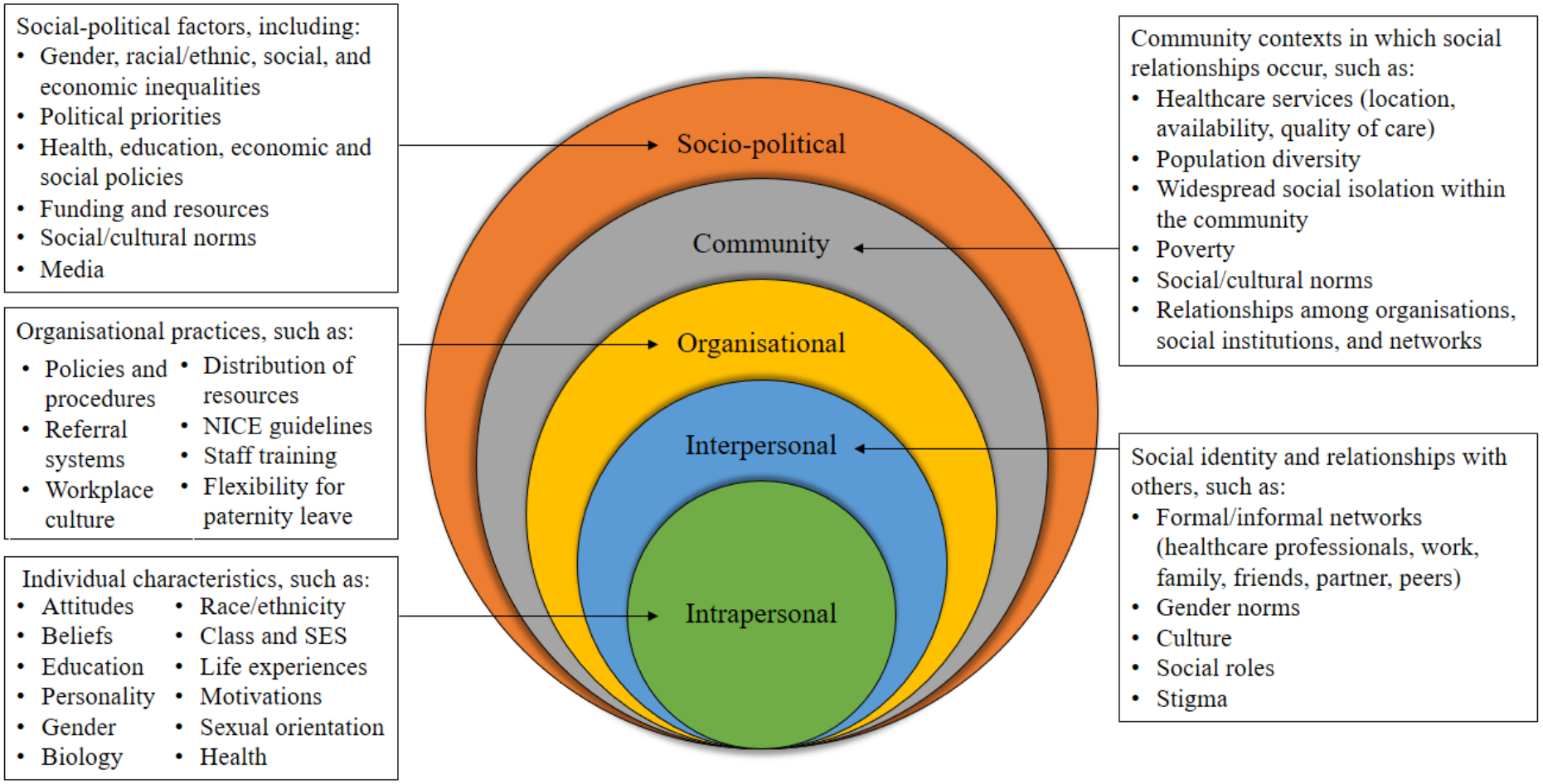


Figure 1. The social ecological model, adapted from McLeroy et al. (1988).

Another important influence may be 'gender norms', which operate in relations between people and become embedded in social institutions, such as family, healthcare, and media (Iacuone, 2005). Internalisation of cultural messages may influence men's behaviours and identities as fathers and their treatment by others (Schmitz, 2016). For instance, fathers in distress have been found to minimise problems to appear mentally strong (Giallo, Dunning, & Gent, 2017), while HCPs may assume men are strong and self-reliant, so offer less help (Courtenay, 2000).

Conceptualisation, endorsement and enactment of dominant masculine ideals within interactions are suggested to differ according to people's sexual orientation, ethnicity, and class in ways that perpetuate social inequalities (Connell, 1987; Connell & Messerschmidt, 2005; Robertson, 2006, 2007; Williams, 2007), which may impact upon their experiences of fatherhood and involvement with perinatal services. The Marmot review emphasised the impact of social inequalities on health and wellbeing and advocated that this should be a key focus of HCPs' work, for every child to receive the best start in life (Department of Health [DoH], 2010).

The social ecological approach to understanding fathers' involvement with services is further supported by research on fathers' engagement with UK family centres, which observed barriers spanning intrapersonal, interpersonal, organisational, and socio-cultural levels (Ghate, Shaw, & Hazel, 2000). The authors emphasised the need for greater clarity in service planning and policy regarding how best to engage fathers. Almost twenty years later, the cultural shift toward involved fatherhood continues, as does the need for more effective attention toward improving father-engagement with services (Hogg, 2014).

Rationale and aims for the current study

Given the increased risk of paternal psychological distress during the perinatal period, and the negative associations with child, couple, and maternal outcomes (Giallo et al., 2013; Kane & Garber, 2004), prevention and early intervention regarding fathers' wellbeing is important for all family members. The transition to parenthood has been highlighted as a high-impact area where midwives and health visitors can make significant differences to parental wellbeing (DoH, 2014; Philpott, 2016). However, it has been stated that "maternity and mental health services do not provide fathers with information and support, despite the wider benefits that this would have for families" (Hogg, 2013, p.38).

Following the NHS value that "everyone counts" (NHS, 2015), this study attempts to give voice to men who may feel marginalised as fathers and facilitate their collaboration with midwives and health visitors. By drawing on experiences and expertise of these key stakeholders operating across different systemic levels, implementation of the recommendation for services to "promote the involvement of men during pregnancy, childbirth and after birth" (WHO, 2015, pg.3) can be better informed. This leads to the following research aims:

1) To gain a greater understanding of fathers' experiences during the perinatal period and of support they receive from HCPs (midwives and health visitors)[6].
2) To understand HCPs' experiences of working with, and understanding of, fathers.
3) To explore fathers' and HCPs' ideas for improving paternal perinatal support.
4) To develop a shared understanding between HCPs and fathers of the most important issues that need addressing in early fatherhood.
5) To identify areas of disagreement between HCPs and fathers and to attempt to understand this gap theoretically.

[6] 'HCPs' will be used to refer to healthcare professionals in midwifery and health visiting roles.

2. Method

Design

A three-round Delphi method (Dalkey & Helmer, 1963) was employed to form collaboration among fathers and HCPs. With the rationale that "*n* heads are better than one" (Dalkey, 1972, p.15), the Delphi method involves two or more rounds of data collection from respondents with real-world knowledge in an area, and encourages consensus-building by sharing feedback among responders (Hsu & Sandford, 2007). This method is widely-used in health research for informing policy, guidelines, and service planning (Jorm, 2015), and is useful for exploring areas where limited research or clarity exists (Hasson, Keeney, & McKenna, 2000).

Qualitative and quantitative methodologies are implemented across the consensus-building process. Qualitative data from open-ended questions at round-one (R1) focus groups are developed into statements. Statements are fed-back in a round-two (R2) online survey to more participants, asking them to rate their agreement with the statements. In round-three (R3), R2 participants receive individualised surveys comprising the same statements, each statement displayed with their previous R2 response and the average response from all participants. Participants are invited to re-rate statements if they wish, in light of the groups' responses, with the aim to clarify consensus and divergence of 'expert' opinions (Hasson et al., 2000).

Participant recruitment

Taking 'expert' to include "any individual with relevant knowledge and experience of a particular topic" (Cantrill, Sibbald, & Buetow, 1996, pg.69), fathers and HCPs were recruited for their expertise of parenthood and of providing or receiving perinatal services (see Table 1 for eligibility criteria). Various recruitment strategies were employed in efforts to acquire representative samples. Fathers were approached in children's centres, given study information

and the opportunity to opt-in. Snowball and purposeful sampling was conducted on the social media website, 'Facebook', via fathers' groups in London and the researcher's personal contacts. Perinatal service managers across London were contacted via telephone and email requesting whether they could distribute study information to their teams, or whether the researcher could present the research in team meetings.

Table 1. Participant inclusion criteria

Fathers	Health visitors and midwives
• Fathers with a 0-3-year-old biological child born in London using NHS services. • Fathers who were involved during the pregnancy, birth, and postnatal year. • Able to speak and read English.	• Qualified and in post with London NHS services for at least 6 months. • Have had at least some contact with fathers to reflect on.

Ethics

This study received approval from the Dulwich Research Ethics Committee, Health Research Authority and local NHS R&D departments (Appendices C-E). The British Psychological Society (BPS) Code of Ethics and Conduct (2009) was followed throughout. Participants received information sheets, detailing the research, risks, participant rights, confidentiality, and resources for help and support (Appendices F-H). Participants were allocated individual participant numbers to maintain anonymity, and were informed that their anonymous responses may be shared with other participants, included in the write-up, and future publications. Informed consent was obtained before participation (see Appendices I-J), and a debrief provided following each round (see Appendices K-M).

Quality assurance and reflexivity

Before data collection, the researcher undertook a 'bracketing' interview to reflect on potential influences of her personal context, subjectivity, and biases regarding the topic (Finlay & Gough, 2008), and endeavoured to find evidence to disconfirm her preconceptions (see Appendix N). Ongoing reflection and consultation with supervisors aided researcher neutrality. Maintenance of a research diary improved dependability of decision-making during the Delphi process (Borg, 2001; Appendix O). The researcher took a critical realist epistemological stance (Bhaskar, 1979), with the idea that real-world processes and structures exist, but our knowledge of these realities is mediated by our discourses and assumptions (Sayer, 2004).

Qualitative and quantitative data collection using different methods (methods triangulation) from participants with heterogenous viewpoints (data source triangulation) facilitated a comprehensive, well-developed, deeper understanding of the topic (Patton, 1999). Online surveys allowed time-efficient data collection, and participant anonymity – reducing conformity and social desirability biases potentially present in focus groups (Bowles, 1999).

Measures

The researcher developed R1 focus group schedules to meet the research aims (Appendix P and Q). Questions designed to measure participant demographics, contextual information, and fathers' exposure to parental stressors were administered at R1 and R2 (Appendices R-V). Each online survey was developed based on the previous round (described further below), and distributed using Bristol Online Survey software. Focus group schedules and online surveys were piloted by a father and a midwife, and reviewed by a research supervisor. Changes were made to broaden focus group questions, and re-word online survey questions.

Data collection and analysis

The three-round Delphi process took six months between August 2017 and February 2018. This section describes the data collection and analysis procedures according to the three rounds. Figure 2 depicts the Delphi procedure flowchart.

R1 focus groups

The researcher facilitated two, approximately 90-minute, focus groups – one with HCPs, and one with fathers. Semi-structured protocols were designed to elicit information regarding the research questions, and applied flexibly to allow participants to take discussions in their desired directions within relevance to the topics.

R2 online survey

R1 data were transcribed and analysed using thematic analysis (Braun & Clarke, 2006), inductively and deductively to identify 'theory-driven' and 'data-driven' codes (Appendices W-X; Booth & Carroll, 2015). Data extracts were ordered by codes, and grouped under subthemes and themes. These grouped data extracts were presented to a colleague (uninvolved in the project). Codes and subtheme titles were randomly organised in another document. The colleague was asked to match the codes and subthemes to the grouped data extracts. This process resulted in an inter-rater agreement of 90% for father data, and 85% for HCP data, which is sufficient according to Miles and Huberman (1994). Minor changes to codes and sub-themes were made in consultation with the second rater.

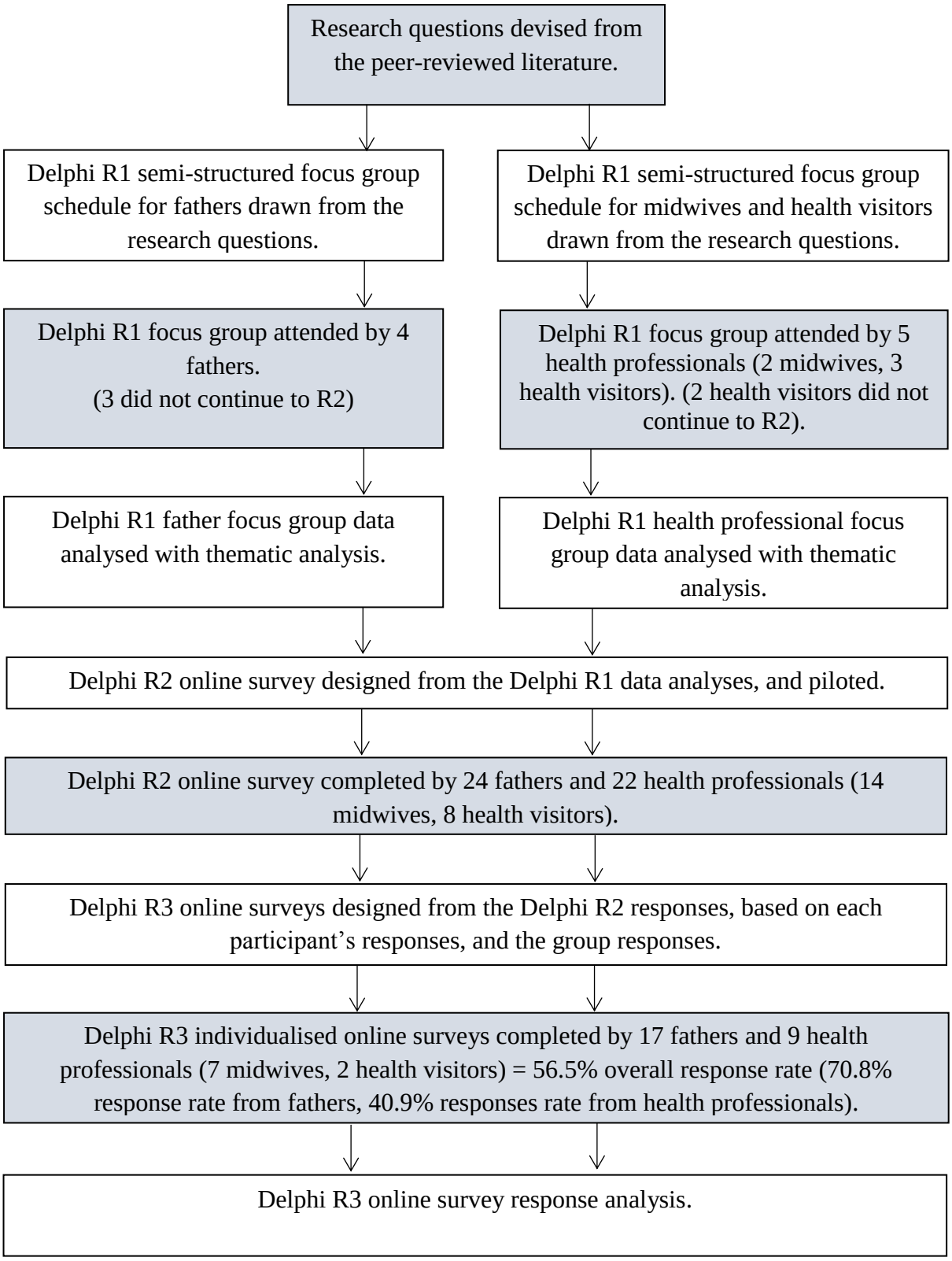


Figure 2: Flow diagram depicting the three-round Delphi procedure

Statements were then devised according to the codes to reflect participants' qualitative responses, using their words where possible. With the aim of gathering consensus between groups, fathers and HCPs needed to complete the same R2 online survey (Appendix Y). Therefore, themes from both focus groups were collapsed together to form six final themes (Table 7, pg. 119). The 82 statements pertaining to the themes were stated in a neutral way to be relevant to fathers and HCPs. Fourteen additional statements were deemed too specific to HCPs' experiences, so were only presented to HCPs. Participants were asked to rate statements on a six-point Likert scale from 'strongly disagree' to 'strongly agree' (see Figure 3), and invited to leave comments upon completing each section. The survey took approximately 25 minutes, and was online for 30 days.

The importance of fathers

Please rate how much each statement is true to your own experiences of being a father **during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year),** or of being a health professional who has contact with fathers during this time. ✱ *Required*

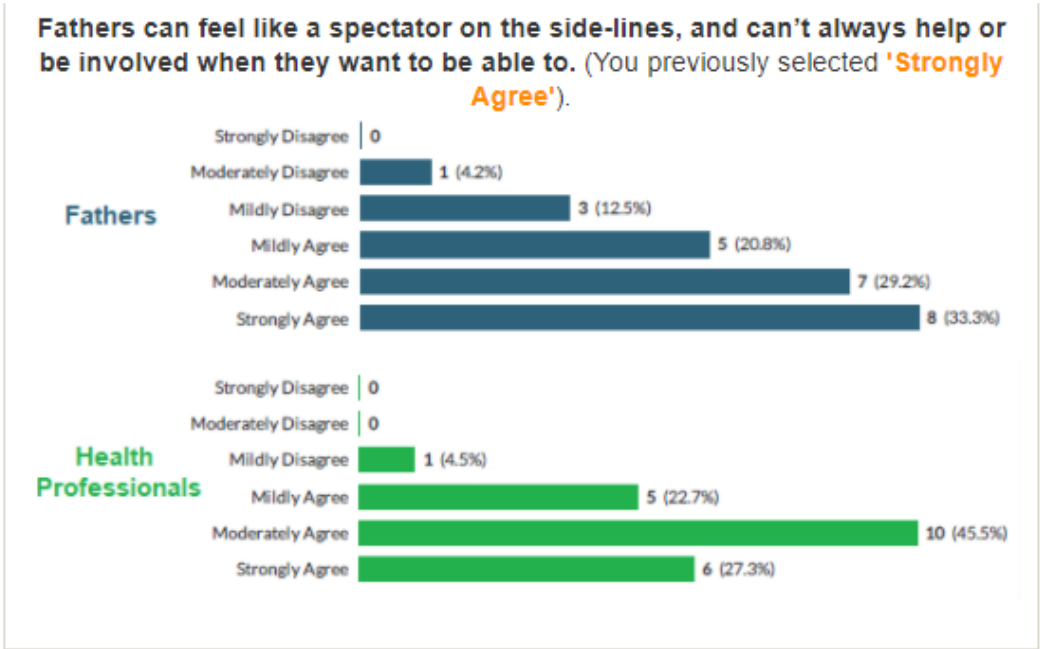
Please don't select more than 1 answer(s) per row.

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
Becoming a parent is just as important to fathers as it is to mothers	☐	☐	☐	☐	☐	☐
Fathers are equally as able as mothers to be good primary caregivers for their children	☐	☐	☐	☐	☐	☐

Figure 3. Example of R2 survey statements

R3 online surveys

R3 had the same statements as R2, except for statements which already reached ≥75% consensus for both groups (leaving 62 statements for both groups, and an additional five for HCPs). R3 surveys (Appendix Z) were individualised for each R2 participant, whereby each statement was presented with their previous response, and both groups' overall responses (see Figure 4). Qualitative R2 comments were anonymously presented at the top each section. Participants were invited to consider both groups' ratings and comments and review and re-rate statements if they wished. R3 surveys were available for three weeks, and took approximately 20 minutes to complete. Participants were sent an email reminder one week before the surveys came offline.



	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐

Figure 4. Example of individualised R3 survey statement.

Quantitative analysis of consensus and divergence

Following data collection, the 6-point Likert scale was collapsed into three categories to indicate participants' disagreement or agreement to statements, as shown in Figure 5 and in line with other studies (South, Jones, Creith, & Simonds, 2015). Only strong or moderate views are presented in the results, in line with the research aims. Percentages of disagreement (sum of percentage of participants selecting 1 and 2 [Figure 5]) and agreement (sum of percentage of participants selecting 5 and 6) were calculated for each statement, separately first for fathers and HCPs, to get within-group consensus percentages, then for both groups together to calculate overall consensus per statement.

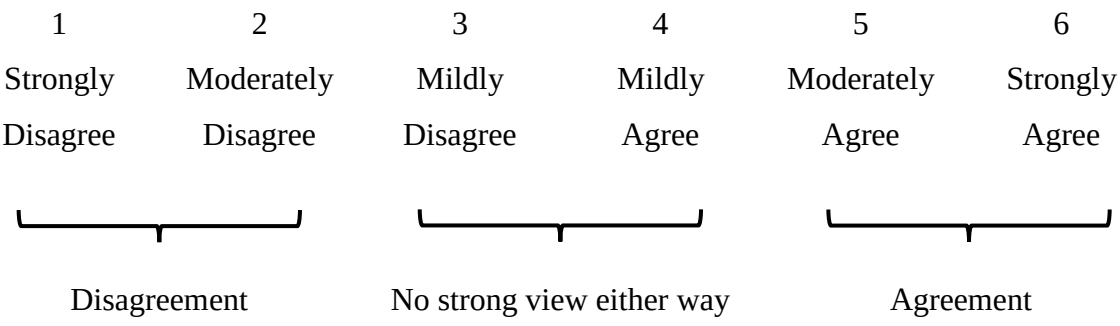


Figure 5. Collapsed categories of Likert scale ratings

Consensus categories are highly variable across Delphi studies, with no consensus levels agreed upon thus far (Hsu & Sandford, 2007). This study chose, in advance, to operationalise strong consensus as 75% or more, as a mid-point between the 70% and 80% cited in other papers (e.g. Berk et al., 2011; Bisson et al., 2010), and due to lower consensus cut-offs recommended for studies with multiple panels (Jorm, 2015). Following other Delphi's (e.g. South et al., 2015), less than 50% was used to define a lack of consensus. The remaining 50-75% was halved to categorise weak and moderate consensus (see Table 2).

Table 2. Consensus categories

Consensus categories	**Level of agreement ('moderately agree' and 'strongly agree') or disagreement ('moderately disagree' and 'strongly disagree')**
Strong consensus	≥75%
Moderate consensus	62.5%-74.9%
Weak consensus	50%-62.4%
Lack of consensus	<50%

It was deemed inappropriate to run tests of significance on the data, as the survey had more items than participants, which reduced power to detect effects and heightened the risk of Type-I error. Attempts to reduce this risk by grouping data by themes for factor analysis was not possible because items within each theme were not measuring the same thing. Therefore, consensus and divergence are interpreted via descriptive statistics.

3. Results

Participant information

A total of 51 participants contributed to the study (27 fathers, 24 HCPs). Figure 2 displays the flow of participants from R1 to R3. R2 responses from participants who did not complete R3 were used as their final responses (Pipon-Young et al., 2010), giving a final sample size of 46 (24 fathers, 22 HCPs). The rate of HCPs (40.9%) and fathers (70.8%) continuing from R2 to R3 represents completion rates expected in Delphi studies (40-75%; Gordon, 1994).

Tables 3 and 4 display participant demographics. Paternal stressors indicated by fathers at R1 (Appendix S) and in qualitative comments at R2 are presented in Table 5, and stressors suggested by fathers' quantitative ratings at R2 (Appendix U) are presented in Table 6.

Table 3. HCP demographic information

Demographic information		**Round 1 (N=5)**	**Round 2 and 3 (N=22)**
Age:	18-24	-	1
	25-34	-	9
	35-44	2	3
	45-54	2	7
	55-64	1	2
Gender:	Female	5	22
Ethnicity:	White	4	17
	Black	1	2
	Mixed ethnicity	-	2
	Any other ethnic group	-	1
Profession:	Midwife	2	14
	Health visitor	3	8
Length of time in role:	Mean	9.7 years	8.3 years
	Range	2.5-18.2 years	2-28 years
Frequency of contact with fathers at work:	As often as mothers	1	3
	Almost as often as mothers	1	8
	Half as often as mothers	3	10
	Rarely	-	1

Table 4. Father demographic information

Demographic information		**Round 1 (N=4)**	**Round 2 and 3 (N=24)**
Age:	25-34	1	13
	35-44	2	10
	45-54	1	-
	65+	-	1
Ethnicity:	White	4	23
	Other mixed	-	1
Educational attainment:	A-Level	1	2
	University degree and higher	3	22
Annual household income:	£26,000-£31,999	-	2
	£32,000-63,999	2	4
	£64,000 or more	2	18
Number of children:	1	4	17
	2 or more	-	7
Age at having first child:	Mean	37.5 years	33.96 years
	Range	28-43 years	24-65 years
Living arrangements:	With mother and child(ren)	3	24
	Apart from the mother with split custody of child(ren)	1	-
Employment status in baby's first year:	Full-time	3	18
	Part-time	-	1
	Self-employed	1	5
Length of paternity leave:	1-2 weeks	1	14
	2-4 weeks	1	4
	1-3 months	1	-
	Longer than 3 months	1	3
	N/A	-	3

Table 5. Paternal stressors reported by fathers in questionnaires given at R1 (Appendix S) and in qualitative comments given without prompts during R2

Stressors during the perinatal period
Unplanned pregnancy
Not in a relationship with the mother
Baby distressed during labour
Baby born by emergency caesarean
Traumatic birth
Concerns over the mother's physical health
Baby had colic
Baby had difficulty feeding
Father felt socially isolated
Father experienced mental health problems
Mother experienced mental health problems
Relationship discord with the mother
Sexual relationship difficulties with mother
Domestic abuse from mother to father
Relationship break-up with the mother
Mother restricted father-baby contact
Child social services involvement
Moved to a new house

Table 6. Prevalence of perinatal difficulties indicated by fathers in the R2 online survey questions (Appendix U)

Stressors	**Disagree**	**Agree**
The pregnancy was straight forward.	12.5%	66.7%
The birth was straight forward.	66.7%	25%
No complications during baby's first year.	25%	41.7%
Few difficult life events or stressors in the postnatal year	50%	37.5%

Delphi round 1

Thematic analysis of each focus group transcript identified significant themes relating to the research aims of: (1) understanding fathers' experiences; (2) understanding HCPs' experiences of working with, and understanding of, fathers; and (3) both groups' ideas for paternal perinatal support improvements. Table 7 displays the how themes from both groups were collapsed together to form six final themes. The 82 statements for the R2 survey were organised within these six final themes for both groups, with 14 additional statements presented separately for HCPs.

Table 7. Themes from the fathers' focus group and healthcare professionals' focus group

Father focus group themes	**HCP focus group themes**	**Collapsed themes for online surveys**
Practical and biopsychosocial aspects of becoming a father; Relationships in the triad; Fathers' position	What staff in perinatal services notice about fathers when they see them; Staff recognition of the importance of fathers	Practical, psychosocial, and relational aspects of becoming a father; The importance of fathers; Fathers' position
The issue of (dis)parity	Societal and cultural context for perinatal staff working with families	Social and cultural context of men as fathers, and for healthcare professionals working with fathers
Perceived strengths and weaknesses of services	How midwives and health visitors respond to and work with fathers within their context and capacity; Service context, provision, and constraints for perinatal staff working with families	Perceived strengths and weaknesses of perinatal services
What fathers want	What is currently working well, and what can be done to improve father experience	Ideas of what services should continue, enhance, or improve to benefit fathers' experiences

Delphi rounds 2 and 3

Results from R2 and R3 are structured according to the six collapsed themes from R1. For each theme, a table displays statements pertaining to that theme. Fathers', HCPs', and both groups' overall levels of agreement and disagreement is displayed with each statement.

Statements are grouped according to the consensus categories that the overall level of agreement fits within, starting with strong consensus (refer to Table 2). When a subgroup's level of consensus differs from the overall general category within which it is displayed, the percentage of agreement/disagreement for that group is in bold to draw the reader's attention to the difference.

To justify the final results including R2 responses from participants who discontinued, the difference in mean Likert-scale scores was calculated between R2 and R3 data for each participant who continued to R3. The difference did not vary more than one Likert scale point for any participant between R2 and R3. Therefore, it was deemed justifiable to include data from R2-completers with data from R3-completers in the final percentage averages displayed in the results tables. Results from each table will be discussed in the text, with illustrative quotes from R1 and R2.

Theme 1: Practical, psychosocial, and relational aspects of becoming a father

Eighteen statements pertained to practical, psychosocial, and relational aspects of becoming a father (Table 8). Both groups strongly agreed that fathers observe changes in themselves, the mother, and their relationship, and that communication, negotiation, and compromise between the parents is important during this time. This is reflected in the following quote from a father:

"These are roles that we're sort of playing…trying to work out what our new sort of position is in our relationship now that there's a third person…there's definitely been a change."

(Focus group father)

Fathers strongly agreed that during pregnancy, men anticipate and build expectations about what fatherhood might bring, which received weak consensus among HCPs. Fathers also strongly agreed that it feels like two caregivers are necessary to meet the demands of parenthood, and that parents experience difficulties in their sexual relationship during this time, which received no consensus from HCPs.

HCPs reached moderate-to-strong consensus regarding statements suggesting that if experiencing difficulties, fathers may not feel able to turn to professionals, parents may want to appear like they are coping, and may worry about what process they might be entered into if they disclosed difficulties. Fathers reached weak-to-no consensus on these statements. Although, it is still worth noting that over half of fathers disagreed with feeling able to approach professionals for support.

A third of statements reached no within- or between-group consensus, such as statements around mother-father relationship difficulties. However, a lack of consensus does not mean the results are unimportant. For instance, at least a third of fathers reported experiencing difficult emotions (e.g. anxiety, low mood), increased partner-conflict, and feeling alone or divided from the mother over the perinatal period.

Table 8. Consensus for statements relating to practical, psychosocial, and relational aspects of becoming a father

Strong consensus overall		**Disagree (%)**	**Agree (%)**
Communication, negotiation, and compromise between the father and mother is important during the perinatal period.	Fathers	0	91.7
	HCPs	0	95.5
	Overall	0	93.5
Men experience personal changes in themselves, and observe personal changes in the baby's mother too.	Fathers	0	91.7
	HCPs	4.5	81.8
	Overall	2.2	87
The relationship dynamic between the mother and father changes when there is the baby in the relationship too.	Fathers	0	79.2
	HCPs	4.5	81.8
	Overall	2.2	80.4
During pregnancy, men anticipate and build expectations about different aspects of what fatherhood might bring	Fathers	4.2	95.8
	HCPs	0	**59.1**[1]
	Overall	2.2	78.3
Moderate consensus overall		**Disagree (%)**	**Agree (%)**
Both parents' priorities are redirected onto the baby	Fathers	0	**83.3**
	HCPs	13.6	63.6
	Overall	6.5	73.9
It feels like two caregivers are necessary to meet the demands of parenthood	Fathers	4.2	**87.5**
	HCPs	18.2	**45.5**
	Overall	10.9	67.4
Men experience a complex mixture of positive, difficult, and deep emotions over the perinatal period	Fathers	4.2	70.8
	HCPs	0	63.6
	Overall	2.2	67.4
Men experience positive emotions much of the time (e.g. excitement, joy) over the perinatal period	Fathers	4.2	**83.3**
	HCPs	0	**40.9**
	Overall	2.2	63
Fathers feel able to turn to professionals or services for support if they are finding it difficult to cope	Fathers	**54.2**	8.3
	HCPs	72.7	0
	Overall	63	4.3
Weak consensus overall		**Disagree (%)**	**Agree (%)**
Fathers and mothers who are together experience difficulties in their sexual relationship during this time	Fathers	8.3	**79.2**
	HCPs	13.6	**40.9**
	Overall	10.9	60.9
During baby's first year, parents may want to appear to health professionals that they are coping well, even if they are really struggling	Fathers	20.8	**29.2**
	HCPs	0	**77.3**
	Overall	10.9	52.2

Parents may worry about what process they might be entered into if they are open with services about difficulties they are having	Fathers	8.3	**37.5**
	HCPs	0	**68.2**
	Overall	4.3	52.2
Lack of consensus overall		**Disagree (%)**	**Agree (%)**
The different roles and experiences fathers and mothers have during the perinatal period (e.g. one parent returning to work, breastfeeding, different emotional experiences, or different levels of childcare involvement) can leave fathers feeling quite alone or divided from the mother	Fathers	16.7	37.5
	HCPs	0	**59.1**
	Overall	8.7	47.8
The mother and father have more arguments and disagreements	Fathers	12.5	37.5
	HCPs	9.1	40.9
	Overall	10.9	39.1
Fathers do not always know how to manage relationship conflict or difficulties if they occur with the mother	Fathers	25	33.3
	HCPs	4.5	40.9
	Overall	15.2	37
There is an overwhelming amount of information and advice for expectant and new fathers to sift through	Fathers	20.8	25
	HCPs	27.3	36.4
	Overall	23.9	30.4
Men experience difficult emotions much of the time (e.g. anxiety, stress, worry, low mood) over the perinatal period	Fathers	29.2	33.3
	HCPs	4.5	27.3
	Overall	17.4	30.4
Fathers feel able to turn to family or friends for support if they are finding it difficult to cope	Fathers	4.2	41.7
	HCPs	27.3	13.6
	Overall	15.2	28.3

[1] A percentage in bold indicates that a groups' level of consensus differs from the consensus category within which it is displayed.

Theme 2: The importance of fathers

Fathers and HCPs demonstrated strong consensus on all nine statements relating to the importance of fathers (Table 9), with 100% agreement that fathers are important for mothers' and babies' psychological wellbeing. Both groups strongly agreed that fathers are equally able as mothers to be good primary caregivers for their children, although fathers did not agree as strongly as HCPs. No participants indicated disagreement with any statements under this theme. As strong consensus was reached on all statements at R2, participants were not asked to re-rate their level of agreement with these statements at R3. One focus group father

highlighted how he is in a position to recognise difficulties that the mother may be experiencing, and inform a HCP:

"I feel that sometimes there is some input I could give to the health visitor about what I've seen that maybe mum hasn't noticed herself, or is trying to hide…which could be helpful."

(Focus group father)

Table 9. Consensus for statements relating to the importance of fathers

Strong consensus overall		**Disagree (%)**	**Agree (%)**
Fathers are important for the psychological wellbeing of the baby (e.g. being an attachment figure for the baby, and supporting the mother's bond with the baby).	Fathers	0	100
	HCPs	0	100
	Overall	0	100
Fathers are important for the psychological wellbeing of the mother (knowing about her mood and coping, and providing support).	Fathers	0	100
	HCPs	0	100
	Overall	0	100
Fathers are important for being the baby's main caregiver if the mother is not able.	Fathers	0	100
	HCPs	0	95.5
	Overall	0	97.8
Fathers are important for being an overall source of help and support.	Fathers	0	95.8
	HCPs	0	95.5
	Overall	0	95.7
When the father has difficulty coping, it makes things more difficult for the mother too.	Fathers	0	95.8
	HCPs	0	95.5
	Overall	0	95.7
Becoming a parent is just as important to fathers as it is to mothers.	Fathers	0	91.7
	HCPs	0	100
	Overall	0	95.7
Fathers are important for the physical health of the baby (e.g. bottle feeding, supporting breastfeeding, being aware of the baby's physical health and what to look out for).	Fathers	0	91.7
	HCPs	0	90.9
	Overall	0	91.3
Fathers may have important information to share about their experiences or coping, which health professionals are unlikely to find out unless they ask fathers directly.	Fathers	0	91.7
	HCPs	0	90.9
	Overall	0	91.3
Fathers are equally as able as mothers to be good primary caregivers for their children.	Fathers	0	75
	HCPs	0	90.9
	Overall	0	82.6

Theme 3: Fathers' position

Of 16 statements relating to the positioning of fathers (Table 10), fathers and HCPs strongly agreed that fathers who are present tend to be involved fathers, and moderately agreed that fathers can feel like a spectator on the side-lines, not always able to help or be involved when they want to. This reflected the discussion between fathers at the focus group, who described feeling like "*an alien in the room", "excluded",* and like *"a secondary figure"*. One father reflected on an experience he had on the ward following the birth when a HCP came to speak to his wife:

> *"a lady came around and pulled the curtain around the bed with me standing on the other side of the curtain…there wasn't even an acknowledgement that I was in the room"*
>
> (Focus group father)

Fathers strongly agreed that they are considerate of the mother's experiences, and of health services and professionals' point of view, and are accepting of how they are treated by services at the time. HCPs moderately agreed with fathers' consideration of mothers, but reached no consensus regarding fathers' consideration and acceptance of HCPs and services. This may be due to HCPs working with a variety of men, making it difficult to generalise. Indeed, one HCP reflected: "*It is difficult to generalise about fathers as everyone is very different and their response to becoming a father is different for each person*".

Fathers strongly agreed that aside from physical/medical care, women should still get more support and attention than men, and the mother of the baby has more power than the father during the perinatal period, whereas HCPs reached no consensus on either statement. Half of

fathers agreed with being aware that health professionals assessed whether they can be trusted with the mother and baby, whereas 4.5% of HCPs agreed that fathers are aware of this.

Table 10. Consensus for statements relating to fathers' position

Strong consensus overall		**Disagree (%)**	**Agree (%)**
Fathers who are present in their baby's life tend to be involved caregivers for their baby	Fathers	0	91.7
	HCPs	0	77.3
	Overall	0	84.8
Fathers are considerate of the mothers' experiences, try to make sure she is okay, and look out for her overall wellbeing	Fathers	0	95.8
	HCPs	0	**72.7**
	Overall	0	84.8
Moderate consensus overall		**Disagree (%)**	**Agree (%)**
Fathers can feel like a spectator on the side-lines, and can't always help or be involved when they want to be able to	Fathers	4.2	62.5
	HCPs	0	72.7
	Overall	2.2	67.4
Weak consensus overall		**Disagree (%)**	**Agree (%)**
The mother of the baby has more power than the father during the perinatal period	Fathers	8.3	**75**
	HCPs	4.5	**45.5**
	Overall	6.5	60.9
Fathers follow the mothers' lead, as the mothers tend to be a few steps ahead regarding information during the perinatal period	Fathers	4.2	54.2
	HCPs	0	**63.6**
	Overall	2.2	58.7
Fathers are considerate and understanding of the health services' and professionals' point of view	Fathers	4.2	**83.3**
	HCPs	13.6	**27.3**
	Overall	8.7	56.5
Fathers are accepting of how they are treated by services, at the time	Fathers	16.7	**75**
	HCPs	9.1	**36.4**
	Overall	13	56.5
Fathers can feel excluded from the baby by perinatal services (e.g. midwives and health visitors)	Fathers	20.8	**45.8**
	HCPs	4.5	**68.2**
	Overall	13	56.5
Aside from the physical aspect of pregnancy, childbirth, and breastfeeding, women should still get more support and attention during the perinatal period than men	Fathers	4.2	**79.2**
	HCPs	18.2	**31.8**
	Overall	10.9	56.5
Fathers are confused about how much they could or should be involved during sessions, classes, appointments, or on the ward	Fathers	16.7	54.2
	HCPs	0	**45.5**
	Overall	8.7	50

Lack of consensus overall		**Disagree (%)**	**Agree (%)**
Fathers can feel excluded from the baby by other people stepping in, such as a mother-in-law, or sister, or aunt	Fathers	41.7	20.8
	HCPs	0	**54.5**
	Overall	21.7	37
Fathers are aware that health professionals are assessing whether fathers can be trusted with the mother and baby	Fathers	20.8	**50**
	HCPs	27.3	4.5
	Overall	23.9	28.3
Fathers find it difficult or uncomfortable to involve themselves during sessions, classes, appointments, or on the ward	Fathers	29.2	29.2
	HCPs	9.1	27.3
	Overall	23.9	28.3
Fathers can feel excluded from the baby by the mother	Fathers	**54.2**	8.3
	HCPs	9.1	36.4
	Overall	32.6	21.7
Fathers openly voice their experiences to health professionals, without being asked	Fathers	25	25
	HCPs	**54.5**	4.5
	Overall	39.1	15.2
Men are less instinctive and attuned to their babies than women are	Fathers	29.2	12.5
	HCPs	31.8	13.6
	Overall	30.4	13

Theme 4: Social and cultural context of men as fathers, and HCPs working with fathers

Three of the five statements regarding the social and cultural context (Table 11) received strong consensus among fathers and moderate consensus among HCPs (creating strong consensus overall): that parenting support for men needs to catch up with society's expectations of men as involved parents, that today's fathers were raised more by their mothers than their fathers, and that sharing parental leave more would have benefits for the family. Two midwives reflected:

> *"the more this time is divided and shared, the better everything will get…men will understand what women are facing and the other way around."*
>
> (focus group HCP)

"they come from a generation…that their parents weren't like that so they're kind of these 'new men'…they're getting more involved in early family life"

(focus group HCP)

Fathers and HCPs moderately agreed that men tend to have less preparation for parenthood than women. The weakest consensus among both groups pertained to whether equality between the sexes is getting better.

Table 11. Consensus for statements relating to the social and cultural context of men as fathers, and HCPs working with fathers

Strong consensus overall		**Disagree (%)**	**Agree (%)**
The parenting support currently provided to men needs to catch up with society's expectations of men as involved parents	Fathers	0	87.5
	HCPs	9.1	**63.6**
	Overall	4.3	76.1
Today's fathers were raised by a generation in which the mothers were more involved in childcare than the fathers were	Fathers	4.2	83.3
	HCPs	9.1	**68.2**
	Overall	6.5	76.1
The more that mothers and fathers share parental leave and childcare equally, the better things will be for the mothers, fathers, the parent relationship, and for the children	Fathers	4.2	79.2
	HCPs	4.5	**72.7**
	Overall	4.3	76.1
Moderate consensus overall		**Disagree (%)**	**Agree (%)**
In life, men tend to have less preparation and support for parenthood than women	Fathers	0	62.5
	HCPs	4.5	68.2
	Overall	2.2	65.2
Weak consensus overall		**Disagree (%)**	**Agree (%)**
Equality between the sexes in our society is getting better	Fathers	4.2	58.3
	HCPs	4.5	50
	Overall	4.3	54.3

Theme 5: Perceived strengths and weaknesses of perinatal services

Of 18 statements pertaining to perceived strengths and weaknesses of perinatal services (Table 12), twelve had weak overall consensus between groups, and four lacked consensus. Only one statement had reached strong consensus overall, suggesting that services are mainly geared towards mothers rather than both parents. One statement reached moderate consensus overall, that support for fathers provided by HCPs varies a lot between different members of staff. This is reflected in the comments from fathers:

"psychological needs are probably very similar…my experience was the mums were reached out to on that properly and quite well…I was certainly never asked."

(Focus group father)

"The midwife was very, very engaging in terms of ready and waiting to answer any questions …showing as much concern for my emotional wellbeing as for [my wife's]."

(Focus group father)

The remaining statements reached weak or no overall consensus – many with different consensus levels between groups. For instance, fathers reached strong consensus in agreeing that the process was unclear as to how they could seek help from services about their own or the mother's coping, whereas HCPs reached no consensus for this statement. HCPs reached weak consensus on three statements that received moderate consensus from fathers, suggesting that fathers are not drawn in by services, and that attention toward the father-baby relationship and fathers' psychological coping is lacking. HCPs reached no consensus for three further statements for which fathers reached moderate consensus in agreeing that there is not enough attention to the father-mother relationship, the family unit, or to the fathers' role and how they

can be involved. HCPs reached moderate consensus in their agreement that HCPs genuinely respect and value fathers, whereas fathers reached no consensus about this.

Neither group reached consensus on whether HCPs do a good job with father-inclusion and engagement.

Table 12. Consensus for statements relating to strengths and weaknesses of perinatal services

Strong consensus overall		**Disagree (%)**	**Agree (%)**
Services are mainly geared towards mothers, rather than both parents	Fathers	4.2	79.2
	HCPs	4.5	**72.7**
	Overall	4.3	76.1
Moderate consensus overall		**Disagree (%)**	**Agree (%)**
Support for fathers provided by health professionals varies a lot between different members of staff	Fathers	8.3	**75**
	HCPs	9.1	68.2
	Overall	8.7	71.7
Weak consensus overall		**Disagree (%)**	**Agree (%)**
Health professionals do not pay enough attention to the father-baby relationship	Fathers	4.2	**70.8**
	HCPs	13.6	50
	Overall	8.7	60.9
Fathers are not drawn in by services to be present and involved – it is down to fathers to actively involve themselves	Fathers	12.5	**66.7**
	HCPs	0	54.5
	Overall	6.5	60.9
Services give a lack of attention to how fathers are coping mentally, psychologically, or emotionally	Fathers	8.3	**62.5**
	HCPs	13.6	54.5
	Overall	10.9	58.7
When services show focus or concern to the father, it is actually out of concern for the mother and/or baby	Fathers	4.2	58.3
	HCPs	13.6	54.5
	Overall	8.7	56.5
Health services do not provide fathers with obvious routes to support regarding their parenting of the baby	Fathers	8.3	58.3
	HCPs	4.5	54.5
	Overall	6.5	56.5
Health professionals genuinely respect and value fathers	Fathers	12.5	**45.8**
	HCPs	0	**63.6**
	Overall	6.5	54.3

The process is not made clear to fathers of how they can seek help from services should they have concerns about their own or the mother's coping	Fathers	4.2	**75**
	HCPs	9.1	**31.8**
	Overall	6.5	54.3
There is a lack of focus on the family unit as a whole from health professionals	Fathers	4.2	**66.7**
	HCPs	13.6	**40.9**
	Overall	8.7	54.3
Fathers receive less contact with health professionals than mothers because fathers are often at work when the appointments happen	Fathers	12.5	58.3
	HCPs	9.1	50
	Overall	10.9	54.3
Health professionals sometimes provide information and advice according to their personal opinions regarding matters where there are several possible evidence-based options that parents could consider	Fathers	4.2	**62.5**
	HCPs	18.2	**40.9**
	Overall	10.9	52.2
Fathers receive a lack of guidance on the father's role, and how they can be involved in the pregnancy, birth, and/or baby's first year	Fathers	8.3	**62.5**
	HCPs	13.6	**40.9**
	Overall	10.9	52.2
Health professionals do not pay enough attention to the father-mother relationship	Fathers	4.2	**66.7**
	HCPs	22.7	**36.4**
	Overall	13	52.2
Lack of consensus overall		**Disagree (%)**	**Agree (%)**
Fathers receive a lack of opportunities to discuss their questions, concerns, or experiences	Fathers	8.3	**54.2**
	HCPs	9.1	36.4
	Overall	8.7	45.7
Health professionals do a good job engaging with fathers, and helping fathers to feel included	Fathers	20.8	29.2
	HCPs	27.3	31.8
	Overall	23.9	30.4
Fathers receive enough invitations to appointments and sessions	Fathers	37.5	20.8
	HCPs	31.8	27.3
	Overall	34.8	23.9
Services prepare fathers well for the physical elements of having a baby	Fathers	33.3	12.5
	HCPs	31.8	18.2
	Overall	32.6	15.2

Theme 6: Ideas of what services should continue, enhance, or improve to benefit fathers' experiences

Eleven of 16 statements related to ideas of what services should continue or improve (Table 13) received strong overall consensus between groups, agreeing that there should be more focus on the father-mother relationship, the psychological, emotional and relational impact of

parenthood, for services to be family-centred, for HCPs to receive more training on working with fathers, and for improved father-inclusion (via body language, invitations to appointments, skin-to-skin with baby after birth, facilitating overnight stays on the ward, and father-specific preparation, information and guidance). As two focus group fathers suggested: *"more of the psychology behind what might be going on and what…could happen"*, and *"more about the…relationship impact"*.

Fathers reached strong consensus in agreeing that it should be a formal service requirement for HCPs to directly check in with fathers on their experiences and coping, while HCPs reached moderate consensus. HCPs reached moderate consensus in agreeing that there should be more single-sex sessions for men and women, while fathers reached no consensus.

The most divergence was seen for the statement suggesting services provide fathers with a 10-minute 'dad-alone' session. A father at R1 suggested having: *"a ten-minute dad-alone session…where you would be able to say more directly what you were really experiencing."* This received agreement with all focus group fathers, and strong agreement among fathers online. However, HCPs reached no consensus, with one HCP from R2 commenting: *"it would be at the expense of time…with pregnant women, which is unacceptable*".

Yet fathers at R1 highlighted wider benefits of the 'dad-alone' time: "*to take your value judgement on…how is mum doing*", and another reflected: *"you kind of wonder now why that doesn't happen… for your benefit, and for the benefit of…your little proto-family."* These fathers' points correspond with the statement that reached strong agreement across both groups that suggested services should be more family-centred.

"we need to be family-centred. We really need to be looking at this unit and not looking at this woman in isolation."

(Focus group HCP)

Table 13. Consensus for statements relating to what services should continue, enhance, or improve to benefit fathers' experiences

Strong consensus		**Disagree (%)**	**Agree (%)**
For fathers to be better accommodated for staying overnight on the ward (e.g. having the option of staying overnight, having a mat to sleep on, a microwave to heat food, somewhere to wash).	Fathers	0	91.7
	HCPs	0	81.8
	Overall	0	87
For antenatal classes to have more content on the father-mother relationship, raising awareness of the impact that having a baby can have on the relationship, how to nurture the parent relationship, and what can be helpful in managing conflict.	Fathers	0	79.2
	HCPs	0	90.9
	Overall	0	84.8
For health professionals to encourage fathers to have skin-to-skin contact with their baby straight after the birth.	Fathers	0	87.5
	HCPs	4.5	77.3
	Overall	2.2	82.6
For health professionals to signpost fathers to a clear and reputable source of parenting information.	Fathers	0	83.3
	HCPs	0	81.8
	Overall	0	82.6
For services to provide more information and preparation regarding the psychological, emotional and relational aspects of parenthood.	Fathers	0	83.3
	HCPs	0	81.8
	Overall	0	82.6
For health professionals to open up conversations between parents about the choices they have (e.g. who to have in the birth room, or whether to have the father stay the night on the ward with the mother).	Fathers	0	79.2
	HCPs	0	86.4
	Overall	0	82.6
For health professionals to involve fathers in communication with body language, direct questions, and prompts for them to speak.	Fathers	0	75
	HCPs	4.5	86.4
	Overall	2.2	78.2
For fathers to receive invitations to appointments, parent education sessions, and classes.	Fathers	0	75
	HCPs	0	77.3
	Overall	0	76.1
For services to be family-centred rather than mother-centred or baby-centred	Fathers	4.2	75
	HCPs	4.5	77.3
	Overall	4.3	76.1

More father-specific preparation, information, and guidance from health professionals about the father experience and role during the perinatal period	Fathers	0	79.2
	HCPs	0	**72.7**
	Overall	0	76.1
For health professionals to be given more training on how to work with and involve fathers	Fathers	0	**66.7**
	HCPs	4.5	86.4
	Overall	2.2	76.1
Moderate consensus overall		**Disagree (%)**	**Agree (%)**
For it to be a formal requirement that health professionals directly check in with fathers on their coping and experiences	Fathers	4.2	**79.2**
	HCPs	4.5	68.2
	Overall	4.3	73.9
For services to make a clearer differentiation in parenting information between what's important to get right (e.g. making sure the water is the right temperature when washing the baby) and what's personal preference (e.g. bottle feeding or breast feeding)	Fathers	0	**75**
	HCPs	9.1	54.5
	Overall	4.3	65.2
Weak consensus		**Disagree (%)**	**Agree (%)**
For services to provide a clearer idea of what to expect practically, with the aid of something like a calendar of key dates showing when appointments and visits with health services are meant to happen	Fathers	0	54.2
	HCPs	9.1	**63.6**
	Overall	4.3	58.7
For services to provide fathers with a 10-minute 'dad-alone' session with a midwife or health visitor, just like the mother has	Fathers	0	**75**
	HCPs	4.5	**40.9**
	Overall	2.2	58.7
For there to be more single-sex sessions for men as well as for women (e.g. a fathers-only antenatal session, and father-baby groups)	Fathers	4.2	**45.8**
	HCPs	9.1	**63.6**
	Overall	6.5	54.3

Additional statements for HCPs, related to service context, provision, and constraints

Of 14 statements specific to HCPs (Table 14), there was strong consensus for nine statements highlighting the stressful workload, stretched resources, time pressures, lack of training to work with fathers, and the absence of a service requirement for professionals to meet with fathers.

"it would be great to offer more but…time and workload too heavy."

(Online HCP)

"I feel I'm not trained… in my training like nearly 18 years ago fathers weren't part of, they were present, but they weren't as involved…everyone says: "you never spend enough time thinking about the fathers", but that's it…There's no like, how do you do this?"

(Focus group HCP)

HCPs did not reach agreement on three statements, including statements relating to HCPs' reactions to fathers, and whether HCPs sometimes do not ask parents about their experiences due to lack of time.

Table 14. Consensus for additional statements for HCPs

Strong consensus	**Disagree (%)**	**Agree (%)**
There are not quite enough health professionals to meet the demands on the service.	0	100
Health professionals are often not able to offer consistent continuity of care to families.	0	90.9
Health professionals do not have as much time as they feel is needed to talk with parents about their psychological experiences or coping.	0	90.9
Health professionals find it difficult to fulfil their roles to their full potential due to time pressure and stretched resources.	0	90.9
Health professionals do not receive enough training on fathers or how best to include fathers (e.g. what fathers want, what their expectations are, or how to address their needs).	4.5	86.4
The workload is stressful.	4.5	86.4
Attitudes towards how much health professionals should involve fathers varies between different midwifery or health visiting colleagues.	0	81.8
For families where the father is involved, it is not a formal service requirement for health professionals to meet with the fathers.	13.6	81.8
There is a constant pressure of people waiting to be seen.	4.5	77.3
Moderate consensus	**Disagree (%)**	**Agree (%)**
For families where the father is involved, it is not a formal service requirement for health professionals to find out about the fathers' coping and well-being during the perinatal period	18.2	72.7

Weak consensus	**Disagree (%)**	**Agree (%)**
By prioritising cases with obvious safeguarding concerns, families with less obvious safeguarding concerns or difficulties might get missed	18.2	54.5
Lack of consensus	**Disagree (%)**	**Agree (%)**
Health professionals sometimes do not ask parents about their experiences in case the parents are having problems and the health professionals do not have time to listen or support them	27.3	45.5
There are times when the father being present and involved feels uncomfortable, awkward, or problematic for health professionals	13.6	36.4
It can be quite surprising to health professionals when fathers are keenly involved	22.7	27.3

4. Discussion

This Delphi study gained understanding of fathers' experiences during the perinatal period and of support received from HCPs, HCPs' experiences and understanding of fathers, and both groups' ideas for improving paternal perinatal support. The findings are discussed in relation to important areas of between-group consensus and divergence and linked with previous empirical and theoretical literature. Strengths, limitations, and implications for future research and clinical practice are considered.

Fathers' experiences during the perinatal period and of support received from HCPs, and HCPs' experiences of working with, and understanding of, fathers

Findings pertaining to this overarching aim are discussed according to the possible ecological levels at which they may be acting in relation to fathers' experiences and involvement by services. This proposed organisation, also presented in Figure 6, is one of many ways of organising the findings due to the inter-relating and dynamic nature of the various factors.

Socio-political

HCPs' responses to their additional statements reflect wider societal constraints on their capacity to involve fathers, such as staff shortages and lack of resources to provide continuity of care. In response to these issues, the UK government recently announced plans to create over 3000 midwifery training places and improve continuity of care, which the Royal College of Midwives welcomed, but expressed that this may only remedy part of the problem (BBC News, 2018).

The change in culture towards more involved fatherhood (Ranson, 2001) is reflected in both groups' agreement that shared parental leave can benefit the whole family. Historical events,

such as law and policy changes (e.g. shared parental leave, closing the gender pay gap) are hypothesised to facilitate changes to social norms (Bronfenbrenner, 1989). However, despite introducing shared parental leave over 40 years before the UK (Crisp, 2017), Scandinavian research suggests that women still have more responsibility for the home and children than men (Haavind & Magnusson, 2005) and fathers still feel excluded by health services (Johansson et al., 2013). This supports the value of attending to the complex interactions that occur across multiple levels of the social ecological system.

Community

Both groups agreed that society's expectations for involved fatherhood is not mirrored by paternal perinatal support in the community. This may be particularly difficult for fathers as participants agreed that men may have fewer life experiences than women to prepare them for parenthood, and possibly come from generations in which their own fathers were less involved. This has been associated with men having less of a parenting role-model, and feeling less skilled for parenthood than women (Condon et al., 2004), which may hinder adjustment to parenthood and bonding with the baby (Fletcher, 2011).

Organisational

HCPs indicated feeling stretched and stressed with their workloads, and agreed that they lack father-specific training or formal service requirements to meet with fathers. Both groups agreed that services are mother-centred. Organisational structures, such as these, have been found to limit HCPs' likelihood of involving fathers (Whitelock, 2016), and fathers' sense of involvement and likelihood to help-seek from services (Rominov et al., 2017).

Consensus among HCPs that fathers can feel excluded from their baby by perinatal services and that parents may not disclose coping difficulties corresponds with previous findings (Darwin et al., 2017). However, this was challenged by fathers who reached weak-to-no consensus for these statements. Nevertheless, over half of fathers indicated feeling unable to disclose difficulties to professionals.

Fathers concurred that services do not attend enough to the father-mother relationship, family unit, or father's role and involvement – associated in the literature with feelings of exclusion and reduced likelihood to help-seek (Rominov et al., 2017). If they did feel able to voice difficulties, most fathers agreed the help-seeking process for their own or the mother's coping was unclear. HCPs did not agree, which is concerning considering the negative associations of parental psychological distress with partner- and child-wellbeing (Kane & Garber. 2004; Ramchandani et al., 2011).

Interpersonal

Both groups agreed that fathers who are present tend to be involved. There was a remarkable level of consensus across groups regarding the importance of fathers, including their potential benefits to the psychological wellbeing of mother and baby – which is strongly supported in the literature (Sarkadi et al., 2008; Whisman et al., 2011). However, participants also agreed that fathers can feel like spectators on the side-lines. This juxtaposition between the acknowledgement of fathers' importance and their reports of feeling side-lined reflects the ambivalence that can occur across systems during times of change (Hunter et al., 2017).

Both groups recognised that fathers can notice changes in the mother and their couple-relationship. For some parents, relationship changes can increase conflict, associated with less

cohesive co-parenting interactions (McHale, 1995), parental psychological distress (Paulson & Bazemore, 2010) and poorer child outcomes (McHale, 2007). Attachment research has moved beyond the 'infant and the other' dyadic model (Winnicott, 2002), and increasingly acknowledges the importance of family cohesiveness to children's locus of security (McHale, 2007). This is supported by participants' agreement that services should be family-centred, rather than mother- or baby-centred.

A response pattern emerged that suggested misunderstandings in the father-HCP relationship, whereby fathers indicated consideration and understanding of health services' and professionals' perspectives, but HCPs did not agree; while HCPs indicated that they genuinely respect and value fathers, but fathers did not agree. Additionally, half of fathers indicated awareness of HCPs assessing their trustworthiness, while HCPs did not think fathers are aware of this.

The father-HCP relationship may be influenced by the high proportion of female staff in perinatal services (Nursing and Midwifery Council, 2016), as reflected in this study's all-female HCP group. Female HCPs could be more likely to take the mothers' perspective (Barker, 2011).

Intrapersonal

Both groups acknowledged that fathers can experience a complex mixture of emotions and notice personal changes in themselves. Fathers reached strong consensus about anticipating and building expectations of fatherhood during pregnancy, and that two caregivers are necessary for the baby. HCPs did not reach consensus on these statements, perhaps due to encountering single mothers coping alone. It may also reflect the mother-focused nature of

services, in which fathers' experiences and involvement can be overlooked or underestimated (Hogg, 2014).

Despite identified shortfalls in service provision, fathers indicated acceptance and understanding toward services and felt that mothers still deserved more attention from services beyond physical and medical reasons. This may suggest ambivalence in fathers regarding their entitlement to support, which emerged as a theme in a recent study with UK fathers (Darwin et al., 2017). HCPs did not reach consensus on these statements, perhaps due to the variety of parents they see.

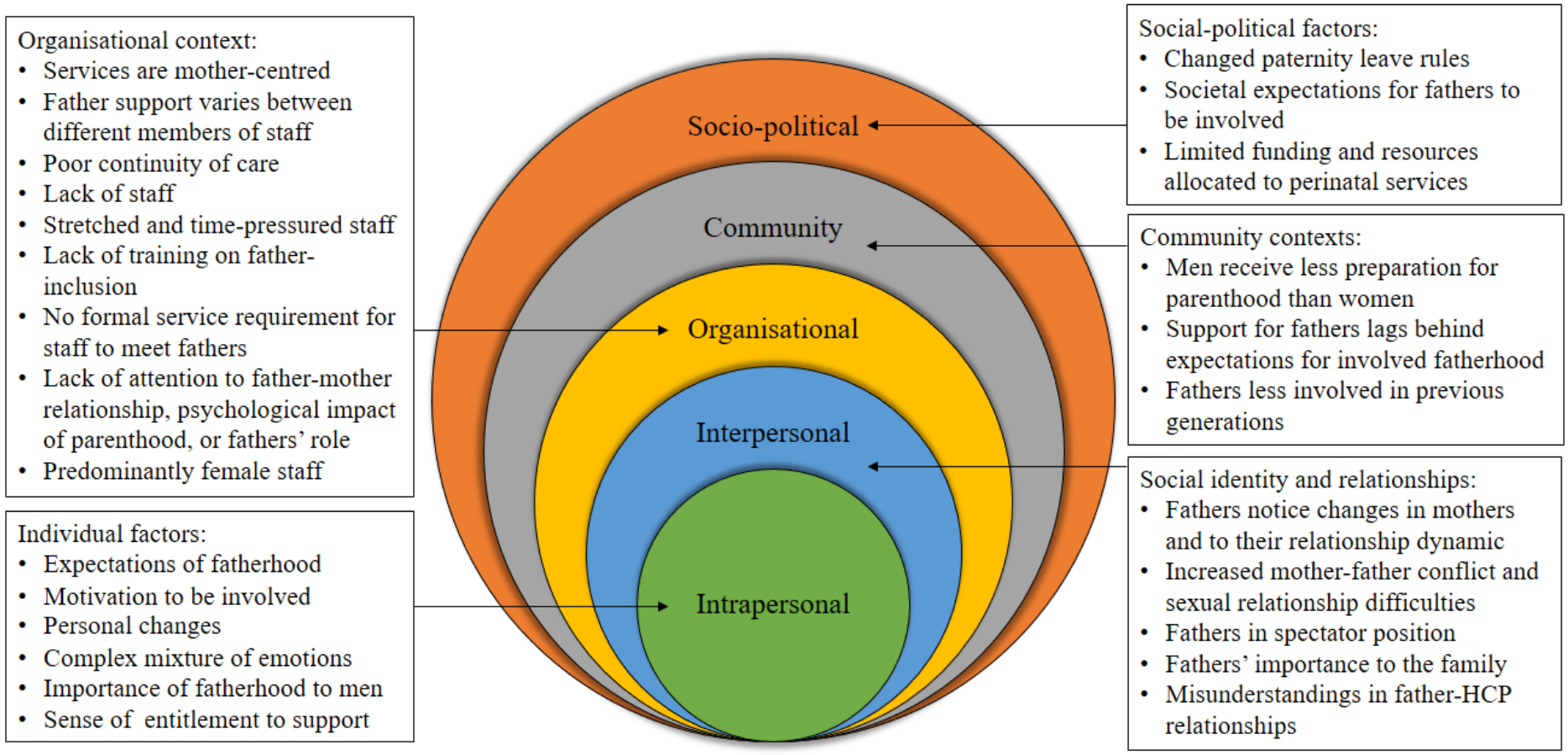


Figure 6. Factors that may affect fathers' experiences and their involvement by perinatal services, as suggested by the results of this study.

Fathers' and HCPs ideas for paternal perinatal support improvements

Areas of consensus

Fathers and HCPs reached moderate-to-strong consensus with several service-improvement ideas, mostly around increasing support for psychological and relational changes that can occur for parents, and improving overall involvement of fathers through communication and practice. These suggestions will be considered further in 'clinical implications' below.

Areas of divergence

Most divergence occurred for the suggestion that services provide fathers with a 10-minute 'dad-alone' session, which received strong consensus among fathers, but not HCPs. This may be due to HCPs' stretched workloads. Although less common, it is important to acknowledge that men can experience male-to-male or female-to-male domestic abuse (Stanko, 2001). Additionally, previous research has found fathers would not disclose psychological difficulties to perinatal services due to perceived lack of opportunities to do so (Colquhoun & Elkins, 2015).

Unlike HCPs, fathers reached no consensus about having more single-sex sessions. This may reflect fathers' desire for less dichotomised treatment of parents. Anderson (2009) proposed that the binary concepts of femininity and masculinity are blurring, which Johansson (2011) extended to suggest that society may stop splitting parents into two categories. However, despite recent challenges to social norms, the current study indicates that fathers still feel side-lined, and perinatal services are hesitant to provide fathers and mothers with equal non-medical support (e.g. the 'dad alone' session).

Strengths

This study made a unique contribution to the literature by collaborating midwives', health visitors', and fathers' expertise to identify areas for attention around father-inclusion. Features of the Delphi methodology improve validity of group consensus judgements while reducing the risk of 'groupthink' (Jorm, 2015). For instance, diversity of expertise between fathers and HCPs produces better quality decisions; online survey anonymity reduces social desirability bias and encourages independent decisions; and participants operate autonomously via the facilitator who uses mechanisms to coordinate and aggregate their expertise (Surowiecki, 2004). Together, these factors are argued to increase the wisdom of crowds (Surowiecki, 2004). Additionally, the current study recruited over twenty participants per panel, which is recommended to produce more stable results (Jorm, 2015). The attrition rate between R2 and R3 was similar to other Delphi studies (Gordon, 1994), and justification was found for including R2 data in the final results.

Limitations and Further Research

Despite efforts to obtain a heterogenous sample using various recruitment methods across diverse areas of London, fathers were predominantly employed, living with the mother and children, white, and university-educated, with high household incomes. This demographic profile represents positions of privilege and power argued to be encouraged by hegemonic masculinity (Connell, 1987). Unrepresented groups may be at higher risk of difficulties. For instance, parents with low socioeconomic status have been observed to find the parenthood transition more stressful (Goyal, Gay, & Lee, 2010), and single fathers have a fourfold risk of mental health problems (Cooper et al., 2007) compared to the general population. Sexuality was not measured in this study, but higher psychological distress is observed in gay and bisexual fathers (Colquhoun & Elkins, 2015). Self-selecting participants were possibly

motivated by certain views on fatherhood and services. Together, these factors limit the generalisability of the results. Future research is needed to explore whether these findings are relevant to random samples from different ethnic, cultural, and socioeconomic backgrounds, and diverse family types, including same-sex couples, single parents, blended families, and adoptive families.

Limited qualitative comments by online survey participants provided insufficient information to interpret *why* groups did not reach consensus. For example, does HCPs' lack of consensus reflect ambivalence regarding fathers' entitlement to ten minutes alone, or their limited capacity with stressful workloads? Qualitative studies exploring the reasons for low consensus would be useful.

Consensus achieved via the Delphi methodology does not indicate 'correct' opinions or answers (Hasson et al., 2000). Rather, this study identified areas important to the participants. Empirical research exploring the need, efficacy, and feasibility of the service improvement ideas endorsed in this study among diverse populations is needed. For example, quantitative research could provide father-specific training to HCPs, and measure the impact on fathers' experiences and the father-baby attachment, paying attention to vulnerable populations. Research could trial the 10-minute 'dad-alone' session and measure: 1) topics that arise compared to fathers not receiving the session; 2) whether patterns emerge among fathers from different backgrounds; 3) how fathers experience it; and 4) how HCPs experience providing it within their capacity. Until further research corroborates ideas suggested in this study, clinical implications drawn from these results must be considered tentatively.

Clinical Implications

Although these findings are only applicable to those who participated (Lincoln & Guba, 1985), the service improvement suggestions correspond with issues commonly reported in empirical research with fathers from different classes and ethnicities (May & Fletcher, 2013). These suggestions speak to the roles of clinical psychology. A BPS (2016) briefing paper states that clinical psychologists are currently integrated within generic NHS perinatal services, providing training, supervision, consultation, and support to midwives and health visitors. However, the paper is mother-focused, with no appearance of the words 'father' or 'men' (BPS, 2016).

Previous literature recommends that services should be more family-focused due to the fathers' importance to mother and baby, and in recognition of the relationship changes that occur within the father-mother-infant triad during the perinatal period (Genesoni & Tallandini, 2009; Ramchandani & Iles, 2014; Sarkadi et al., 2008; Whisman et al., 2011). Statements relating to these issues reached strong consensus between participants in this study. Clinical psychologists could use a systemic approach when training midwives and health visitors, to increase their focus on the triad, as shown in Figure 7. In line with participants' ideas, and to bring fathers into the family focus, clinical psychologists could support HCPs to improve father involvement via communication and father-specific support relating to fathers' roles and experiences, and to prepare both parents for the psychological, emotional and relational aspects of parenthood (including the potential impact on the couple relationship).

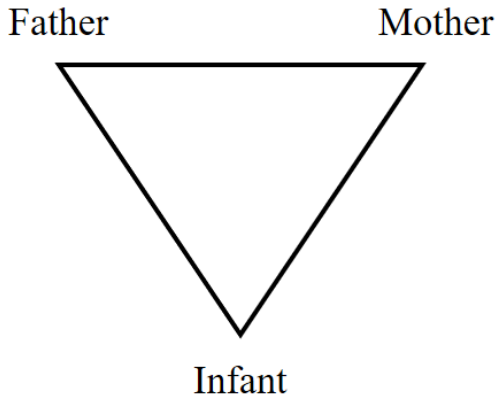


Figure 7. The father-mother-infant relationship triad

As well as partnership working with clinical psychologists, perinatal services could draw upon evidence-based information and resources on 'The Fatherhood Institute' website. Parents could be signposted to the 'Dads Matter UK' website, which provides information and resources for fathers to access mental health support for themselves or their partner. Both groups agreed that services should be formally required to check on fathers' coping. Fathers felt this could effectively be done with a 10-minute 'dad-alone' slot, like the mothers have. However, few HCPs agreed that this should be offered.

HCPs work hard to support the survival and wellbeing of mothers and babies, and although the current findings indicate examples of positive father-inclusion, HCPs' capacity to offer more is constrained by limited resources. Increased allocation of resources to improve father-inclusion is justified by evidence that paternal postnatal psychological distress increases community healthcare costs via fathers' increased contact with GPs and psychologists (Edoka, Petron, & Ramchandani, 2011). Early intervention can benefit the wellbeing of all family members by potentially preventing their involvement with psychological services in the future.

Gendered provision of perinatal services potentially marginalises a large proportion of parents. Clinical psychologists have a duty to recognise the impact of discrimination on wellbeing and promote equality (BPS, 2017; DoH, 2010) – not only for fathers, but for partners and children too. Clinical psychologists can influence change and encourage social discourses that break-down stereotyped differences at the levels of policy, commissioning, standards of clinical excellence, organisational structures, and clinical practice (BPS, 2016). This could help to lift structural constraints on HCPs' capacity to involve fathers. Intervening at multiple ecological levels could also facilitate changes to hegemonic ideologies around masculinity and fatherhood that are entrenched in social institutions (Connell, 1987; Cornwall, Edstrom, & Greig, 2011). This could have far-reaching benefits for fathers, mothers, children, and wider society.

5. Conclusion

Fatherhood is a social construction expressed through numerous sociocultural and interpersonal processes, embedded within a larger ecological context. Interrelated with fatherhood, is society's understanding of 'masculinity', suggested to be becoming more permissive and nurturing (Anderson, 2009). This is reflected in the overwhelming consensus across participants in this study regarding the importance of fathers in caring for the family. However, this time of change creates an ambivalent society in which fathers and HCPs exist, whereby traditional values of fatherhood co-occur with newer cultural values. This may partly explain why fathers continue to report feeling like a secondary figure.

This Delphi study encouraged collaboration between fathers and HCPs, and supported them to build consensus around important areas for attention regarding father-inclusion in perinatal services. Participants' suggestions for more support around psychological and relational aspects of parenthood, and inclusion of fathers as part of the family system calls for greater

integration between perinatal services and clinical psychology. However, study limitations include poor representation of fathers from diverse backgrounds, potential selection bias, and limited understanding of why low consensus occurred. Further research is needed to deepen our understandings of fathers' and HCPs' experiences and perspectives, and to corroborate service-improvement suggestions endorsed in these findings among more diverse groups of fathers. Continued efforts to close the gap between mothers and fathers in research and clinical practice could have substantial benefits across all ecological systems. This could include a generational shift, whereby role-models provided by more positively involved fathers today could support the next male generations' future transitions to fatherhood.

References

Anderson, E. (2009). *Inclusive masculinities: The changing nature of masculinity*. London: Routdledge.

Barker, S. (2011). *Midwives' emotional care of women becoming mothers.* Cambridge Scholars Publishing: England. Retrieved from: http://www.cambridgescholars.com/download/sample/59603

Barrows, P. (1999). Fathers in parent–infant psychotherapy. *Infant Mental Health Journal, 20,* 333–345. doi:10.1002/(sici)1097-0355(199923)20:3%3C333::aid-imhj9%3E3.0.co;2-m

BBC News (2018). *NHS: Over 3,000 more midwifery training places offered*. Retrieved from: http://www.bbc.co.uk/news/health-43529877

Beardshaw, T. (2001). Supporting the role of fathers around the time of birth. *MIDIRS – Midwifery Digest, 11,* 476–479.

Berk, L., Jorm, A. F., Kelly, C. M., Dodd, S., & Berk, M. (2011). Development of guidelines for caregivers of people with bipolar disorder: a Delphi expert consensus study. *Bipolar Disorders, 13,* 556–570. doi:10.1111/j.1399-5618.2011.00942.x

Bhaskar R (1979) *The possibility of naturalism.* Brighton: Harvester Press.

Bisson, J. I., Tavakoly, B., Witteveen, A. B., Ajdukovic, D., Jehel, L., Johansen, V. J., … Olff, M. (2010). TENTS guidelines: development of post-disaster psychosocial care guidelines through a Delphi process. *British Journal of Psychiatry, 196*, 69–74. doi:10.1192/bjp.bp.109.066266

Booth, A., & Carroll, C. (2015). How to build up the actionable knowledge base: The role of 'best fit' framework synthesis for studies of improvement in healthcare. *BMJ Quality & Safety, 24*, 700-708. doi:10.1136/bmjqs-2014-003642

Borg, S. (2001). The research journal: A tool for promoting and understanding researcher development. *Language Teaching Research, 5*, 156-177. doi:10.1177/136216880100500204

Bowen, M. (1978). *Family therapy in clinical practice.* New York: Aronson.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock Publications.

Bowles, N. (1999). The Delphi technique. *Nursing Standard, 13*, 32–36. doi:10.7748/ns1999.07.13.45.32.c2650

Bradley, R., & Slade, P. (2011). A review of mental health problems in fathers following the birth of a child. *Journal of Reproductive and Infant Psychology, 29*, 19-42. doi:10.1080/02646838.2010.513047

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101. doi:10.1191/1478088706qp063oa

British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society.* Leicester, England: British Psychological Society.

British Psychological Society (2016). *Perinatal service provision: The role of perinatal clinical psychology*. Leicester, England: British Psychological Society. Retrieved from: https://www1.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/rep108_perinatal_service_provision.pdf

British Psychological Society. (2017). *Practice guidelines, third edition*. Leicester, England: British Psychological Society. Retrieved from: https://www.bps.org.uk/sites/beta.bps.org.uk/files/Policy%20-%20Files/BPS%20Practice%20Guidelines%20(Third%20Edition).pdf

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development* (pp. 187 – 249). Greenwich, CT: JAI Press.

Buist, A., Morse, C., & Durkin, S. (2003). Men's adjustment to fatherhood: Implications for obstetric health care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 32,* 172–180. doi:10.1177/0884217503252127

Cantrill, J. A., Sibbald, B., & Buetow, S. (1996). The Delphi and nominal group techniques in health services research. *International Journal of Pharmacy Practice, 4,* 67–74. doi:10.1111/j.2042-7174.1996.tb00844.x

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine, 74,* 498–505. doi:10.1016/j.socscimed.2011.08.002

Cleaver, H., Unell, I., & Aldgate, J. (2011). *Children's Needs – Parenting Capacity. Child Abuse: Parental mental illness, learning disability, substance misuse and domestic violence (2nd edition)*. London: The Stationery Office.

Colquhoun, G., & Elkins, N. (2015). *Healthy Dads? The challenge of being a new father.* Australia: Hall & Partners | Open Mind. Retrieved from: https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0313-beyondblue-healthy-dads-full-report.pdf?sfvrsn=6f0243ea_0

Condon, J. (2006). What about dad? Psychosocial and mental health issues for new fathers. *Australian family physician, 35,* 690-692.

Condon, J. T., Corkindale, C. J., & Boyce, P. (2004). The First-Time Fathers Study: A prospective study of the mental health and wellbeing of men during the transition to parenthood. *Australian & New Zealand Journal of Psychiatry, 38,* 56–64. doi:10.1177/000486740403800102

Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics.* Chicago, IL: Stanford University Press.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity. *Gender & Society, 19*, 829–859. doi:10.1177/0891243205278639

Cooper, C., Bebbington, P. E., Meltzer, H., Bhugra, D., Brugha, T., Jenkins, R., … King, M. (2007). Depression and common mental disorders in lone parents: results of the 2000 National Psychiatric Morbidity Survey. *Psychological Medicine, 38*. doi:10.1017/s0033291707001493

Cornwall, A., Edström, J. & Greig, A. (2011). *Men and development: Politicising masculinities.* London: Zed Press.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social science & medicine*, *50*, 1385-1401. doi.org/10.1016/S0277-9536(99)00390-1

Crisp, J. (2017). *Take five months parental leave, Swedish fathers told.* The Telegraph. Retrieved from: https://www.telegraph.co.uk/news/2017/12/19/take-five-months-parental-leave-swedish-fathers-told/

Dads Matter UK. (n.d.). *Supporting dads and mums suffering from anxiety, depression and post-traumatic stress.* Retrieved from: http://www.dadsmatteruk.org/

Dalkey, N., & Helmer, O. (1963). An experimental application of the DELPHI method to the use of experts. *Management Science, 9,* 458–467. doi:10.1287/mnsc.9.3.458

Dalkey, N. C. (1972). The Delphi method: An experimental study of group opinion. In N. C. Dalkey, D. L. Rourke, R. Lewis, & D. Snyder (Eds.). *Studies in the quality of life: Delphi and decision-making* (pp. 13-54). Lexington, MA: Lexington Books.

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., & Gilbody, S. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth, 17*, 1-15. doi:10.1186/s12884-017-1229-4

Deave, T., & Johnson, D. (2008). The transition to parenthood: What does it mean for fathers? *Journal of Advanced Nursing Original Research, 63,* 626-633. doi:10.1111/j.1365-2648.2008.04748

Department of Health. (2010). *Fair society, healthy lives. The Marmot review. Strategic review of health inequalities in England post-2010.* London: Department of Health. Retrieved from: http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

Department of Health (2014). *Early years high impact area 1 – Transition to parenthood and the early weeks*. London: Department of Health. Retrieved from http://tinyurl.com/EYHIa1

Department for Business, Energy, and Industrial Strategy (2018). *Parents' guide to shared parental leave and pay*. Crown copyright: London. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/679664/Parents__Guide_to_Shared_Parental_Leave_and_Pay_FINAL.pdf

Dennis, C. L., & Ross, L. (2006). Women's perceptions of partner support and conflict in the development of postpartum depressive symptoms. *Journal of Advanced Nursing, 56,* 588–599. doi:10.1111/j.1365- 2648.2006.04059.x

Edoka, I. P., Petrou, S., & Ramchandani, P. G. (2011). Healthcare costs of paternal depression in the postnatal period. *Journal of Affective Disorders, 133,* 356–360. doi:10.1016/j.jad.2011.04.005

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social science & medicine, 62,* 2246-2257. doi:10.1016/j.socscimed.2005.10.017

Finlay, L., & Gough, B. (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. Mahwah, NJ: Wiley.

Fletcher, R. (2011). *The dad factor: How father–baby bonding helps a child for life.* New South Wales, Australia: Finch Publishing Sydney.

Genesoni, l., & Tallandini, M. (2009). Men's psychological transition to fatherhood: an analysis of the literature, 1989–2008. *Birth, 36,* 305–17. doi:10.1111/j.1523-536X.2009.00358.x

Ghate, D., Shaw, C., & Hazel, N. (2000). *Fathers at the centre: family centres, fathers and working with men.* London: Policy Research Bureau. Retrieved from: http://www.prb.org.uk/publications/P103%20report%20v12%20RN%2020.10.05.pdf

Giallo, R., D'Esposito, F., Christensen, D., Mensah, F., Cooklin, A., Wade, C., . . . Nicholson, J. M. (2012). Father mental health during the early parenting period: Results of an Australian population based longitudinal study. *Social Psychiatry and Psychiatric Epidemiology, 47,* 1907–1916. doi:10.1007/s00127-012-0510-0

Giallo, R., D'Esposito, F., Cooklin, A., Mensah, F., Lucas, N., Wade, C., & Nicholson, J. M. (2013). Psychosocial risk factors associated with fathers' mental health in the postnatal period: results from a population-based study. *Social Psychiatry and Psychiatric Epidemiology, 48,* 563–573. doi:10.1007/s00127-012-0568-8

Giallo, R., Cooklin, A., Brown, S., Christensen, D., Kingston, D., Liu, C. H., … Nicholson, J. M. (2015). Trajectories of fathers' psychological distress across the early parenting period: Implications for parenting. *Journal of Family Psychology, 29,* 766–776. doi:10.1037/fam0000109

Giallo, R., Dunning, M., & Gent, A. (2017). Attitudinal barriers to help-seeking and preferences for mental health support among Australian fathers. *Journal of*

Reproductive and Infant Psychology, 35, 236–247. doi:10.1080/02646838.2017.1298084

Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing, 45,* 26–35. doi:10.1046/j.1365-2648.2003.02857.x

Gordon, T. J. (1994). *The Delphi method.* Washington, DC: American Council for the United Nations University.

Goyal, D., Gay, C., & Lee, K. A. (2010). How much does low socioeconomic status increase the risk of prenatal and postpartum depressive symptoms in first-time mothers? *Women's Health Issues, 20,* 96–104. doi:10.1016/j.whi.2009.11.003

Grube, M. (2004). Pre- and postpartal psychiatric disorders and support from male partners. A first qualitative approximation. *Der Nervenarzt, 75,* 483–488. doi:10.1007/s00115-003- 1551- 0

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing, 32,* 1008-15. doi:10.1046/j.1365-2648.2000.t01-1-01567.x

Haavind, H., & Magnusson, E. (2005). The Nordic countries – welfare paradises for women and children? *Feminism Psychology, 15,* 227–235.

Henwood, K. & Proctor, J. (2003). The 'good father': Reading men's accounts of paternal involvement during the transition to first-time fatherhood. *British Journal of Social Psychology, 42,* 337-355. doi:10.1348/014466603322438198

Hogg, S. (2014). *All babies count: The dad project*. London: NSPCC. Retrieved from: https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-dad-project.pdf

Hogg, S. (2013). *All babies count: spotlight on perinatal mental health – prevention in mind.* London: NSPCC. Retrieved from: https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf

Hsu, C., & Sandford, B. A. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research & Evaluation, 12,* 1-8. doi:10.4018/978-1-4666-0074-4.ch011

Hunter, S. C., Riggs, D. W., & Augoustinos, M. (2017). Hegemonic masculinity versus a caring masculinity: Implications for understanding primary caregiving fathers. *Social and Personality Psychology Compass, 11,* e12307. doi:10.1111/spc3.12307

Iacuone, D. (2005). "Real men are tough guys": Hegemonic masculinity and safety in the construction industry. *The Journal of Men's Studies, 13*, 247–266. doi:10.3149/jms.1302.247

Johansson, T. (2011). Fatherhood in transition: Paternity leave and changing masculinities. *Journal of Family Communication, 11,* 165–180. doi:10.1080/15267431.2011.561137

Johansson, M., Rubertsson, C., Rådestad, I., & Hildingsson, I. (2013). Improvements of postnatal care are required by Swedish fathers. *International Journal of Health Care Quality Assurance, 26,* 465–480. doi:10.1108/ijhcqa-08-2011-0052

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry, 49*, 887–897. doi:10.1177/0004867415600891

Kane, P., & Garber, J. (2004). The relations among depression in fathers, children's psychopathology, and father–child conflict: a meta-analysis. *Clinical Psychology Review, 24,* 339–360. doi:10.1016/j.cpr.2004.03.004

Kelly, J. G. (2006). *Becoming ecological: An expedition into community psychology.* New York: Oxford University Press.

Kim, P. & Swain, J. (2007). Sad dads: Paternal postpartum depression. *Psychiatry (Edgmont), 4*, 35-47. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922346/pdf/PE_4_2_36.pdf

Kvalevaag, A. L., Ramchandani, P. G., Hove, O., Assmus, J., Eberhard-Gran, M., & Biringer, E. (2013). Paternal mental health and socioemotional and behavioral development in their children. *Pediatrics, 13,* e463–e469. doi:10.1542/peds.2012-0804

Lamb, M. E. (2000). The history of research on father involvement. *Marriage & Family Review, 29,* 23–42. doi:10.1300/j002v29n02_03

Lamb, M. E. (1975). Fathers: Forgotten contributors to child development. *Human Development, 18,* 245-266.

Lieberman, M., Doyle, B., & Markiewicz, D. (1999). Developmental patterns in security of attachment to mother and father in late childhood and early adolescence: associations with peer relations. *Child Development, 70,* 202–213. doi: 10.1111/1467-8624.00015

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* London: Sage.

Macfadyen, A., Swallow, V., Santacroce, S., & Lambert, H. (2011). Involving fathers in research. *Journal for Specialists in Pediatric Nursing, 16,* 216–219. doi:10.1111/j.1744-6155.2011.00287.x

Machin, A. (2015). Mind the gap: The expectation and reality of involved fatherhood. *Fathering, 13,* 36-59. doi:10.3149/fth.1301.36

May, C., & Fletcher, R. (2013). Preparing fathers for the transition to parenthood: Recommendations for the content of antenatal education. *Midwifery, 29*, 474-478. doi:10.1016/j.midw.2012.03.005

McBride, B. A., Brown, G. L., Bost, K. K., Shin, N., Vaughn, B., & Korth, B. (2005). Paternal identity, maternal gatekeeping and father involvement. *Family Relations, 54,* 360–72. doi: 10.1111/j.1741-3729.2005.00323.x

Mchale, J. P. (2007). When infants grow up in multiperson relationship systems. *Infant Mental Health Journal, 28,* 370–392. doi:10.1002/imhj.20142

McHale, J. P. (1995). Coparenting and triadic interactions during infancy: The roles of marital distress and child gender. *Developmental Psychology, 31,* 985–996. doi:10.1037/0012-1649.31.6.985

McLeroy, K. R., Steckler, A. and Bibeau, D. (1988). The social ecology of health promotion interventions. *Health Education Quarterly, 15,* 351-377.

Mezulis, A., Hyde, J., & Clark, R. (2004). Father involvement moderates the effect of maternal depression during a child's infancy on child behavior problems in kindergarten. *Journal of Family Psychology, 18,* 575–88. doi:10.1037/0893-3200.18.4.575

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* England: Sage Publications.

National institute for clinical excellence (2012). *Social and emotional wellbeing: early years.* Public health guidelines (PH40). Retrieved from: https://www.nice.org.uk/guidance/ph40/chapter/1-recommendations

National institute for clinical excellence (2006). *Postnatal care up to 8 weeks after birth.* Clinical guidance [CG37]. Retrieved from: https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations

NHS (2015). *The NHS constitution: the NHS belongs to us all.* England: Crown copyright. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

Nursing and Midwifery Council (2016). *Annual equality and diversity report 2015-2016.* Nursing and Midwifery Council: England. Retrieved from: https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/equality-and-diversity-report-2015-16.pdf

O'Brien, M. (2005). *Shared caring: Bringing fathers into the frame*. Manchester: Equal Opportunities Commission. Retrieved from: https://core.ac.uk/download/pdf/4155069.pdf

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *HSR: Health Services Research, 34*, 1189-1208.

Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *JAMA: Journal of the American Medical Association, 303*, 1961–1969. doi:10.1001/jama.2010.605

Philpott, L. F. (2016). Paternal postnatal depression: How midwives can support families. *British Journal of Midwifery, 24,* 470–476. doi:10.12968/bjom.2016.24.7.470

Pipon-Young, L., Cupitt, C., & Callanan, M. (2010). Experiences of clinical psychologists in assertive outreach teams: A Delphi survey. *Clinical Psychology Forum, 212,* 17-21.

Pleck, E. & Pleck, J. (1997). Fatherhood ideals in the United States: Historical dimensions. In: Lamb, M., (Ed.). *The father's role in child development* (pp. 33–48). New York: John Wiley & Sons.

Pleck, J. H. (2007). Why could father involvement benefit children? Theoretical perspectives. *Applied Developmental Science, 11,* 196–202. doi:10.1080/10888690701762068

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. (2005). Paternal depression in the postnatal period and child development: a prospective population study. *Lancet, 365,* 2201–2205. doi:10.1016/S0140-6736(05)66778-5

Ramchandani, P., Stein, A., O'Connor, T., Heron, J., Murray, L., & Evans, J. (2008). Depression in men in the postnatal period and later child psychopathology: A population cohort study. *Journal of the American Academy of Child & Adolescent Psychiatry, 47,* 390–398. doi:10.1097/chi.0b013e31816429c2

Ramchandani, P. G., Domoney, J., Sethna, V., Psychogiou, L., Vlachos, H., & Murray, L. (2012). Do early father-infant interactions predict the onset of externalising behaviours

in young children? Findings from a longitudinal cohort study. *Journal of Child Psychology and Psychiatry, 54*, 56–64. doi:10.1111/j.1469-7610.2012.02583.x

Ramchandani, P., & Psychogiou, L. (2009). Paternal psychiatric disorders and children's psychosocial development. *Lancet, 374*, 646-653. doi:10.1016/s0140-6736(09)60238-5

Ramchandani, P. G., Psychogiou, L., Vlachos, H., Iles, J., Sethna, V., Netsi, E., & Lodder, A. (2011). Paternal depression: an examination of its links with father, child and family functioning in the postnatal period. *Depression and Anxiety, 28*, 471–477. doi:10.1002/da.20814

Ramchandani, P., & Iles, J. (2014). Commentary: Getting fathers into parenting programmes - a reflection on Panter-Brick et al. (2014). *Journal of Child Psychology and Psychiatry, 55*, 1213–1214. doi:10.1111/jcpp.12321

Ranson, G. (2001). Men at work: Change—or no change in the era of the "new father". *Men and Masculinities, 4*, 3-26. doi:10.1177/1097184X01004001001

Robertson, S. (2006). "Not living life in too much of an excess": lay men understanding health and well-being. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 10*, 175–189. doi:10.1177/1363459306061787

Robertson, S. (2007). *Understanding men and health: masculinities, identity and well being.* Maidenhead: Open University Press.

Rominov, H., Giallo, R., Pilkington, P. D., & Whelan, T. A. (2017). "Getting help for yourself is a way of helping your baby:" Fathers' experiences of support for mental health and parenting in the perinatal period. *Psychology of Men & Masculinity.* Advanced online publication. doi:10.1037/men0000103

Royal College of Midwives (2011). *Reaching Out: Involving Fathers in Maternity Care.* London: Royal College of Midwives.

Russell, S., Lang, B., Clinton, J., Adams, C., & Lamb, J. (2013). *Perinatal mental health experiences of women and health professionals*. Boots Family Trust Alliance. Retrieved from: http://www.bftalliance.co.uk/wp-content/uploads/2014/02/boots-perinatal-mental-health-09-10-13-web.pdf

Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: a systematic review of longitudinal studies. *Acta Paediatrica, 97*, 153-158. doi: 10.1111/j.1651-2227.2007.00572.x

Sarkadi, A. (2014). The invisible father: How can child healthcare services help fathers to feel less alienated? *Acta Paediatrica, 103,* 234–235. doi:10.1111/apa.12523

Sayer, A. (2004) Foreword: why critical realism? In: Fleetwood, S., Ackroyd, S. (Eds). *Critical Realist Applications in Organisation and Management Studies*. London: Routledge.

Schmitz, R. M. (2016). Constructing men as fathers. *The Journal of Men's Studies, 24,* 3–23. doi:10.1177/1060826515624381

Selin, H. (2014). *Parenting across cultures: Childrearing, motherhood and fatherhood in Non-Western Cultures.* New York: Springer Science & Business.

Sethna, V., Murray, L., Netsi, E., Psychogiou, L., & Ramchandani, P. G. (2015). Paternal depression in the postnatal period and early father–infant interactions. *Parenting, 15*, 1–8. doi:10.1080/15295192.2015.992732

Sethna, V., Murray, L., Edmondson, O., Iles, J., & Ramchandani, P. G. (2018). Depression and playfulness in fathers and young infants: A matched design comparison study. *Journal of Affective Disorders, 229,* 364–370. doi:10.1016/j.jad.2017.12.107

South, R., Jones, F. W., Creith, E., & Simonds, L. M. (2015). Understanding the concept of resilience in relation to looked after children: A Delphi survey of perceptions from education, social care and foster care. *Clinical Child Psychology and Psychiatry, 21,* 178–192. doi:10.1177/1359104515577485

Stanko, E. A. (2001). The day to count: Reflections on a methodology to raise awareness about the impact of domestic violence in the UK. *Criminal Justice, 1,* 215–226. doi:10.1177/1466802501001002005

Steen, M., Downe, S., Bamford, N., & Edozien, L. (2012). Not-patient and not-visitor: A metasynthesis fathers' encounters with pregnancy, birth and maternity care. *Midwifery, 28*, 422–431. doi:10.1016/j.midw.2011.06.009

StGeorge, J., & Freeman, E. (2017). Measurement of father-child rough-and-tumble play and its relations to child behaviour. *Infant Mental Health Journal, 38,* 709–725. doi:10.1002/imhj.21676

Surowiecki J (2004) *The wisdom of crowds: Why the many are smarter than the few*. London: Abacus.

The Fatherhood Institute (n.d.). *The fatherhood institute: A great dad for every child.* Retrieved from: http://www.fatherhoodinstitute.org/

Wee, K. Y., Pier, C., Milgrom, J., Richardson, B., Fisher, J., & Skouteris, H. (2013). Fathers' mental health during the ante-and postnatal periods: Knowledge, recommendations and interventions. *British Journal of Midwifery, 21,* 342-353. doi:10.12968/bjom.2013.21.5.342

Whisman, M., Davila, J., & Goodman, S. (2011). Relationship adjustment, depression, and anxiety during pregnancy and the postpartum period. *Journal of Family Psychology, 25*, 375–383. doi:10.1037/a0023790

Whitelock, A. (2016). Why do health visitors screen mothers and not fathers for depression in the postnatal period? *Journal of Health Visiting, 4,* 312–321. doi:10.12968/johv.2016.4.6.312

Williams, R. A. (2007). Masculinities fathering and health: The experiences of African-Caribbean and white working class fathers. *Social Science & Medicine, 64,* 338–349. doi:10.1016/j.socscimed.2006.08.019

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review, 30,* 167–180. doi:10.1016/j.cpr.2009.10.007.

Wilson, S., & Prior, M. (2011). Father involvement and child well-being. *Journal of Paediatrics and Child Health, 47,* 405-407. doi:10.1111/j.1440-1754.2010.01770.x

Winnicott, D. (2002). *Winnicott on the child.* Cambridge, MA: Perseus.

World Health Organisation. (2015). *WHO recommendations on health promotion interventions for maternal and newborn health.* Switzerland: World Health Organisation. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/172427/9789241508742_report_eng.pdf;jsessionid=E2A404D70B6C4F08109C3998BB81FC77?sequence=1

Appendix A: The Appraisal Tool for Cross-Sectional Studies (AXIS; Downes et al., 2016)

Author(s) and title			
	Questions	**Yes/No/ Partly**	**Comments**
Intro	Were the aims/objectives of the study clear?		
Methods	Was the study design appropriate for the stated aim(s)?		
	Was the sample size justified?		
	Was the target population clearly defined? Is it clear who the research is about?		
	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?		
	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?		
	Were measures undertaken to address and categorise non-responders?		
	Were the risk factor and outcome variables measured appropriate to the aims of the study?		
	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled/piloted or published previously?		
	Is it clear what was used to determine statistical significance and/or precision estimates (e.g. p values, CIs)		
	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?		
Results	Were the basic data adequately described?		
	Does the response rate raise concerns about non-response bias?		
	If appropriate, was information about non-responders described?		
	Were the results internally consistent?		
	Were the results for the analyses described in the methods, presented?		
Discussion	Were the authors' discussions and conclusions justified by the results?		
	Were the limitations of the study discussed?		
Other	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?		
	Was ethical approval or consent of participants attained?		

Appendix B: CASP Cohort Study Checklist (2013), using Mickelson et al. (2017) as an example

Section A: Are the results of the study valid?		
1. Did the study address a clearly focused issue?	Yes ✔ Can't Tell No	HINT: A question can be 'focused' in terms of • the population studied • the risk factors studied • is it clear whether the study tried to detect a beneficial or harmful effect • the outcomes considered
Comments: To examine the process of perceived stigma and PPD symptoms in mothers and fathers when transitioning to parenthood. The authors predicted that internalised PPD stigma will be related to greater PPD symptoms through lower levels of parenting efficiacy; experienced PPD stigma will be related to greater PPD symptoms through higher indirect informal support seeking; and fathers' internalised pathway will be stronger than their experieced pathway, whereas mothers will utilise both pathways in the perceived stigma process.		
2. Was the cohort recruited in an acceptable way?	Yes Can't Tell No ✔	HINT: Look for selection bias which might compromise the generalisability of the findings: • was the cohort representative of a defined population • was there something special about the cohort • was everybody included who should have been
Comments: The authors specifically sought expectant first-time, heterosexual parents, with low-risk pregnancies, and did not recruit from low-income neighbourhoods due to the potential for lower SES to confound findings between PPD symptoms and other factors. Convenience sampling via local birthing classes and online message boards in the US.		
Is it worth continuing?		

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3. Was the exposure accurately measured to minimise bias?

Yes	
Can't Tell	✔
No	

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- were all the subjects classified into exposure groups using the same procedure

Comments: Perceived stigma was measured using eight items, that had low Cronbach alphas, suggesting questionable internal consistency. Also subjective self-report measures.

4. Was the outcome accurately measured to minimise bias?

Yes	
Can't Tell	✔
No	

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- has a reliable system been established for detecting all the cases (for measuring disease occurrence)
- were the measurement methods similar in the different groups
- were the subjects and/or the outcome assessor blinded to exposure (does this matter)

Comments: Prenatal depression measured using a validated tool with good internal consistency. Postpartum depression and support seeking had good internal consistencies. However, the measure of parenting efficacy had questionable internal consistency. All were subjective self-report measures.

5. (a) Have the authors identified all important confounding factors?

Yes	
Can't Tell	✔
No	

HINT:
- list the ones you think might be important, and ones the author missed

Comments: Authors identified: SES, difficult pregnancies, sexual orientation, marital/cohabiting status, number of children, and prenatal depression symptoms.
Authors missed: Age, race/ethnicity, education of parents, and life stressors

5. (b) Have they taken account of the confounding factors in the design and/or analysis?

Yes	
Can't Tell	✔
No	

HINT:
- look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

Comments: Authors attemped to control for SES, difficult pregnancies, sexual orientation, first child, marital/cohabiting status through the recruitment process, and controlled for prenatal depression symptoms in the analyses.

6. (a) Was the follow up of subjects complete enough?

Yes	
Can't Tell	
No	✔

HINT: Consider
- the good or bad effects should have had long enough to reveal themselves
- the persons that are lost to follow-up may have different outcomes than those available for assessment
- in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort

6. (b) Was the follow up of subjects long enough?

Yes	
Can't Tell	✔
No	

Comments:	The cohort was only from 1 month to 4 months postpartum, and the mediators and outcomes were measured at the same wave. 7 couples lost to follow-up were compared to completers. No significant differences were observed.

Section B: What are the results?

7. What are the results of this study?

HINT: Consider
- what are the bottom line results
- have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference
- how strong is the association between exposure and outcome (RR)
- what is the absolute risk reduction (ARR)

Comments:	23% mothers and 9.9% fathers had possible clinical depression. From 1-4 months, PPD symptoms significantly decreased in mothers and fathers. Indirect help-seeking significantly decreased for fathers (not mothers) from 1-4 months. Greater indirect (thus less effective) informal help-seeking was significantly associated with greater internalised and externalised stigma, and with increased depression symptoms for mothers and fathers. For mothers at 1-month postpartum, internalised stigma significantly predicted less parenting efficacy, more indirect help-seeking, and more PPD symptoms. For fathers at 1-month postpartum, experienced stigma significantly predicted less parenting efficacy and more PPD symptoms.

8. How precise are the results?

HINT:
- look for the range of the confidence intervals, if given

Comments:	95% confidence intervals P value at p<.05

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9. Do you believe the results?

Yes	
Can't Tell	✔
No	

HINT: Consider
- big effect is hard to ignore
- can it be due to bias, chance or confounding
- are the design and methods of this study sufficiently flawed to make the results unreliable
- Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

Comments: The authors present the results in a confusing way - first proposing that some variables predict others, then later highlighting that the mediators and outcomes were measured in the same way so causal ordering of variables cannot be inferred. This reduces confidence in some of the results.

Section C: Will the results help locally?

10. Can the results be applied to the local population?

Yes	
Can't Tell	✔
No	

HINT: Consider whether
- a cohort study was the appropriate method to answer this question
- the subjects covered in this study could be sufficiently different from your population to cause concern
- your local setting is likely to differ much from that of the study
- you can quantify the local benefits and harms

Comments: The participants predominantly represent white, college or university educated, employed, married couples. These results cannot be applied to members of the local population not representing these demographics.

11. Do the results of this study fit with other available evidence?

Yes	
Can't Tell	✔
No	

Comments: Corrigan et al. (2006), Paulson et al. (2006)

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12. What are the implications of this study for practice?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making
- for certain questions, observational studies provide the only evidence
- recommendations from observational studies are always stronger when supported by other evidence

Comments: Results are preliminary.
Practitioners should be aware of stigma in new parents, and try to normalise experiences of depression, encourage help-seeking (particularly with fathers), and assess whether stigma is impacting on parents' perception of their parenting abilities.

Appendix C: Dulwich Research Ethics Committee letter of favourable ethical opinion

This text has been removed from the electronic copy

Appendix D: Health Research Authority letter of approval

This text has been removed from the electronic copy

Appendix E: R&D approval for recruiting staff for research

From: [redacted]

Sent: 06 April 2018 14:58

To: Fenton, Sophie (s.e.fenton383@canterbury.ac.uk)

Subject: RE: IRAS number: 218419 Psychology PhD project_Sponsor Canterbury [redacted] site approval

Hi Sophie,

We have had confirmation from the HRA that for [redacted] a retrospective R&D review is not necessary.

We have been in contact with the local personnel involved to do some re-training as R&D should have been notified.

All best and good luck

[redacted]

[redacted]
R&D Governance Specialist
[redacted] Research Centre
[redacted]

From: [redacted], Contact ([redacted]LONDON NHS FOUNDATION TRUST)

<[redacted]@nhs.net>

Sent: 06 April 2018 16:34

To: Fenton, Sophie (s.e.fenton383@canterbury.ac.uk)

Subject: RE: For the attention of [redacted]

Dear Sophie,

RE: IRAS 218419 - Fathers' and health professionals' perceptions of paternal perinatal support and their ideas for improvement.

Thank you for contacting [redacted] and notifying us. As the above study has already been implemented this email confirms, retrospectively, that the above staff study has been received and acknowledged at the following [redacted] NHS partner Trusts:

- [redacted] NHS Foundation Trust
- The [redacted] NHS Trust

As this is a "low risk" staff study no further action is required however, please can I advise that all future projects that have been defined as 'Research' and receive HRA (and/or REC) Approval will need to be reviewed by the relevant local R&D office in order to determine whether the research is feasible to take place there by the local confirmation of capacity and capability.

All the best with submitting your thesis!

Please do not hesitate to contact Noclor if you have any queries regarding research in the future.

Kind Regards,
[redacted]

[redacted] [redacted]
Research Facilitator

From: [redacted]<[redacted]@[redacted].nhs.uk>

Sent: 06 April 2018 16:32

To: Camic, Paul (paul.camic@canterbury.ac.uk); Fenton, Sophie

(s.e.fenton383@canterbury.ac.uk)

Cc: [redacted], [redacted]

Subject: Retrospective Confirmation of Capacity and Capability for the proeject with IRAS

218419

Dear Professor Paul Camic and Sophie Fenton,

RE: IRAS 218419. Retrospective Confirmation of Capacity and Capability at Chelsea and Westminster Hospital NHS Foundation Trust

Study Title	**Fathers' and health professionals' perceptions of paternal perinatal support and their ideas for improvement.**
IRAS Number	**218419**

REC Reference	**17/LO/0396**
Sponsor	**Canterbury Christ Church University**
C&W Reference	**C&W18/017**
Principal Investigator	**Sophie Fenton**

This email confirms that [redacted] NHS Foundation Trust had the capacity and capability to deliver the above referenced study at [redacted] Hospital. Please find attached our agreed Statement of Activities as confirmation.

Please note that [redacted] NHS Foundation Trust is now using a national Research Management System called [redacted] for registering their research projects and for uploading their recruitment figures.
If you have any queries, please do not hesitate to contact me. Meanwhile, may I take this opportunity to wish you well with your research. We look forward to hearing the progress and outcomes for the study.

With kind regards,
[redacted]

[redacted] | **Research Delivery Facilitator**

Dear Sophie,

RE: IRAS 218419. Retrospective Confirmation of Capacity and Capability at [redacted] NHS Trust.

Full Study Title: Fathers' and health professionals' views of paternal perinatal support

This email confirms that [redacted] NHS Trust are aware that the above named study was conducted at [redacted]. Please find attached our Statement of Activities as confirmation.

BW
[redacted]
Research & Development Facilitator
[redacted] NHS Trust
R&D Department

Appendix F: Information sheet for fathers recruited at R1

Canterbury Christ Church University

INFORMATION SHEET FOR FATHER PARTICIPANTS

Project Title: Fathers' and health professionals' views of paternal perinatal support

My name is Sophie Fenton and I am a trainee clinical psychologist studying at Canterbury Christ Church University (CCCU). I am inviting you to take part in a research project I am conducting as part of my doctoral training. My project is being sponsored by the Salomons Centre of Applied Psychology and is supervised by Dr Trish Joscelyne and Dr Siobhan Higgins. This research has been approved by the London-Dulwich Research Ethics Committee.

The purpose of this project
This research project aims to explore fathers' experiences of becoming a parent, the support they receive from health visitors and midwives, and how fathers and health professionals perceive that paternal perinatal support could be improved in the NHS. This study defines the perinatal period as the time encompassing pregnancy, birth, and the first year of the baby's life post-birth. To explore these areas, I would very much appreciate your participation in this project.

What taking part will involve

1) If you choose to participate you will be asked to complete a consent form stating that you have read this information sheet and agree to take part in the research project.
2) You will then be asked to complete two parts to the study:
    a. Part 1: You will be asked to attend a focus group in Lambeth with other fathers. The focus group will take between 60 - 90 minutes overall. There will be some questions planned for the group to consider, but it will generally be an open conversation. There are no right or wrong answers, and you are free to choose how much or how little to contribute to the discussion.
    b. Part 2: You will then be asked to complete 2 online surveys over a 4-month period. Each survey should take less than 30 minutes to complete, and consist of some short answer questions and some questions encouraging you to elaborate on your responses as much as you feel is necessary.

In the focus group and online surveys, please do not disclose any identifying information about yourself or others, or any information you do not feel comfortable sharing.

Expenses and payments
For Part 1 you will be given a £15 Amazon voucher to compensate you for your time and efforts. For Part 2 you will be entered into a prize draw to win a £20 Amazon voucher after completing the second online survey.

What will this research achieve?
The project aims to gather valuable information from fathers and health professionals around the support provided to fathers in NHS perinatal services, and their ideas for improvement. The aim is that the results of the study will inform practice delivered by health visitors and midwives in their future work with fathers during the perinatal period.

To participate in this research:
You must be over 18 years-old
You must have had a child in within the last 3 years and been present during the perinatal period (from pregnancy to the first year of your child's life)

Feedback
Following completion of the project you will receive an email containing a brief outline of the investigation's findings. The final report will be submitted for publication to a range of academic journals; details of which will be emailed to you if the report is accepted for publication.

Your rights and confidentiality
If you choose to participate you will be allocated an individual participant number. This will allow you to participate anonymously so that you will not be identifiable to anyone other than the researcher during and after data collection. Your anonymous responses may be shared with other participants and included in the write up and future publications of this investigation. However, no identifying information will be attached to this information at any time. Participation is confidential, however information may be shared with relevant third parties if there appears to be sufficient evidence to raise serious concern about your safety or the safety of others.

All data and personal information will be kept confidential and stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Audio recordings from the focus groups will be transferred to a password protected memory stick, and deleted from the recording device. Only my supervisors and I will have access to this information. After completion of the study, all personal information associated with data will be removed.

You have the right to decline to answer any questions during the study. Prior to study completion you have the right to withdraw yourself or any data you have supplied during the study, without explanation.

Benefits and risks
Your participation has the potential to influence future policy and practice of how health visitors and midwives work with fathers across the UK. However, topics covered might include experiences of mental health difficulties or stress. This may feel challenging and cause some minor distress. You will be asked only to disclose information you feel comfortable sharing with others, and your participation is voluntary.

If you have any concerns about the mental health of yourself or others, please make use of the resources below for help and support. You can also contact me by email at sfentonresearch@gmail.com for enquiries of more specific help or resources.

Visit the NHS Choices website at www.nhs.uk if you would like information on mental health difficulties and services available near you.

The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters, provides information on the NHS complaints procedure, and provides information on support groups outside the NHS. You can find your nearest PALS office on the NHS Choices website (www.nhs.uk), by asking your GP, or by phoning the non-emergency NHS number on '111'.

Let your GP know if you are experiencing mental health difficulties. They can provide advice and support, and put you in touch with local services.

Improving Access to Psychological Therapies (IAPT) services provide free talking therapies on the NHS for people experiencing mild to moderate mental health difficulties, such as depression, anxiety, or post-traumatic stress disorder. You can self-refer or you can ask your GP to refer you. Please find more details at www.slam-iapt.nhs.uk.

The following mental health charities provide emotional support and information to anyone affected by mental health difficulties:

MIND
www.mind.org.uk
Call 0300 123 3393
Text 86463

SANE
www.sane.org.uk
Call 0300 304 7000

SAMARITANS
www.samaritans.org
Call 116 123
Email jo@samaritans.org

Further information
If you have any questions or comments, please contact me by email at sfentonresearch@gmail.com.

If you would like to make a complaint, please contact Trish Joscelyne, Clinical Psychologist and Academic Tutor (Salomons) at trish.joscelyne@canterbury.ac.uk.

Thank you.

APPENDIX A

PROCEDURE IN DETAIL

Part 1: If you choose to participate in the research, you will be given an individual participant number which will allow you to participate anonymously. You will receive an email invite to a focus group in Lambeth with other fathers, and you will be offered the chance to talk to the researcher by email, telephone, or in person before the focus group to ask any questions.

It is hoped that around 8-10 fathers will be able to attend the group. The focus group will be held at a local NHS building. Upon arrival to the focus group, you will be welcomed into a private room where the group will take place. Refreshments will be available. You will be asked to read the information sheet, and given another opportunity to ask any questions. If you would still like to participate, then you will be given a consent form and registration form to read and sign. You will also be given a questionnaire to measure which stressors you may have experienced in the perinatal period before and after your child was born. You will be given a £15 Amazon voucher to compensate you for your time and efforts. The focus group will then commence while being audio recorded. This will be an open group discussion facilitated by questions made by the lead researcher. At the end of the focus group, you will receive a thorough debrief, and an opportunity to ask any questions or make any comments. It is expected that the focus group will last 60-90 minutes from the time of arrival to the time of departure.

Following the group, the lead researcher will transcribe the audio recording, using pseudonyms and excluding any identifying information. She will code and analyse the data to produce a series of anonymous statements that represent themes that emerged from the group discussion.

Part 2: Roughly 2-3 months later you will receive an email containing your unique participant number and a link to an online survey. The survey will ask you to provide your unique participant number rather than your name, to keep your data anonymous. The online survey will consist of a series of statements derived from the focus group that you took part in, and also from focus groups with health visitors and midwives. You will be asked to rate your agreement with the ideas from all groups, and rank them in order of importance. You will be asked to give a brief explanation for your decisions. Your anonymous responses to this survey will be shared with other participants in this research, however no identifying information will be attached to the data at any time. The survey will mainly include short answer and multiple choice questions, so should take no longer than 30 minutes to complete. You are free to complete the survey at your leisure within a 4-week period.

You will receive an email link to a second online survey within about 2 months of having received the link to the first online survey. This survey will be similar to the first, however this time you will be able to see the general level of agreement with each statement by fathers and health professionals. The purpose of the second survey is to give you the opportunity to review and alter your original ratings should you wish to. You will be asked to provide your reasons for changing your ratings. It is expected that this second survey will take 15 to 30 minutes to complete, and again you are free to complete it at your leisure within a 4-week period. Once you have completed the second online survey you will receive an online debrief, and be entered into a prize draw to win a £20 Amazon voucher.

Appendix G: Information sheet for healthcare professionals recruited at R1

INFORMATION SHEET FOR MIDWIFE AND HEALTH VISITOR PARTICIPANTS

Project Title: Fathers' and health professionals' views of paternal perinatal support

My name is Sophie Fenton and I am a trainee clinical psychologist studying at Canterbury Christ Church University (CCCU). I am inviting you to take part in a research project I am conducting as part of my doctoral training. My project is being sponsored by the Salomons Centre of Applied Psychology and is supervised by Dr Trish Joscelyne and Dr Siobhan Higgins. This research has been approved by the London-Dulwich Research Ethics Committee.

The purpose of this project
This research project aims to explore fathers' experiences of becoming a parent, the support they receive from health visitors and midwives, and how fathers and health professionals perceive that paternal perinatal support could be improved in the NHS. This study defines the perinatal period as the time encompassing pregnancy, birth, and the first year of the baby's life post-birth. To explore these areas, I would very much appreciate your participation in this project.

What taking part will involve
If you choose to participate you will be asked to complete a consent form stating that you have read this information sheet and agree to take part in the research project.
You will then be asked to complete two parts to the study:
Part 1: You will be asked to attend a focus group in Lambeth with other midwives or health visitors. The focus group will take between 60 - 90 minutes. There will be some questions planned for the group to consider, but it will generally be an open conversation. There are no right or wrong answers, and you are free to choose how much or how little to contribute to the discussion.
Part 2: You will then be asked to complete 2 online surveys over a 4-month period. Each survey should take less than 30 minutes to complete, and consist of some short answer questions and some questions encouraging you to elaborate on your responses as much as you feel is necessary.

In the focus group and online surveys, please do not disclose any identifying information about yourself or others, or any information you do not feel comfortable sharing.

What will this research achieve?
The project aims to gather valuable information from fathers and health professionals around the support provided to fathers in NHS perinatal services, and their ideas for improvement. The aim is that the results of the study will inform practice by health visitors and midwives in their future work with fathers during the perinatal period.

To participate in this research, you must:
You must be a health visitor or midwife currently employed by the NHS to work with parents during the perinatal period
You must have been qualified and in post for at least six months
You must have had some experience of having contact with fathers during your work

Feedback
Following completion of the project you will be emailed a brief outline of the findings of the investigation. The final report will be submitted to a range of academic journals for publication; details of which will be emailed to you if the report is accepted for publication.

Your rights and confidentiality
If you choose to participate you will be allocated an individual participant number. This will allow you to participate anonymously so that you will not be identifiable to anyone other than the researcher during

and after data collection. Your anonymous responses may be shared with other participants and included in the write up and future publications of this investigation. However, no identifying information will be attached to this information at any time. Participation is confidential, however information may be shared with relevant third parties if there appears to be sufficient evidence to raise serious concern about your safety or the safety of others.

All data and personal information will be kept confidential and stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Audio recordings from the focus groups will be transferred to a password protected memory stick, and deleted from the recording device. Only my supervisors and I will have access to this information. After completion of the study, all personal information associated with data will be removed.

You have the right to decline to answer any questions during the study. Prior to study completion you have the right to withdraw yourself or any data you have supplied during the study, without explanation.

Benefits and risks
Your participation has the potential to influence future policy and practice of how health visitors and midwives work with fathers across the UK. However, topics covered might include experiences of mental health difficulties or stress. This may feel challenging and cause some minor distress. You will be asked only to disclose information you feel comfortable sharing with others, and your participation is voluntary.

If you have any concerns about the mental health of yourself or others, please make use of the resources below for help and support. You can also contact me by email at sfentonresearch@gmail.com for enquiries of more specific help or resources.

Visit the NHS Choices website at www.nhs.uk if you would like information on mental health difficulties and services available near you.

The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters, provides information on the NHS complaints procedure, and provides information on support groups outside the NHS. You can find your nearest PALS office on the NHS Choices website (www.nhs.uk), by asking your GP, or by phoning the non-emergency NHS number on '111'.

Let your GP know if you are experiencing mental health difficulties. They can provide advice and support, and put you in touch with local services.

Improving Access to Psychological Therapies (IAPT) services provide free talking therapies on the NHS for people experiencing mild to moderate mental health difficulties, such as depression, anxiety, or post-traumatic stress disorder. You can self-refer or you can ask your GP to refer you. Please find more details at www.slam-iapt.nhs.uk.

The following mental health charities provide emotional support and information to anyone affected by mental health difficulties:

MIND	**SANE**	**SAMARITANS**
www.mind.org.uk	www.sane.org.uk	www.samaritans.org
Call 0300 123 3393	Call 0300 304 7000	Call 116 123
Text 86463		Email jo@samaritans.org

Further information
If you have any questions or comments, please contact me by email at sfentonresearch@gmail.com.

If you would like to make a complaint, please contact Trish Joscelyne, Clinical Psychologist and Academic Tutor (Salomons) at trish.joscelyne@canterbury.ac.uk.

Thank you.

APPENDIX A

PROCEDURE IN DETAIL

Part 1: If you choose to participate in the research, you will be given an individual participant number which will allow you to participate anonymously. You will receive an email invite to a focus group at an NHS building in Lambeth with other health visitors/midwives, and you will be offered the chance to talk to the researcher by email, telephone, or in person before the focus group to ask any questions.

It is hoped that around 8-10 health visitors/midwives will be able to attend the group. Upon arrival to the focus group, you will be welcomed into a private room where the group will take place. Refreshments will be available. You will be asked to read the information sheet, and given another opportunity to ask any questions. If you would still like to participate, then you will be given a consent form and registration form to read and sign. The focus group will then commence while being audio recorded. This will be an open group discussion facilitated by questions made by the lead researcher. At the end of the focus group, you will receive a thorough debrief, and an opportunity to ask any questions or make any comments. It is expected that the focus group will last 60-90 minutes from the time of arrival to the time of departure.

Following the group, the lead researcher will transcribe the audio recording, using pseudonyms and excluding any identifying information. She will code and analyse the data to produce a series of anonymous statements that represent themes that emerged from the group discussion.

Part 2: Roughly 2-3 months later you will receive an email containing your unique participant number and a link to an online survey. The survey will ask you to provide your unique participant number rather than your name, to keep your data anonymous. The online survey will consist of a series of statements derived from the focus group that you took part in, and also from a focus groups with fathers. You will be asked to rate your agreement with the ideas from all groups, and rank them in order of importance. You will be asked to give a brief explanation for your decisions. Your anonymous responses to this survey will be shared with other participants in this research, however no identifying information will be attached to the data at any time. The survey will mainly include short answer and multiple choice questions, so should take no longer than 30 minutes to complete. You are free to complete the survey at your leisure within a 4-week period.

You will receive an email link to a second online survey within about 2 months of having received the link to the first online survey. This survey will be similar to the first, however this time you will be able to see the general level of agreement with each statement by fathers and health professionals. The purpose of the second survey is to give you the opportunity to review and alter your original ratings should you wish to. You will be asked to provide your reasons for changing your ratings. It is expected that this second survey will take 15 to 30 minutes to complete, and again you are free to complete it at your leisure within a 4-week period. Once you have completed the second online survey you will receive an online debrief.

Appendix H: Information sheet for fathers and healthcare professionals recruited at R2

Welcome to Round 2 of the Delphi Consultation

This survey closes on Wednesday 17th January

Study Information

Hello, and thank you for showing an interest in this project. My name is Sophie Fenton and I am a trainee clinical psychologist at the Salomons Centre for Applied Psychology (Canterbury Christ Church University). I am inviting you to take part in this research that I am conducting as part of my doctoral training. This research has been approved by the London-Dulwich Research Ethics Committee.

This research is looking at:

- How fathers experience the transition to parenthood, and their experiences of receiving generic perinatal services (i.e. from midwives and health visitors during the pregnancy, birth, and first year of their child's life)
- Midwives' and health visitors' experiences of having contact with fathers during the perinatal period
- The ideas that fathers and health professionals have for how services can improve the support provided to fathers during the time from pregnancy to the first year of the baby's life.

What will the study involve?

This research is using a Delphi methodology, which aims to collate the views of 'expert panellists' within a particular field – in this case, fathers with lived experience, and midwives and health visitors who have contact with fathers during the perinatal period (during pregnancy, birth, and first year of the child's life).

For the current questionnaire, **you will be asked to rate how much you agree or disagree with a series of statements**. These statements have been constructed based on responses provided in the first round of the study by a focus group of fathers and a focus group of health professionals. There are spaces provided to leave further written responses if you wish to do so. To maintain anonymity, please do not disclose any identifying information about yourself or others. The survey should take approximately **20 minutes** to complete.

For the third and final round of this research, online surveys will be emailed to you and the other participants according to your participant numbers. Each survey will be personalised according to each participants' responses to the current survey. The third-round survey will be shorter as it will be reduced to the statements which have the largest amount of consensus or disagreement. You will be able to see the overall level of agreement to each statement by the father participant group, and by the health professional participant group, and will have the opportunity to change your ratings if you wish to do so.

Expenses and payments (father participants only)

Upon completing the second online survey, fathers will be entered into a prize draw to win a £20 'Love2shop' voucher, accepted at over 20,000 high street shops in the UK (one £20 voucher for every 5 participants).

To participate in this research:

- You must be over 18 years-old
- You must either be:

1. a father who's child was born in London within the last 3 years, and been present during the perinatal period (from pregnancy to the first year of your child's life),

OR

2. a midwife or health visitor who has been qualified and working with families during the perinatal period, in London, for at least 6 months.

Feedback

Following completion of the project you will be emailed a brief outline of the findings. The final report will be submitted to a range of academic journals for publication, details of which will be emailed to you if the report is accepted for publication.

Your rights and confidentiality

You will be allocated an individual participant number, which will allow you to participate anonymously so that you will not be identifiable to anyone other than the researcher during and after data collection. Your anonymous responses may be shared with other participants and included in the write up and future publications of this investigation. However, no identifying information will be attached to this information at any time. Prior to study completion you have the right to withdraw yourself or any data you have supplied during the study, without explanation.

Benefits and risks

Topics covered might include difficult experiences, which may feel challenging and cause some minor distress. Your participation is voluntary, and you have the right to withdraw at any time. In gathering this information, this project intends to inform the practice of health visitors and midwives who come into contact with fathers during their transition to parenthood. Your participation has the potential to influence future practice within perinatal services and improve the support that fathers receive during this time.

Appendix I: Consent form for fathers and healthcare professionals recruited at R1

Canterbury Christchurch University, Faculty of Social and Applied Sciences,
Clinical Psychology Doctoral Programme Major Research Project

CONSENT FORM

Title of Project: Fathers' and health professionals' views of paternal perinatal support

Name of Researcher: Sophie Fenton (under the supervision of Dr Trish Joscelyne and Dr Siobhan Higgins)

Participant ID Number:

1.	I confirm that I have read and understood the information sheet for the above study and have had the opportunity to consider the information, ask questions and had these answered satisfactorily.
2.	I understand that my participation is voluntary and that I am free to withdraw at any time prior to the completion of the study, without giving a reason, and without my legal rights being affected.
3.	I understand that if I lose capacity to consent during the study, I would be withdrawn from the study and no new data would be collected, but any data already collected would still be used unless I ask for it to be withdrawn and destroyed.
4.	I understand that information I share in this study may be looked at by individuals from Canterbury Christ Church University or regulatory authorities, where relevant. I give permission for these individuals to have access to my anonymous responses to this research.
5.	I agree that anonymous quotes from my responses to this research may be used in the write-up of the study, and in published reports of the study findings. However, my name and any identifying information will not be attached to this information.
6.	I understand that although my responses to the research will be anonymous, if the researcher has concerns about my safety or the safety of others, they will be obliged to share this information with relevant third parties.
7.	I am aware of the potential risks of taking part in this study (such as potentially emotive content being discussed in the focus group which could lead to some distress).
8.	I agree to take part in the above study.

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

Please complete two copies: one copy to be kept by the participant, and one copy to be kept by the researcher

Appendix J: Consent form for fathers and healthcare professionals recruited at R2

CONSENT

- I confirm that I have read and understood the information sheet for the above study
- I understand that my participation is voluntary and that I am free to withdraw at any time prior to the completion of the study, without giving a reason, and without my legal rights being affected.
- I understand that anonymised information I share in this study may be looked at by individuals from Canterbury Christ Church University or regulatory authorities, where relevant. I give permission for these individuals to have access to my anonymous responses to this research.
- I agree that anonymous quotes from my responses to this research may be used in the write-up of the study, and in published reports of the study findings. However, my name and any identifying information will not be attached to this information.
- I understand that although my responses to the research will be anonymous, if the researcher has concerns about my safety or the safety of others, they will be obliged to share this information with relevant third parties within safeguarding policy guidelines.

By clicking "next", you confirm that you have read and understood the information provided, and you consent to participate in this study.

Next >

Appendix K: Debrief provided to participants following R1 focus groups

Thank you for taking part in this study, which is exploring fathers' and health professionals' experiences of NHS perinatal support for fathers, and their ideas for improvement.

Research highlights the importance of fathers for improving the healthy development and wellbeing of their children. Positive father involvement is also beneficial to the health and wellbeing of mothers, for instance by reducing the risk of postnatal depression, and improving the mother's capacity to care for their baby. However, fathers have been reported to often feel side-lined as a helpmate or breadwinner. Despite being in a key position to support fathers in their transition to parenthood, research into perinatal services provided to fathers in the UK is lacking.

This project is exploring the experiences of two groups who have expertise in this area: (i) fathers who have received perinatal services, and (ii) midwives and health visitors who provide perinatal services. The focus group component of this project aimed to gather the experiences of the expert groups, and any ideas that the two expert groups may have for service improvement. Audio recordings of the focus groups will be transcribed and analysed to pick out key themes. These themes will be used to develop an online survey, from which the researcher aims to gather an idea of the level of consensus within and between the different groups regarding perinatal support given to fathers and how the NHS can improve services to fathers.

The hope is that this project will provide greater insights into how fathers experience perinatal support during the transition to parenthood, how health professionals experience the giving of support to fathers, and how both expert groups feel that perinatal support for fathers could be improved.

If you have any questions or comments regarding this study, please contact Sophie Fenton (lead researcher) at sfentonresearch@gmail.com. Or if you would like to make a complaint, please contact Dr Trish Joscelyne (research supervisor) at trish.joscelyne@canterbury.ac.uk.

If participation in this research has raised any concerns about the mental health of yourself or others, please make use of the resources below for help and support. You can also contact me by email at sfentonresearch@gmail.com for enquiries of more specific help or resources.

- **Visit the NHS Choices website at www.nhs.uk if you would like information on mental health difficulties and services available near you.**
- **The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters, provides information on the NHS complaints procedure, and provides information on support groups outside the NHS. You can find your nearest PALS office on the NHS Choices website (www.nhs.uk), by asking your GP, or by phoning the non-emergency NHS number on '111'.**
- **Let your GP know if you are experiencing mental health difficulties. They can provide advice and support, and put you in touch with local services.**
- **Improving Access to Psychological Therapies (IAPT) services provide free talking therapies on the NHS for people experiencing mild to moderate mental health difficulties, such as depression, anxiety, or post-traumatic stress disorder. You can self-refer or you can ask your GP to refer you. Please find more details at www.slam-iapt.nhs.uk.**
- **The following mental health charities provide emotional support and information to anyone affected by mental health difficulties:**

MIND www.mind.org.uk Call 0300 123 3393 Text 86463	SANE www.sane.org.uk Call 0300 304 7000	SAMARITANS www.samaritans.org Call 116 123 Email jo@samaritans.org

Many thanks for making a valuable contribution to this area of research.

Appendix L: Debrief provided to participants following R2 online survey

THANK YOU

Thank you for completing the second round of this study. This research is exploring fathers' and health professionals' experiences, including their experiences of NHS perinatal support for fathers, and their ideas for improvement.

For the third and final round of this research, online surveys will be emailed to you and the other participants according to your participant numbers. Each survey will be personalised according to each participants' responses to the current survey. The third-round survey will be shorter as it will be reduced to the statements which have the largest amount of consensus or disagreement. Participants will be able to see the overall level of agreement to each statement by the father participant group, and by the health professional participant group, and will have the opportunity to change their ratings if they wish to do so.

The hope is that this project will provide greater insights into how fathers experience perinatal support during the transition to parenthood, and how health professionals experience giving support to fathers. Furthermore, by gathering an idea of the level of consensus within and between the different groups regarding paternal perinatal support, this research has the potential to inform NHS service improvements.

If you have any questions or comments regarding this study, please contact Sophie Fenton (lead researcher) at s.e.fenton383@canterbury.ac.uk. Or if you would like to make a complaint, please contact Professor Paul Camic (research sponsor) at paul.camic@canterbury.ac.uk.

Many thanks for making a valuable contribution to this area of research.

If participation in this research has raised any concerns about the mental health of yourself or others, please make use of the resources below for help and support. You can also contact me by email at s.e.fenton383@canterbury.ac.uk for enquiries of more specific help or resources.

- Visit the NHS Choices website at www.nhs.uk if you would like information on mental health difficulties and services available near you.
- The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters, provides information on the NHS complaints procedure, and provides information on support groups outside the NHS. You can find your nearest PALS office on the NHS Choices website (www.nhs.uk), by asking your GP, or by phoning the non-emergency NHS number on '111'.
- Let your GP know if you are experiencing mental health difficulties. They can provide

advice and support, and put you in touch with local services.

- Improving Access to Psychological Therapies (IAPT) services provide free talking therapies on the NHS for people experiencing mild to moderate mental health difficulties, such as depression, anxiety, or post-traumatic stress disorder. You can self-refer or you can ask your GP to refer you. Please find more details at www.slam-iapt.nhs.uk.
- The following mental health charities provide emotional support and information to anyone affected by mental health difficulties:

1. MIND

   www.mind.org.uk

   Call 0300 123 3393

   Text 86463

2. SANE

   www.sane.org.uk

   Call 0300 304 7000

3. SAMARITANS

   www.samaritans.org

   Call 116 123

   Email jo@samaritans.org

Appendix M: Debrief provided to participants following R3 online survey

Page 7: THANK YOU

Thank you for completing the final round of this study. Your contribution to this research exploring experiences of fathers and health professionals and their views of NHS perinatal support for fathers, is greatly appreciated!

The hope is that this project will provide greater insights into how fathers experience perinatal support during the transition to parenthood, and how health professionals experience giving support to fathers. Furthermore, by gathering an idea of the level of consensus within and between the different groups regarding paternal perinatal support, this research has the potential to inform NHS service improvements.

If you have any questions or comments regarding this study, please contact Sophie Fenton (lead researcher) at s.e.fenton383@canterbury.ac.uk. Or if you would like to make a complaint, please contact Professor Paul Camic (research sponsor) at paul.camic@canterbury.ac.uk.

Many thanks for making a valuable contribution to this area of research.

(Prize draw winners will be contacted in due course).

These are the statements which reached high levels of agreement in the previous round by both fathers and health professionals:

- Men experience personal changes in themselves, and observe personal changes in the baby's mother too.
- The relationship dynamic between the mother and father changes when there is the baby in the relationship too.
- Communication, negotiation, and compromise between the father and mother is important during the perinatal period.
- Becoming a parent is just as important to fathers as it is to mothers.
- Fathers are equally as able as mothers to be good primary caregivers for their children.
- Fathers are important for the physical health of the baby (e.g. bottle feeding, supporting breastfeeding, being aware of the baby's physical health and what to look out for).
- Fathers are important for the psychological wellbeing of the baby (e.g. being an attachment figure for the baby, and supporting the mother's bond with the baby).
- Fathers are important for the psychological wellbeing of the mother (knowing about her mood and coping, and providing support).
- Fathers may have important information to share about their experiences or coping, which health professionals are unlikely to find out unless they ask fathers directly.
- Fathers are important for being the baby's main caregiver if the mother is not able.
- Fathers are important for being an overall source of help and support.
- When the father has difficulty coping, it makes things more difficult for the mother too.

The following is important to fathers' experiences during the perinatal period:

- For health professionals to signpost fathers to a clear and reputable source of parenting information.
- For services to provide more information and preparation regarding the psychological, emotional and relational aspects of parenthood.
- For antenatal classes to have more content on the father-mother relationship, raising awareness of the impact that having a baby can have on the relationship, how to nurture the parent relationship, and what can be helpful in managing conflict.
- For fathers to receive invitations to appointments, parent education sessions, and classes.
- For health professionals to encourage fathers to have skin-to-skin contact with their baby straight after the birth.
- For health professionals to involve fathers in communication with body language, direct questions, and prompts for them to speak.
- For health professionals to open up conversations between parents about the choices they have (e.g. who to have in the birth room, or whether to have the father stay the night on the ward with the mother).
- For fathers to be better accommodated for staying overnight on the ward (e.g. having the option of staying overnight, having a mat to sleep on, a microwave to heat food, somewhere to wash).

Statements specific to health professionals that reached a high level of agreement:

- Attitudes towards how much health professionals should involve fathers varies between different midwifery or health visiting colleagues.
- The workload is stressful.
- There is a constant pressure of people waiting to be seen.
- Health professionals are often not able to offer consistent continuity of care to families.
- There ae not quite enough health professionals to meet the demands on the service.
- Health professionals do not receive enough training on fathers or how best to include fathers (e.g. what fathers want, what their expectations are, or how to address their needs).
- Health professionals find it difficult to fulfil their roles to their full potential due to time pressure and stretched resources.
- Health professionals do not have as much time as they feel is needed to talk with parents about their psychological experiences or coping.
- For families where the father is involved, it is not a formal service requirement for health professionals to meet with the fathers.

If participation in this research has raised any concerns about the mental health of yourself or others, please make use of the resources below for help and support. You can also contact me by email at s.e.fenton383@canterbury.ac.uk for enquiries of more specific help or resources.

- Visit the NHS Choices website at www.nhs.uk if you would like information on mental health difficulties and services available near you.

- The Patient Advice and Liaison Service (PALS) offers confidential advice, support, and information on health-related matters, provides information on the NHS complaints procedure, and provides information on support groups outside the NHS. You can find your nearest PALS office on the NHS Choices website (www.nhs.uk), by asking your GP, or by phoning the non-emergency NHS number on '111'.
- Let your GP know if you are experiencing mental health difficulties. They can provide advice and support, and put you in touch with local services.
- Improving Access to Psychological Therapies (IAPT) services provide free talking therapies on the NHS for people experiencing mild to moderate mental health difficulties, such as depression, anxiety, or post-traumatic stress disorder. You can self-refer or you can ask your GP to refer you. Please find more details at www.slam-iapt.nhs.uk.
- The following mental health charities provide emotional support and information to anyone affected by mental health difficulties:

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   Call 0300 123 3393

   Text 86463

2. SANE

   www.sane.org.uk

   Call 0300 304 7000

3. SAMARITANS

   www.samaritans.org

   Call 116 123

   Email **jo@samaritans.org**

Appendix N: Abridged notes from the bracketing interview

Preconceptions formed by the literature

From reading the existing literature, I had developed the impression that men often feel side-lined as a secondary parent. I had read that midwives and health professionals have been found to look upon fathers as 'helpers' for the mother and baby, and when referring to fathers, would do so in relation to the mother, rather than fathers being considered as a parent in their own right. When writing my research proposal, I realise on reflection, that I was quite tied to these findings – perhaps because it justified the need for my research.

Personal experiences of observing friends as parents

Many of my friends are either expecting a baby, or have recently become parents. I notice, when talking to my female friends that the conversation is very much around their experiences of pregnancy, childbirth, breastfeeding, and their care of the baby. I ask about how their partners feel or respond, but the conversation does not tend to go that far regarding the fathers. With most of my friends, the fathers are very involved, but I often get the sense of the focus being more on the mother-baby pair (especially as all of the fathers quickly returned to work).

My own upbringing and experiences

As a childless woman who has had no previous contact with perinatal services, my knowledge and understanding of fathers' experiences and of perinatal services is very limited. As a white middle-class woman, my main social constructions of fatherhood and parenthood come from a white middle-class background, with only some insight into other cultures through friends, work, and literature.

**Further notes on my upbringing and experiences removed for privacy reasons. Themes centred around:*
- experiences of my own parents
- the value-systems of the older generation in my family
- gender roles and norms within my family, and how these related to ideas of parenthood
- my own endorsement of gender norms changing as I grew older
- preconceptions that I have around fathers, where these preconceptions came from, how they have been challenged or confirmed, and how they have changed.

Society

Shared parental leave is a recent thing, many men are still not aware of it, and perhaps many work-places are not implementing it properly yet. Mothers and babies are still predominantly the duo found in children's centres, play groups, and out and about during the week, rather than the father-baby pair. Men tend to quickly go back to work and have less daily hours with the baby.

Look out for anything that challenges my preconceptions or biases, such as:

- Fathers do feel involved and treated with equal importance to mothers
- Fathers do not feel the need, or desire to be more included
- Fathers are satisfied with the support they have received
- Babies can depend on fathers as much as mothers
- Health visitors and midwives help fathers to feel as equally involved as mothers
- Fathers do not only count themselves as a helper, and see themselves as having equal rights to have their needs met

Appendix O: Abridged extract from the authors' research and reflections diary

August 2017

Recruitment of health visitors and midwives into the focus group was relatively easily due to the contacts that the LEAP manager had (through my external supervisor). I was nervous for the staff focus group, but they made my job easier by being incredibly open and engaged. I felt appreciative of their contributions, and felt like I learnt a lot from their perspectives, especially considering that I did not have much insight into perinatal services. There were moments when I noticed the language and comments reflected that the acknowledgement of fathers' entitlement to be more involved is a recent change. When the staff spoke about not being trained to work with fathers, wanting to involve fathers, but not knowing what they want, I felt excited about the potential to meet these needs through my research.

September 2017

I went to the AIMH conference about fathers. I felt reassured that I was aware of the key literature they referenced. A strong theme in that conference was the importance of the mother-father relationship to the wellbeing of the baby, and the triadic relationship, whereby the baby has a need for there to be harmony in the relationships of the triad. This made me realise I had been thinking more about the mother-baby, father-baby dyads without quite as much thought to the mother-father relationship or to the triadic relationship. I was very pleased to listen to Prof. Ramchandani – one of the key contributors to the literature on fathers.

October 2017

The whole of October was spent doing thematic analysis of the staff focus group and trying to recruit fathers from children's centres. I have been having great difficulty so applied for an amendment to IRAS to expand my recruitment area to the wider London area, and to be able to use Facebook and snowball sampling through friends.

Finally, I found a group at a children's centre that ran on a Saturday where there were loads of fathers. I encountered a mixture of fathers who felt it was an important topic, and a few who said everything was fine with their experiences of services. Many were busy with work so I am worried about how many I will get at the focus group, but I nevertheless feel a lot more hopeful now I have met so many fathers.

November 2017

3rd Nov: Focus group with fathers completed (what a relief!)

I was struck by how a lot of the conversation between the fathers involved topics that were general parenting concerns, rather than gender-specific issues that I realised I was expecting more of. There was also a mixture of experiences of feeling excluded and unsatisfied with services, and positive experiences of feeling included and highly satisfied with services. I was aware that the fathers who attended the group were white, middle-class, and employed. One represented single fathers, but otherwise I had not managed to achieve a diverse sample for the first round.

I met with my supervisor and we had a discussion about how to merge the data from both groups so both groups can do the same online survey. While doing the staff focus group thematic analysis, I had noticed there were some topics that would be too specific to staff for fathers to be able to answer. We agreed that some additional statements might have to be presented separately for just one group if they have no relevance to the other group. We also discussed Section A, and my rationale for including and excluding papers.

I met with a member of the research staff to ask questions about thematic analysis that had arisen for me during the process of analysing the staff focus group. I realised from this meeting that I had not done it thoroughly enough, and had to go back and do it all again!

December 2017

I continued with the thematic analysis. I have pretty much been at my laptop during all waking hours when I am not at placement. Driven by the desire to get this research done by April and not need an extension.

Converting the codes into statements while representing the data extracts as much as possible has taken a lot of careful consideration.

There are too many statements. The survey would take so long that I doubt I would manage to get many participants to complete it. I found justification in the literature to omit infrequently occurring items. Also, if two statements were very similar, I merged the two (noting my process and justification for each change). I checked these over with my supervisor. We also discussed how I was uncomfortable about wording the statements in the third person, due to wanting participants to answer based on their own personal experiences and views, rather than fathers or health professionals in general. The justification for wording them in the third person made sense however, to have both participants complete the same survey. I made a few further changes to the wording based on my supervisor's feedback. I also aimed to make it as clear as possible in the online survey to remind participants to reflect on how much the statements are true to them, rather than their group in general.

I have ended up with 82 items for both groups and 14 further items for staff. I sent the two versions of the survey to a father and midwife (known to me) who could pilot them and give feedback.

Timely approval received from HRA to expand the recruitment area to all of London, to snowball sample through friends and colleagues, and to use Facebook as a platform to recruit.

Made minor changes to the survey after piloting, and then distributed the online survey.

January 2018

Finishing off my Section A draft, I had a horrible sense that I had pathologised parenthood! The literature on parental mental health is quite problem-saturated, which became reflected in

my write-up. I made some edits to clarify that not all parents experience psychological distress, attempted to normalise distress for parents who do have a more difficult time, and also clarified that this does not mean that the children will definitely have any negative outcomes from parental distress.

I submitted my Section A draft to my internal supervisor, and we met shortly afterward to discuss the feedback. This involved a discussion about my rationale for not doing quality ratings for the included papers due to the subjective nature of it. My internal supervisor suggested that I describe methodological issues of the papers more in the text, rather than just including a table.

The Round 2 survey came offline on 19th January. I am relieved to have a good number of participants, and have enjoyed looking through the responses. A few of the qualitative responses from the fathers made me feel emotional. One father described a particularly distressing experience when his baby was born. This increased my faith in this project being valuable. Although, the HCPs' qualitative comments included feedback about being so stretched, listing all of the things they already are required to do, and needing to make sure mother and baby stay alive for 40 days. This left me feeling less hopeful about the project. I sympathised with the HCPs, and worried that I am being unreasonable to come from a different profession and make suggestions about even more responsibilities that HCPs should have. I drew my attention back to the suggestions made by participants in the study, and reassured myself that many of the changes that they are agreeing upon would not take many resources (e.g. involving fathers more in communication and body language). Other suggestions are also more aimed at the wider service structures changing, such as becoming more family-centred, and providing staff with more father-inclusive training. I hope that this project can be used, with other evidence, to inform commissioning bodies to allocate more resources to perinatal services.

R3 surveys sent out on 30th January. Feeling very pleased that I do not need to do any more recruitment activities for this round.

February 2018

I have been working on the Section A corrections while waiting for the R3 surveys to come offline on 21st February. Since the surveys have come offline, I have been pulling the data out of the R3 surveys and calculating the average percentages within and between groups for each statement.

March 2018

1st March: Second draft of Section A, and skeleton draft of Section B submitted to my internal supervisor.

8th March: Consultation with statistician at Salomons. I have learned that my quantitative data is not appropriate for statistical tests beyond descriptive statistics.

Writing the discussion, I have decided to indicate divergence between groups as being two or more consensus categories apart (e.g. strong-weak consensus; moderate-no consensus).

During the Section B write-up, I have found it easy to get swept up into the narrative that fathers need more support, and services are not meeting their needs. I have to keep reminding myself not to let this paint HCPs in a bad light, as they are clearly working very hard with limited staff and resources. Under these circumstances, of course they would practically need to prioritise the mother and babies due to the physical health risks. In relation to providing psychological support to both parents on top of that, I imagine that HCPs' emotional resources to do this may also be limited due to the stressful work environments that many of them reported experiencing. In this sense, the ecological model is helping me to remove the responsibility as existing within one system. Generally, this systemic, non-individualistic way of thinking fits with my preferred approach to problems. I hope that any HCPs who might read this project will not feel blamed in any way.

Appendix P: Fathers' focus group schedule

"Thank you all very much for making the time and effort to attend the group. My name is Sophie Fenton and I am a trainee clinical psychologist. I am the lead researcher on this project. As described on the information sheet, the purpose of this focus group is to gain an understanding of what your experiences have been in becoming fathers, and the support you received from perinatal services during that transition to parenthood. I am also really interested in hearing about how your experiences may have given you ideas about how services could improve the support they provide to fathers during the pregnancy, birth, and first year of their child's life.

Please do not feel you have to share anything that you do not feel comfortable sharing. I would like to remind you that everything shared in this group is confidential. The only instance in which confidentiality would only be broken is if any information came up that raised concerns over your safety or the safety of others. If this happens I would only inform relevant third parties in accordance with the NHS Trust's policies and procedures, and I would endeavour to speak with you after the group about this first. You will all be given pseudonyms when the audio recording is transcribed, and no identifying information will be used in the write-up of the project. I ask you all to maintain one another's confidentiality once the group has ended, and not discuss anybody's personal information outside of the group. I also encourage you all to treat what each other says with respect. It is important to emphasise that there are no right or wrong answers, and everybody's experiences and opinions are valid. Some topics raised may bring up difficult emotions. Should this happen, please feel free to take a break or leave the group without having to give a reason, and without your rights being affected. I will provide a debrief at the end of the group and the opportunity to ask questions. I will also be available for some time after that if anybody would like to discuss anything else privately.

If you would like to take a comfort break at any time, please do so. The toilets are… And in the case of a fire or emergency, the emergency exits are… and the meeting place is…"

"Let's have a round of introductions. Please only give first names, or you can use a pseudonym if you prefer. As we go round it would also be nice to know how many children you have and their ages."

(Do introductions).

"As outlined earlier, I am going to audio record the focus group, but this information will be kept confidential and stored securely. Does anybody have any questions before we start?"

(Answer questions, and when everybody is ready, tell participants I am pressing 'record' on the audio recorder).

1. **What was it like finding out that you were going to be a father?**
2. **What was it like for you during the pregnancy?**

3. **Has anyone got any memories of particularly positive/negative experiences with health professionals during the pregnancy? How did you experience the support you received from…?**
4. **What could have helped you during this time?**
5. **What were your experiences during the birth of your child?**
6. **Has anyone got any memories of particularly positive/negative experiences with health professionals during the birth? How did you experience the support you received from…?**
7. **What could have helped you during this time?**
8. **How was the transition to fatherhood once your baby was born? What was life like in that first year?**
9. **Has anyone got any memories of particularly positive/negative experiences with health professionals during the first year of your child's life? How did you experience the support you received from…?**
10. **What could have helped you during this time?**
11. **Did you feel you would have benefitted from more or different support from health professionals at any stage?**
12. **What do you find most difficult about being a father?**
13. **What do you enjoy most about being a father?**
14. **Is there anything else you feel we have not touched upon that you would like to say?**

General prompts to facilitate discussion:

- **Does that resonate with anyone else?**
- **Does anyone have any different experiences?**
- **Can you remember any particular worries, concerns, challenges or needs that you had during this time?**
- **Was this different from your expectations?**
- **How was the support you received from health professionals during this time?**
- **How much do you feel your needs were met?**
- **Was there anything that you found helpful (if so, what)? Was there anything that you found unhelpful or lacking (if so, what)?**
- **What would you have liked to have been different? How?**
- **How was your mood?**
- **How was your relationship with the mother of your baby?**
- **Were any other areas of your life affected?**
- **Were there any changes in you, or the mother of your baby, that you were not expecting?**
- **Did either you or the mother of your baby experience any distress or mental health difficulties during this time?**

Appendix Q: Healthcare professionals' focus group schedule

"Thank you all very much for making the time and effort to attend the group. My name is Sophie Fenton and I am a trainee clinical psychologist. I am the lead researcher on this project. As described on the information sheet, the purpose of this focus group is to gain an understanding of what your experiences have been as health professionals working with fathers during the perinatal period (through pregnancy, birth, and the first year of the baby's life). I am also interested in hearing about any barriers you might encounter in your work with fathers, and how your experiences may have given you ideas about how services could improve the support provided to fathers during the perinatal period.

Please do not feel you have to share anything that you do not feel comfortable sharing. I would like to remind you that everything shared in this group is confidential. The only instance in which confidentiality would only be broken is if any information came up that raised concerns over your safety or the safety of others. If this happens I would only inform relevant third parties in accordance with the NHS Trust's policies and procedures, and I would endeavour to speak with you after the group about this first. You will all be given pseudonyms when the audio recording is transcribed, and no identifying information will be used in the write-up of the project. I ask you all to maintain one another's confidentiality once the group has ended, and not discuss anybody's personal information outside of the group. I also encourage you all to treat what each other says with respect. It is important to emphasise that there are no right or wrong answers, and everybody's experiences and opinions are valid. Some topics raised may bring up difficult emotions. Should this happen, please feel free to take a break or leave the group without having to give a reason, and without your rights being affected. I will provide a debrief at the end of the group and the opportunity to ask questions. I will also be available for some time after that if anybody would like to discuss anything else privately.

If you would like to take a comfort break at any time, please do so. The toilets are… And in the case of a fire or emergency, the emergency exits are… and the meeting place is…"

"Let's have a round of introductions. Please only give first names, or you can use a pseudonym if you prefer. ~~As we go round it would also be nice to know how many children you have and their ages~~."

(Do introductions).

"As outlined earlier, I am going to audio record the focus group, but this information will be kept confidential and stored securely. Does anybody have any questions before we start?"

(Answer questions, and when everybody is ready, tell participants I am pressing 'record' on the audio recorder).

1. **What is working life like as a health visitor/midwife?**
2. **What are you experiences of working with expectant/new fathers?**

3. **Do you feel that fathers and mothers cope with the transition to parenthood differently? How?**
4. **Do you feel that mothers and fathers have different needs? What are the differences?**
5. **Has anyone had any experiences of working more closely with the father than with the mother? Or an equal amount as the mother?**
6. **Have you experienced any barriers or challenges in supporting fathers in your work?**
7. **Can you think of anything that could be helpful in supporting you to work with fathers?**
8. **How do you feel support to fathers during the perinatal period could change or improve? (If at all)**
9. **Has anybody got any good stories about working with a father?**
10. **Is there anything else you feel we have not touched upon that you would like to say?**

General prompts to facilitate discussion:

- **Does that resonate with anyone else?**
- **Does anyone have any different experiences?**
- **Can you remember any particular worries, concerns, challenges or needs that you had during this time?**
- **What would you have liked to have been different? How?**

Appendix R: Demographic/registration form for health professionals at R1

1) Age …….

2) Gender …….

3) Ethnic group

- a. White ☐
- b. Indian ☐
- c. Pakistani ☐
- d. Other Asian ☐
- e. Bangladeshi ☐
- f. Chinese ☐
- g. African ☐
- h. Caribbean ☐
- i. Other Black ☐
- j. White and Black Caribbean ☐
- k. White and Black African ☐
- l. White and Asian ☐
- m. Other mixed ☐
- n. Arab ☐
- o. Any other ethnic group ☐

4) What is your current profession?

- a. Midwife ☐
- b. Health visitor ☐

5) How long have you been in this role for?

……. years, …… months

6) How often do you have contact with fathers?

- a. As often as I see mothers ☐
- b. Almost as often as I see mothers ☐
- c. Half as often as I see mothers ☐
- d. Rarely ☐
- e. Never ☐

7) When do you normally see fathers?

……
……
……
……

Appendix S: Demographic/registration form and paternal stressor questions for fathers at R1

1) **Age …….**

2) **Ethnic group**
   a. White ☐
   b. Indian ☐
   c. Pakistani ☐
   d. Other Asian ☐
   e. Bangladeshi ☐
   f. Chinese ☐
   g. African ☐
   h. Caribbean ☐
   i. Other Black ☐
   j. White and Black Caribbean ☐
   k. White and Black African ☐
   l. White and Asian ☐
   m. Other mixed ☐
   n. Arab ☐
   o. Any other ethnic group ☐

3) **Level of educational attainment**
   a. No formal qualification ☐
   b. GCSE ☐
   c. Apprenticeship ☐
   d. A-Level ☐
   e. Diploma ☐
   f. Bachelor's degree ☐
   g. Postgraduate degree ☐

4) **What is your annual household income?**
   a. Less than £13,000 ☐
   b. £13,000 – £18,999 ☐
   c. £19,000 – £25,999 ☐
   d. £26,000 – £31,999 ☐
   e. £32,000 – £47,999 ☐
   f. £48,000 – £63,999 ☐
   g. £64,000 – £95,999 ☐
   h. £96,000 or more ☐

5) **How many children do you have?**
   ……

6) **How old were you when you had your first child?**
……

In answering the questions below, please think about your experiences during the first year of your youngest child's life.

7) **During the first year of their life, were you:**
   a. Living with your child/children and their mother ☐
   b. Living with and having full custody of your child/children while not living with their mother ☐
   c. Living apart from your child/children and their mother, with scheduled contact or custody arrangements ☐
   d. Other living arrangement (please detail) ☐

8) **During the first year of their life, were you:**
   a. In full-time employment ☐
   b. In part-time employment ☐
   c. Full-time student ☐
   d. Self-employed ☐
   e. Unemployed ☐

9) **If employed, how much paternity leave did you take when they were born?**
   a. None ☐
   b. 1 – 2 weeks ☐
   c. 2 – 4 weeks ☐
   d. 1 – 3 months ☐
   e. Longer than 3 months ☐

Measure of paternal stress from conception to baby's first birthday

In answering the questions below, please think about your experiences during the pregnancy, birth, and first year of your youngest child's life.

During pregnancy	
The pregnancy was unplanned	
I was not in a long-term relationship with the mother at the time	
I experienced a relationship breakup with the mother of my baby during pregnancy	
I did not want to have a baby at that time, or with the mother	
There were concerns over my baby's development during pregnancy	
The mother was saying she would restrict my contact with my baby, or move away	
Concerns related to birth	
My baby was born by emergency caesarean	
The mother haemorrhaged from the birth	
My baby was in distress during labour, or had a shallow heart beat	
My baby was breached at birth	
There were concerns over my baby's physical safety/health	
There were concerns over the mother's physical safety/health	
Concerns or difficulties in first year post-birth	
My baby had difficulty feeding	
My baby had difficulty sleeping	
My baby had difficulty settling	
My baby had colic	
I had difficulty bonding with my baby	
I felt I had more difficulty adjusting to fatherhood than I had expected	
There were concerns over my baby's development	
I experienced difficulties negotiating changes in responsibilities with the mother of my baby	
I experienced a relationship breakup with the mother of my baby	
The mother restricted my contact with my baby against my wishes	
There were concerns over my baby's physical safety/health	
There were concerns over the mother's physical safety/health	
Other life events that may have occurred during pregnancy and the first year post-birth	
I lost my job, or felt under threat of losing my job	
I experienced a significant bereavement of a loved one	
I, or a loved one, experienced serious injury or illness	
I, and/or the mother of my baby, experienced some form of mental distress, such as depression or anxiety	
I was prescribed medication for the mental distress I was experiencing	
The mother of my baby was prescribed medication for the mental distress she was experiencing	
I moved house	
I lost my home	
I was living in overcrowded/uncomfortable living conditions	
Financial strain caused me to worry about providing basic care for my baby	
I worked over 60 hours per week	
I experienced significant and prolonged stress at work	
Social services became involved over concerns for my baby's welfare	

There was some drug or alcohol abuse: By me By the mother By both of us	
I experienced relationship dissatisfaction/discord with the mother	
I experienced a change in the sexual relationship with my partner	
I felt socially isolated	
I experienced domestic abuse from my partner (including emotional abuse)	
Any other major stressor during pregnancy and the first year of your baby's life?	
…….. …….. ……..	

Appendix T: Demographic questions for both groups at R2

Please could you complete the following items to help us to have an idea of the demographics and circumstances of our participants.

How old are you?

- 18 – 24
- 25 – 34
- 35 – 44
- 45 – 54
- 55 – 64
- 65+

What ethnicity do you identify as?

- White
- Indian
- Pakistani
- Other Asian
- Bangladeshi
- Chinese
- African
- Caribbean
- Other Black
- White and Black Caribbean
- White and Black African
- White and Asian
- Other mixed
- Arab
- Any other ethnic group
- Other

What is your highest level of educational attainment?

- ○ No formal qualification
- ○ GCSE
- ○ Apprenticeship
- ○ A-Level
- ○ Diploma
- ○ Bachelor's degree
- ○ Postgraduate degree

What is your annual household income?

- ○ Less than £13,000
- ○ £13,000 – £18,999
- ○ £19,000 – £25,999
- ○ £26,000 – £31,999
- ○ £32,000 – £47,999
- ○ £48,000 – £63,999
- ○ £64,000 – £95,999
- ○ £96,000 or more

Appendix U: Circumstances and parental stressors questions for fathers at R2

Fathers

If you are taking part as a father, how many biological children do you have?

- ○ 1
- ○ 2
- ○ 3
- ○ 4 or more

How old were you when you had your first child?

How old is your youngest child? * *Required*

If your youngest child is over the age of three, please do not proceed as your data cannot be used for this study.

For fathers of more than one child, please reflect on your experiences when having your child who is currently aged 3 or younger.

For fathers with two children aged 0-3 years, please decide now which time of becoming a parent you would like to feed back on for the purpose of completing this survey.

During the first year of your child's life, were you:

- ○ Living with your child/children and their mother
- ○ Living with and having full custody of your child/children while not living with their mother
- ○ Living apart from your child/children and their mother, with scheduled contact or custody arrangements
- ○ Other

Which London Borough, or NHS Trust did you and the mother of your baby receive perinatal services from?

During the first year of your child's life, were you:

- In full-time employment
- In part-time employment
- Full-time student
- Self-employed
- Unemployed

If employed, how much paternity leave did you take when your child was born?

- 1-2 weeks
- 2-4 weeks
- 1-3 months
- Longer than 3 months
- Other
- Not applicable

Please indicate how much each statement is true to your own experiences during the perinatal period, regarding the child that you have been reflecting on for the purpose of this survey.

Please don't select more than 1 answer(s) per row.

Please select at least 4 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
The pregnancy was straight forward	☐	☐	☐	☐	☐	☐
The birth was straight forward	☐	☐	☐	☐	☐	☐
There were no complications during the baby's first year	☐	☐	☐	☐	☐	☐
There were few difficult external life events or stressors during our baby's first year	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

Appendix V: Circumstances for HCPs at R2

Health professionals

If you are taking part as a health professional, please indicate your current profession *
Required

- Midwife
- Health visitor

How long have you been qualified for?

What gender do you identify as?

Which London borough(s) or NHS Trust do you provide services for?

How often do you have contact with fathers?

- As often as I see mothers
- Almost as often as I see mothers
- Half as often as I see mothers
- Rarely
- Never

When do you normally see fathers?

Appendix W: Extract of coded transcript

Pt		Coding
4	And I know those aren't many answers because you know it's, it's a very [inaudible] thing, but just a little bit more guidance.	Acknowledging lack of answers but wish for some guidance;
1	1:01:49 Addressing it is probably important, I mean if that's someone explicitly at one point making a fairly prominent piece saying "you will feel useless, um, and that's understandable. Maybe these are things you can do. Talk to your partner before. Trying to come up with a plan", to so that she doesn't have to figure out how to make you feel less useless then a little bit, you know, there is things which, yeh that they could make more.	Wants explicit message; Fs feel useless; How Fs can help; Communicate with M; Planning
4	Yeh, you are not going to agree on how to change the nappy, or you're not going to agree on bed, just, just, yeh as I say signposting those things.1:02:21	Signposting; relationship disagreements
R	Mmm, yeh	
3	And if you could landscape a little bit more of what the, the, the um, the experience looks like. Both in terms of lead up and maybe the first year or something, um, that would have been really helpful. I, I think the other thing, and maybe it's just how my brain works, but you know, um a real rough kind of um calendar even with sort of key dates, and like, you know like the injections, and the jabs and the weighing thing, when the health visitor comes, and I was kind of, I was really living week-to-week. I, in the way my brain works, and I'd love to have had a, um not as a sort of you know, because clearly it's not scheduled, but just all the most kind of like a sort of plan for it, which is like you know "the first year is going to be really interesting for you guys, this is now, and then you're going to have see the doctors, and after the first year they'll sign off the baby and you have to go every couple of months to get them weighed", do you know what I mean? 1:03:25 Just so you can sort of visualise what that world looks like a bit, and to "guys there will be various moments when you get, you know, stressed and shout at each other. That's normal, that's what you would expect, and that's the way that these relationships happen, and remember there's lots of reasons why those things happen." Um, the important thing is that you find a way through it. I loved when you were saying before about differentiating between what's important and not, because particularly for the first child around, you don't necessarily know that. So, I'd have loved, whatever those items are, whether it turns out to be breastfeeding, or nappy choice, or sleep times, or dummies, or whatever it happens to be, it's a if you, if you were sort of saying "look guys there are some things you really need to be on top of alright". So you can be on top of sleeping, make sure the bath isn't boiling you know, and feeding at regular times. That's going to help a lot with sleeping and humour and stuff, but actually when it comes down to deciding whether this, you're right, these silly 'teaching them to crawl' devices, or you know you should be playing them you	Wants more info on what to expect in perinatal period and calendar of key dates; Wants more of a clear plan; Not knowing what was happening; Stress; Relationship conflict; Wanting reassurance of what to expect with relationship changes; Wanting clarity on what's important and what's not;

	know music in the bath or whatever. 1:04:29 You know, those things are up to you.	
R		
	Yeh	
3		Wanting to know what's advised and what's personal choice;
	Do you see what I mean? Do you see what I mean? I'd really have liked to have all the stuff that's a choice versus the stuff that's really kind of "guys you need to do this properly, and this is currently what the advice is", you know. That, that's, those things would have helped me a lot I think. 1:04:45	
R		
	Yeh, okay.	
3		
	Yeh, but I like that idea of yours a lot.1:04:48	
R		
	Did, are there any other ideas?	
1		Ms get a list of appointments drawing them in; Fs have to be active in seeking support; Fs' entitlement; Invitations for Fs may help inclusion; MW pregnancy appointments unhelpful for him;
	I think, I mean, the, it's an obvious perspective but for the pregnant woman you get given a list of appointments: please come to this, please come to this, please come to this. And there are, there are mechanisms drawing you in. Whereas, there is a support there for fathers but it's very much like: you have to go and get it. Um, I'm not necessarily advocating that fathers should be invited into more stuff, but if they were then maybe they would go to more, and maybe they would feel actually more included, or not. I mean, my experience of going to the, the midwifery led appointments before, um before the birth weren't necessarily that helpful, I mean it was just the same sort of information I think that was made sure everyone who went there received it. 1:05:46	
R		
	Yeh	
1		Box-ticking
	There was box ticking in the same way that some of the NCT course was and some of the antenatal NHS course was.	
R		
	Mmm	Info more necessary for Ms; Info-seeking up to the Fs
1		
	Um, but, yeh it's an obvious reason, I mean for the pregnant woman they need them to come to give them information. Whereas for the partner, father it's like 'well, it's up to you'.	
R		
	Yeh	
2		More active invitations for Fs to feel more included;
	But, if they said actually, you know if there was more fuss say 'please come along to...', then some fathers would feel included who may otherwise not feel included, if that makes sense.	
R		
	Mm, yeh.	
2		

	Um, if you're asking whether there were routes to help if you felt in trouble at any point, um I think uh, particularly before birth at the various midwife appointments we sensed they were actively looking out for mental health problems. 1:06:33	MWs actively looking for mental health (in Ms, not in Fs);
R 2	Okay.	
	And afterwards as well, in a you know, skillful way. Um, but for the mother not the father.	MWs skilled with mothers;

Appendix X: Extract of themes, subthemes, codes, data extracts

Theme	Subtheme	Code	Examples of HCP data extracts
Service context, provision, and constraints for perinatal staff working with families	Existing formal provisions, activities, and prompts for father inclusion in perinatal services	Overnight hospital stays for fathers	"hospitals now allow to have people stay there overnight, but that's probably the only active thing" "We've recently, well not, when did we start doing it? Maybe two years ago that they stay overnight" "I think having people staying overnight is a big, um we both do it" "on the antenatal ward, so we have an induction area…Then they stay there"
		Activities with fathers	"we're advocating skin-to-skin contact all the time" "We now do in our parent education, we now do the feeding session with both parents and we do breastfeeding and bottle feeding"
		Formal service prompts for staff to communicate with fathers, or with mothers about fathers	"We have a question asking about partner's expectations and experiences don't we." "I try and ask the dad [laughter]. But there is a tick box on our templates." "we have a leaflet that we talk about postnatal depression and that includes dads" "have they been in care or had problems with the police?" "Demographics" "we have to ask the name and date of birth, and place of birth now don't we" "there's I think one antenatal, the booking, one question that says "do you have any twins in your family?" That's about it." "So there's like history, family history, so you go through everything: allergies, eye sight, um any particular…For both…When if it's a single parent, er and the father is not available then obviously, you know, we are limited in the response. But usually we ask both of them when they are there."

	Lack of formal provisions or staff preparation for father inclusion in perinatal services	Nowhere for fathers staying overnight to sleep, eat, or wash	“There aren't beds for them” “it's silly things like on the ward we don't have washing or um changing facilities for the men. We don't provide meals for them.” “We don't even have anywhere, we don't have anywhere, we don't let them use the microwave because it might get too hot. It's like, these are adults.”
		No allowance for hospital stays for fathers	“lots of trusts don't do it still…So they're, they’re there for visiting hours” “lots of trusts don't do it at all... So lots and lots of parents don't get that option.” “I don't think they stay antenatally.” “Oh they are [sent home] in many, many places around the country still.”
		Perinatal wards not as well equipped for fathers as children’s wards	“on children's wards there's a family room that you can make tea and coffee, you can heat up your food, there's a fridge where you can keep your food. It's and it's great actually. You feel welcome and you feel part of what's going on in the ward, and you're right we're not doing that for men. At all.” “in children's wards now you know that there's a bed where the parent can sleep…It is one parent, but you can take turns”
		Staff not trained to work with fathers	“I feel I'm not trained.” “I think as a midwife you rely on your own personal experiences maybe because in my training like nearly 18 years ago fathers weren't part of” “everyone says "you never spend enough time thinking about the fathers" but that's it. That's all we're told. There's no like, how do you do this?”
		Staff not triggered to check in on fathers’ wellbeing	“nothing about them” “And “how are you coping?” …we're not triggered to ask it to the man” “that's not one of the things on our tick box, how is it for the fathers. No questions you have to ask the father at all” “there's no formal focus on the father”
		Not enough staff	“You don't ever feel you have quite enough staff to do what needs to be done.”

	Lack of resources to meet demands		“it's a huge patch” “at the moment, it feels like a very stretched service” “the seniors also don't have…They’re stretched…They are very stretched as well”
		Not enough physical resources	“They just need beds, and there is no beds.”
	Impact of lack of resources	Stressful work environment	“um it's easier for me now that I'm part time, but if you're a full time frontline midwife it's very stressful” “so that's been more stress. And er, and also even on the labour ward you feel they want you to move people along and move downstairs, and keep going and keep going and keep going.” “having just left the postnatal ward, it's just, it's just intense… And everyone's busy” “The clinic is busy, there's all other, all other pressures” “It worries me sometimes”
		Staff unable to fulfil role	“and it's very difficult to provide truly sort of woman-centred or family-centred care in that environment” “it's not fair on them really, on the junior staff because they're learning in an environment where they can't be their full midwifery or health-visiting selves really. Can’t fulfil the role.” “maybe they [the juniors] don’t have enough support from the seniors” “I just feel like everyone's cutting corners. Not cutting corners, that's wrong. But that you're always not giving them everything that you possibly could…So it's not that extra enhanced service…You're kind of doing the minimum that's safe” “if they're interpreting and sometimes we do, we shouldn't but we do, we allow them [fathers] to interpret [for mothers]” “I think our guidelines are really focused about being woman-centred, which is a struggle. It's a struggle anyway being woman-centred rather than service-centred.”

		Staff have a lack of time to spend with patients	"often you don't feel you have, I don't feel you have time to talk as much as you'd like to" "like I can see women and do complicated cases but I know that if I spend too long then someone else isn't getting that because I've only got a finite number of hours in the day" "a lot of time pressure to get through people." "we used to have an hour and a half, but they said to try and do it for an hour now" "everything the midwife doesn't have time to do" "I tried in postnatal visits, although I don't always have time [to include fathers]" "it's quite difficult to "okay you can trust me, but we have about 10 seconds to cover this issue"."
		Staff do not want to find problems	"you don't want to find problems. So you just kind of don't necessarily always ask" "yeh, I agree with what you said about not asking" "And you can see how lots of staff don't do it, I mean don't ask too" "midwife doesn't need two patients [laughter]"
		Staff have lack of continuity with clients	"you're not having that continuity with the, with the um clients anymore" "from one baby to the next you're not seeing the same family" "You won't have a named health visitor" "the majority of people, I think certainly in my trust, still don't get continuity"
		Staff prioritising safeguarding clients if possible	"you can see the alarm bells that, you know. Like a junior member staff just came over and I'm just like "Okay there's lots of alarm bells so you can't ignore those ones"." "Unless it's screaming at you" "then really then if there's no safeguarding concerns then any other health visitor will then be able to see you in clinic at some point… our safeguarding clients we would keep, but if there's too many for one person then they will be distributed again to different um colleagues"

Theme	Subtheme	Code	Examples of father data extracts
Relationships in the triad	Having a third person there	Redirected priorities	"our priorities now obviously are completely redirected onto this, onto [baby]"; "I think that's the thing, it's not you know where do we eat or something, it's what is good for, for the baby."; "And my wife and I said this to each other, is we've said you know as much as I love you, as much as she loves me, both of us feel a sort of heavier deeper love for our child than we do for each other, for our parents, for family"; "worrying um what effect adult decisions or adult behaviour will have on the child"; "we were trying to keep more focused on actually just being happy and having the baby as much as possible.";
		Change in dynamic	"These are roles that we're sort of playing or beginning to assume and trying to, and trying to work out what our new sort of position is in our relationship now that there's a third person there. It's, so there's definitely been a change."; "on a basic level I mean, when you don't have an extra person around then you, you figure out how to deal with conflict between you, and then that's how a relationship goes on. Um, having a new person steering your focus, it creates problems"; "there's now three of you in the relationship and not two, and that changes the dynamic"; "on the baby side of the pregnancy…shared experiences that sort of brought you closer together";
	Relationship problems	Conflict between the parents	"the er sort of rapid attempt to get to know each other a bit more…went badly"; "And I think that this first year, we've done a lot more falling out this year than we have in the previous 20 put together. It's been very difficult. And it can come from just disagreeing on how best to make sure [baby's] asleep at night, you know: "Do we go in and check?", "You don't need to go in and check. Keep the door closed"."; "recently clashed over things like, do you shut the door, or how do you change this nappy? Just practical things… each had a different instinct.";

			“we had the same conflict over things”; “I came back at half past five and [my wife] was ready to kill me because she was like "I have not slept a second because this child, I practically dropped this child out of my arms, where were you?"”; “I got back at five, six in the morning when they first let me in, and um she was furious about it… It was "I can't believe you left me, and leaving the hospital, you haven't [inaudible] father for two days". It's like where did all this come from?!”; “you are not going to agree on how to change the nappy, or you're not going to agree on bed”; “things get more you know heated as they do in any kind of you know, relationship. Particularly if you've had a big, um an easy week or a difficult week”; “first six months of child's life for us um went pretty well from the, as far as I could tell from the baby's point of view, but disastrously from the adults’ point of view”;
	Making it work	Communication and Negotiation	“we had discussed beforehand whether or not I would stop at the hospital that first night”; “Talk to your partner before”; “I have slightly more of a scientific approach, sort of to, um the universe perhaps then, um you know I'm not a, I don't have a great, a lot of time for things like sort of homeopathy and things like that. I don't like that sort of squidgy alternative side when it comes to medicine. So, um, er you know it was trying to work out how, I'd never really discussed with my wife how she'd felt about everything. You know, did she want to get, er be you know give birth in a you know paddock full of dandelions or I don't know, no idea.”; “So, learning to negotiate new boundaries that never used to exist and understanding and understanding ‘I really need to step back here because if I push this door any further she's going to explode’ and similarly she's had to do the same with me. And it's, I think we're both aware of that”; “that's how we dealt with it. Um and just compromised”; “I went home for a night…we agreed that would be the sane thing to do”;

			“just taking five minutes to think about it [relationship changes] and not think about whether or not, you know, you need the latest electric cot thing or you know sort of internet ready radio so you can hear your child”;
		“It needed two of us”	“that if you go home then at least one of us has got at least some sleep so that when you come back early in the morning at six o'clock you can sort of take over and mum can have a bit of a sleep”; “It needed two of us just to scrape together 10% of brain power to even listen to what the midwife was telling us, let alone actually functioning.”; “you can't just say "right, you do the baby thing, I'll organise the bits, and see you in 9 months” “I thought "crikey mum's not ready yet to be on her own for this many hours of the day", and you know "I'm not personally ready to go back yet"”; “when we stopped listening to that pressure we felt, I felt that there was a weight off our shoulders. I felt like, you know what, actually we're doing it”; “did everything together equally and went to all of the appointments… we both did it and it was all good”;
		Finding support for the relationship	“I suppose I was kind of lucky in that I have um family around me, I've got lots of friends who've gone through very similar things where they've had sort of kids”; “I found myself relying very much on my mum… more than I'd ever done…this year was the first year I actually sort of said to her, "look, mum what's going on here? What would you… do in this situation you know? Because I seem to just be falling out with her all week…” And sort of depending on her very much to give me the female point of view even though she's you know 30 years senior.”; “it's more for relationship counselling rather than necessarily anything to do with um the baby, um. So yeh, that's how we dealt with it”;

Appendix Y: R2 online survey for both groups

Practical, psychosocial, and relational aspects of becoming a father

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how much you agree or disagree with each statement from your own experiences of being a father **during the pregnancy and/or baby's first year**, or of being a health professional who has contact with fathers during this time.

Please don't select more than 1 answer(s) per row.

Please select at least 5 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
During pregnancy, men anticipate and build expectations about different aspects of what fatherhood might bring	☐	☐	☐	☐	☐	☐
There is an overwhelming amount of information and advice for expectant and new fathers to sift through	☐	☐	☐	☐	☐	☐
Men experience positive emotions much of the time (e.g. excitement, joy) over the perinatal period	☐	☐	☐	☐	☐	☐
Men experience difficult emotions much of the time (e.g. anxiety, stress, worry, low mood) over the perinatal period	☐	☐	☐	☐	☐	☐
Men experience a complex mixture of positive, difficult, and deep emotions over the perinatal period	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below. *Optional*

This part of the survey uses a table of questions, view as separate questions instead?

In the first year of the baby's life…

Please don't select more than 1 answer(s) per row.

Please select at least 13 answer(s).

Men experience personal changes in themselves, and observe personal changes in the baby's mother too	☐	☐	☐	☐	☐	☐
Both parents' priorities are redirected onto the baby	☐	☐	☐	☐	☐	☐
The relationship dynamic between the mother and father changes when there is the baby in the relationship too	☐	☐	☐	☐	☐	☐
The mother and father have more arguments and disagreements	☐	☐	☐	☐	☐	☐
Fathers do not always know how to manage relationship conflict or difficulties if they occur with the mother	☐	☐	☐	☐	☐	☐
Communication, negotiation and compromise between the father and mother is important during the perinatal period	☐	☐	☐	☐	☐	☐

The different roles and experiences fathers and mothers have during the perinatal period (e.g. breastfeeding, one parent returning to work, different levels of involvement with childcare, or different emotional experiences) can leave fathers feeling quite alone or divided from the mother	☐	☐	☐	☐	☐	☐
Fathers and mothers who are together experience difficulties in their sexual relationship during this time	☐	☐	☐	☐	☐	☐
It feels like two caregivers are necessary to meet the demands of parenthood	☐	☐	☐	☐	☐	☐
Fathers feel able to turn to family or friends for support if they are finding it difficult to cope	☐	☐	☐	☐	☐	☐
Fathers feel able to turn to professionals or services for support if they are finding it difficult to cope	☐	☐	☐	☐	☐	☐
During baby's first year, parents may want to appear to health professionals that they are coping well, even if they are really struggling	☐	☐	☐	☐	☐	☐
Parents may worry about what process they might be entered into if they are open with services about difficulties they are having	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below. *Optional*

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The importance of fathers

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how much each statement is true to your own experiences of being a father **during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year),** or of being a health professional who has contact with fathers during this time. ✱ *Required*

Please don't select more than 1 answer(s) per row.

Please select at least 9 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
Becoming a parent is just as important to fathers as it is to mothers	☐	☐	☐	☐	☐	☐
Fathers are equally as able as mothers to be good primary caregivers for their children	☐	☐	☐	☐	☐	☐
Fathers are important for the physical health of the baby (e.g. bottle feeding, supporting breastfeeding, being aware of the baby's physical health and what to look out for)	☐	☐	☐	☐	☐	☐

Fathers are important for the psychological wellbeing of the baby (e.g. being an attachment figure for the baby, and supporting the mother's bond with the baby)	☐	☐	☐	☐	☐	☐
Fathers are important for the psychological wellbeing of the mother (knowing about her mood and coping, and providing support)	☐	☐	☐	☐	☐	☐
Fathers may have important information to share about their experiences or coping, which health professionals are unlikely to find out unless they ask fathers directly	☐	☐	☐	☐	☐	☐
Fathers are important for being the baby's main caregiver if the mother is not able	☐	☐	☐	☐	☐	☐
Fathers are important for being an overall source of help and support	☐	☐	☐	☐	☐	☐
When the father has difficulty coping, it makes things more difficult for the mother too	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below. *Optional*

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The position that fathers can find themselves in

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how much each statement is true to your own experiences of being a father **during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year)**, or of being a health professional who has contact with fathers during this time.

Please don't select more than 1 answer(s) per row.

Please select at least 16 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
Fathers can feel like a spectator on the side-lines, and can't always help or be involved when they want to be able to	☐	☐	☐	☐	☐	☐
Fathers follow the mothers' lead, as the mothers tend to be a few steps ahead regarding information during the perinatal period	☐	☐	☐	☐	☐	☐
The mother of the baby has more power than the father during the perinatal period	☐	☐	☐	☐	☐	☐
Fathers are considerate and understanding of the health services' and professionals' point of view	☐	☐	☐	☐	☐	☐
Fathers are accepting of how they are treated by services, at the time	☐	☐	☐	☐	☐	☐
Fathers are considerate of the mothers' experiences, try to make sure she is okay, and look out for her overall wellbeing	☐	☐	☐	☐	☐	☐
Fathers are aware that health professionals are assessing whether fathers can be trusted with the mother and baby	☐	☐	☐	☐	☐	☐

Fathers who are present in their baby's life tend to be involved caregivers for their baby	☐	☐	☐	☐	☐	☐
Fathers are confused about how much they could or should be involved during sessions, classes, appointments, or on the ward	☐	☐	☐	☐	☐	☐
Fathers find it difficult or uncomfortable to involve themselves during sessions, classes, appointments, or on the ward	☐	☐	☐	☐	☐	☐
Fathers openly voice their experiences to health professionals, without being asked	☐	☐	☐	☐	☐	☐
Fathers can feel excluded from the baby by perinatal services (e.g. midwives and health visitors)	☐	☐	☐	☐	☐	☐
Fathers can feel excluded from the baby by the mother	☐	☐	☐	☐	☐	☐
Fathers can feel excluded from the baby by other people stepping in, such as a mother-in-law, or sister, or aunt	☐	☐	☐	☐	☐	☐
Aside from the physical aspect of pregnancy, childbirth, and breastfeeding, women should still get more support and attention during the perinatal period than men	☐	☐	☐	☐	☐	☐
Men are less instinctive and attuned to their babies than women are	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

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Fathers' and health visitors' perceived strengths and weaknesses of perinatal services

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how much each statement is true to your own experiences of being a father **during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year),** or of being a health professional who has contact with fathers during this time.

Please don't select more than 1 answer(s) per row.

Please select at least 18 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
Health professionals genuinely respect and value fathers	☐	☐	☐	☐	☐	☐
Health professionals do a good job engaging with fathers, and helping fathers to feel included	☐	☐	☐	☐	☐	☐
Services prepare fathers well for the physical elements of having a baby	☐	☐	☐	☐	☐	☐
Fathers receive enough invitations to appointments and sessions	☐	☐	☐	☐	☐	☐
Fathers are not drawn in by services to be present and involved – it is down to fathers to actively involve themselves	☐	☐	☐	☐	☐	☐

Services give a lack of attention to how fathers are coping mentally, psychologically, or emotionally	☐	☐	☐	☐	☐	☐
Fathers receive a lack of guidance on the father's role, and how they can be involved in the pregnancy, birth, and/or baby's first year	☐	☐	☐	☐	☐	☐
Fathers receive a lack of opportunities to discuss their questions, concerns, or experiences	☐	☐	☐	☐	☐	☐
Health services do not provide fathers with obvious routes to support regarding their parenting of the baby	☐	☐	☐	☐	☐	☐
The process is not made clear to fathers of how they can seek help from services should they have concerns about their own or the mother's coping	☐	☐	☐	☐	☐	☐
Health professionals sometimes provide information and advice according to their personal opinions regarding matters where there are several possible evidence-based options that parents could consider	☐	☐	☐	☐	☐	☐
Support for fathers provided by health professionals varies a lot between different members of staff	☐	☐	☐	☐	☐	☐

There is a lack of focus on the family unit as a whole from health professionals	☐	☐	☐	☐	☐	☐
Health professionals do not pay enough attention to the father-baby relationship	☐	☐	☐	☐	☐	☐
Health professionals do not pay enough attention to the father-mother relationship	☐	☐	☐	☐	☐	☐
Fathers receive less contact with health professionals than mothers because fathers are often at work when the appointments happen	☐	☐	☐	☐	☐	☐
Services are mainly geared towards mothers, rather than both parents	☐	☐	☐	☐	☐	☐
When services show focus or concern to the father, it is actually out of concern for the mother and/or baby	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

Ideas of what services should continue, enhance, or improve to benefit fathers' experiences

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how strongly you agree with the following statements as being important to improving fathers' experiences during the perinatal period

Please don't select more than 1 answer(s) per row.

Please select at least 16 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
For services to provide a clearer idea of what to expect practically, with the aid of something like a calendar of key dates showing when appointments and visits with health services are meant to happen	☐	☐	☐	☐	☐	☐
For services to make a clearer differentiation in parenting information between what's important to get right (e.g. making sure the water is the right temperature when washing the baby) and what's personal preference (e.g. bottle feeding or breast feeding)	☐	☐	☐	☐	☐	☐
More father-specific preparation, information, and guidance from health professionals about the father experience and role during the perinatal period	☐	☐	☐	☐	☐	☐
For health professionals to signpost fathers to a clear and reputable source of parenting information	☐	☐	☐	☐	☐	☐

For services to provide more information and preparation regarding the psychological, emotional and relational aspects of parenthood	☐	☐	☐	☐	☐	☐
For it to be a formal requirement that health professionals directly check in with fathers on their coping and experiences	☐	☐	☐	☐	☐	☐
For services to provide fathers with a 10-minute 'dad-alone' session with a midwife or health visitor, just like the mother has	☐	☐	☐	☐	☐	☐
For antenatal classes to have more content on the father-mother relationship, raising awareness of the impact that having a baby can have on the relationship, how to nurture the parent relationship, and what can be helpful in managing conflict	☐	☐	☐	☐	☐	☐
For fathers to receive invitations to appointments, parent education sessions, and classes	☐	☐	☐	☐	☐	☐
For health professionals to encourage fathers to have skin-to-skin contact with their baby straight after the birth	☐	☐	☐	☐	☐	☐
For health professionals to involve fathers in communication with body language, direct questions, and prompts for them to speak	☐	☐	☐	☐	☐	☐

For health professionals to open up conversations between parents about the choices they have (e.g. who to have in the birth room, or whether to have the father stay the night on the ward with the mother)	☐	☐	☐	☐	☐	☐
For services to be family-centred rather than mother-centred or baby-centred	☐	☐	☐	☐	☐	☐
For there to be more single-sex sessions for men as well as for women (e.g. a fathers-only antenatal session, and father-baby groups)	☐	☐	☐	☐	☐	☐
For health professionals to be given more training on how to work with and involve fathers	☐	☐	☐	☐	☐	☐
For fathers to be better accommodated for staying overnight on the ward (e.g. having the option of staying overnight, having a mat to sleep on, a microwave to heat food, somewhere to wash)	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

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Social and cultural context of men as fathers, and for health professionals working with fathers

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how much each statement is true to your own experiences or views from being a father **during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year)**, or from being a health professional who has contact with fathers during this time.

Please don't select more than 1 answer(s) per row.

Please select at least 5 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
Today's fathers were raised by a generation in which the mothers were more involved in childcare than the fathers were	☐	☐	☐	☐	☐	☐
Equality between the sexes in our society is getting better	☐	☐	☐	☐	☐	☐
The parenting support currently provided to men needs to catch up with society's expectations of men as involved parents	☐	☐	☐	☐	☐	☐
In life, men tend to have less preparation and support for parenthood than women	☐	☐	☐	☐	☐	☐
The more that mothers and fathers share parental leave and childcare equally, the better things will be for the mothers, fathers, the parent relationship, and for the children	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

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Almost done!

Thank you, you are almost finished. There are some final statements that are unique to the father experience and unique to experiences of working as a midwife or health visitor. To complete the final statements relevant to your expertise, please indicate which group you belong to for the purpose of completing this survey.

- ○ Father
- ○ Health professional

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Final questions for health professionals

This part of the survey uses a table of questions, view as separate questions instead?

Please rate how much each statement is true to your own experiences of being a health professional who has contact with fathers during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year).

Please don't select more than 1 answer(s) per row.

Please select at least 3 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
Attitudes towards how much health professionals should involve fathers varies between different midwifery or health visiting colleagues	☐	☐	☐	☐	☐	☐
It can be quite surprising to health professionals when fathers are keenly involved	☐	☐	☐	☐	☐	☐
There are times when the father being present and involved feels uncomfortable, awkward, or problematic for health professionals	☐	☐	☐	☐	☐	☐

Please rate how much each statement is true to your own experiences of being a health professional who has contact with fathers during the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year).

Please don't select more than 1 answer(s) per row.

Please select at least 11 answer(s).

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
The workload is stressful	☐	☐	☐	☐	☐	☐
There is a constant pressure of people waiting to be seen	☐	☐	☐	☐	☐	☐
Health professionals are often not able to offer consistent continuity of care to families	☐	☐	☐	☐	☐	☐
There are not quite enough health professionals to meet the demands on the service	☐	☐	☐	☐	☐	☐
Health professionals do not receive enough training on fathers or how best to include fathers (e.g. what fathers want, what their expectations are, or how to address their needs)	☐	☐	☐	☐	☐	☐
Health professionals find it difficult to fulfil their roles to their full potential due to time pressure and stretched resources	☐	☐	☐	☐	☐	☐
Health professionals do not have as much time as they feel is needed to talk with parents about their psychological experiences or coping	☐	☐	☐	☐	☐	☐

Health professionals sometimes do not ask parents about their experiences in case the parents are having problems and the health professionals do not have time to listen or support them	☐	☐	☐	☐	☐	☐
By prioritising cases with obvious safeguarding concerns, families with less obvious safeguarding concerns or difficulties might get missed	☐	☐	☐	☐	☐	☐
For families where the father is involved, it is not a formal service requirement for health professionals to find out about the fathers' coping and well-being during the perinatal period	☐	☐	☐	☐	☐	☐
For families where the father is involved, it is not a formal service requirement for health professionals to meet with the fathers	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

Appendix Z: R3 anonymous online survey example for a healthcare professional participant

Fathers' and health professionals' experiences and views of paternal perinatal support, and their ideas for improvement: A Delphi Study. Round 3 (Participant: Fa-319922)

Page 1: Welcome to the FINAL round of the Delphi Consultation!

Participant: Fa-319922

This survey closes at 11pm on Wednesday 21st February.

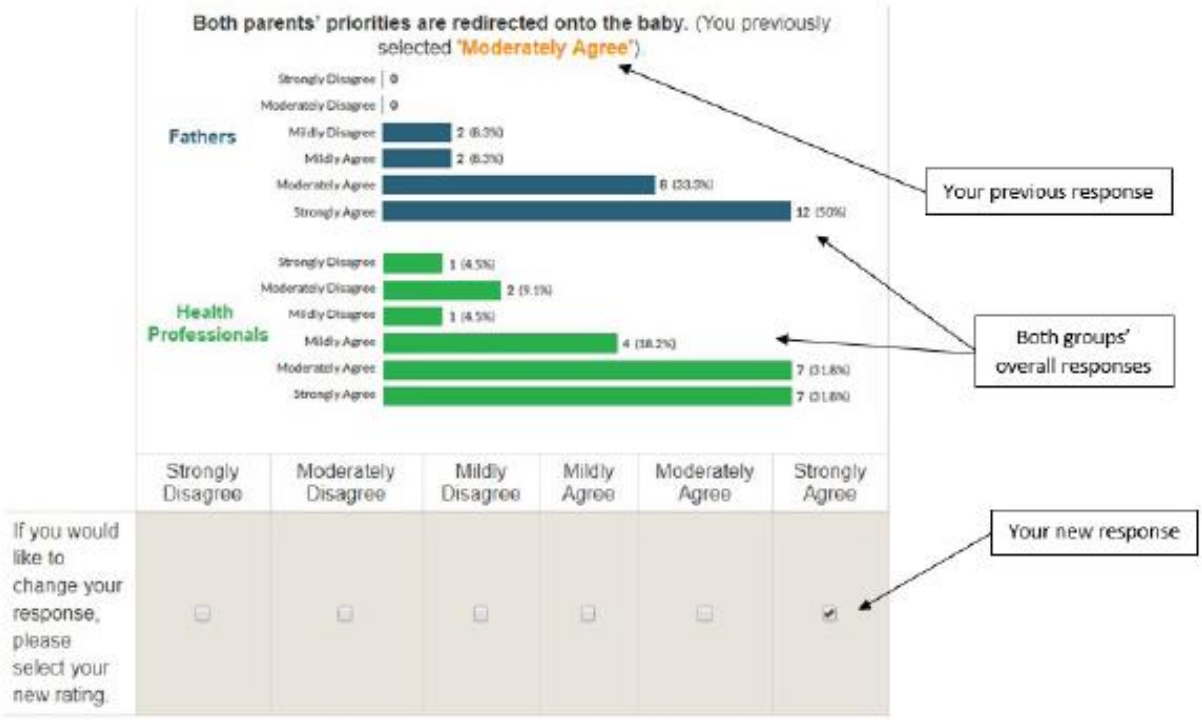
Upon completion of this final survey you will be entered into the prize draw for a 1 in 5 chance of winning a £20 'Love2Shop' voucher (valid in over 20,000 UK stores).

In this final round you will see the same statements shown in the previous round. **This round has fewer statements**, because the ones with high levels of agreement among participants have not been included. With each statement you will see your response (indicated in **bold orange**), and figures demonstrating the overall group responses of fathers and health professionals (midwives and health visitors). Some of the comments made by participants in the previous round will be anonymously presented at the top of each page.

This is your opportunity to either change or validate your previous responses.

If you would like to change your rating, please select your new rating on the Likert scale below each statement. If you want to keep the same rating you gave on the previous round, please leave the boxes blank for that statement and move onto the next statement.

Example



Remember, fathers and health professionals have been referred to in the third person to allow both groups to complete the same survey. Your ratings are meant to reflect **how much the statements are true to your own experiences and opinions**, rather than on the behalf of other people or colleagues that you know.

"Health professionals" here refers to **midwives and health visitors.**

"Father" here refers to **biological fathers who are present in their child's life during the perinatal period.**

"Perinatal period" here refers to the period including the **pregnancy, labour, birth, and first year of the child's life.**

Page 2: Practical, psychosocial, and relational aspects of becoming a father

Fathers' comments from the previous round:

"In general I found pregnancy exciting but the birth its worrying."

"The experience for IVF parents is a roller coaster of emotions. Intense and often difficult."

"The variety and depth of emotions I felt during this period was a surprise to me."

"we experienced a traumatic [birth] and I did not feel prepared at all. There was also a lack of information on what to do when the baby arrived (e.g. my role)"

"its difficult to understand the hormonal changes going on with you gf or wife. This lead to a lot of misunderstandings and confusion for me at least!"

"My partner feels like fathers are not as inportant as the mothers so this leads to a lot of conflict with us"

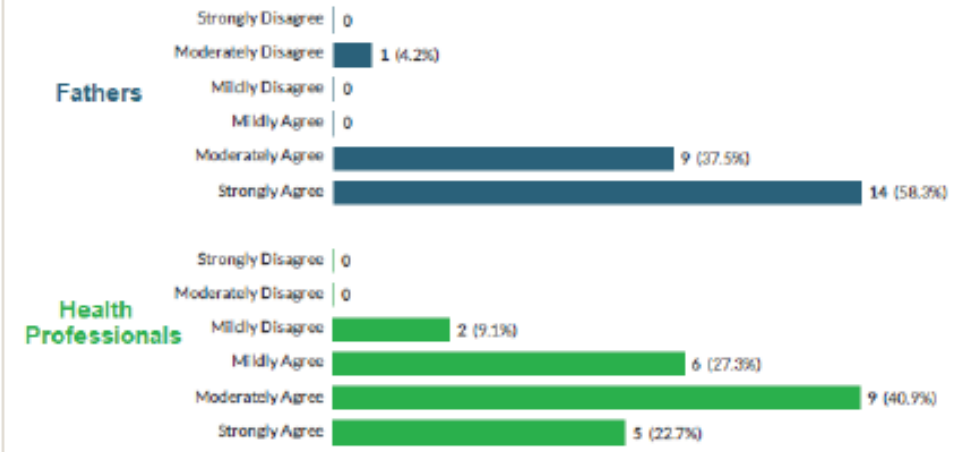
Health professionals' comments from the previous round:

"From experience of the men I meet, they feel they don't have much part in the antenatal period but will attend antenatal classes. During labour, they again feel at a loose end, anxious and can get agitated as a result of feeling out of control. Postnatally, again men feel frustrated they can't be more helpful as the women are in pain and trying to breastfeed etc. Many want to be helpful but are not sure how to be. I think there is also a lot of pressure knowing they have to go back to work and their partner in anxious about this. Men can be quite distressed after the birth if there has been an emergency."

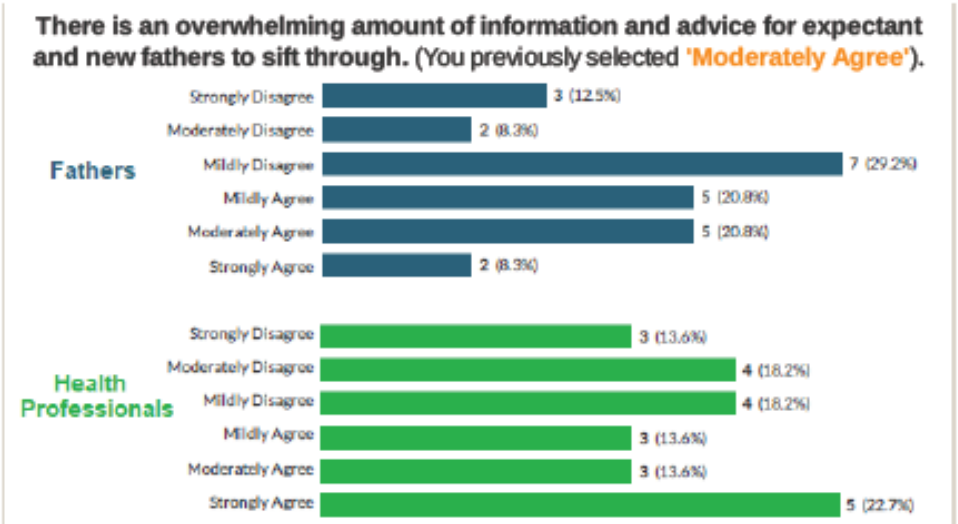
"I think we need to include men more in the perinatal period. It is difficult for them to get involved as they are not allowed time off work for antenatal visits etc and are therefore excluded from the offset."

In the previous round you were asked to rate the extent to which you agree or disagree with the following statements from your experiences during the pregnancy and/or baby's first year. Please look at the responses given by other participants in the previous round and decide whether you would like to change your response (highlighted in orange) or keep it the same.

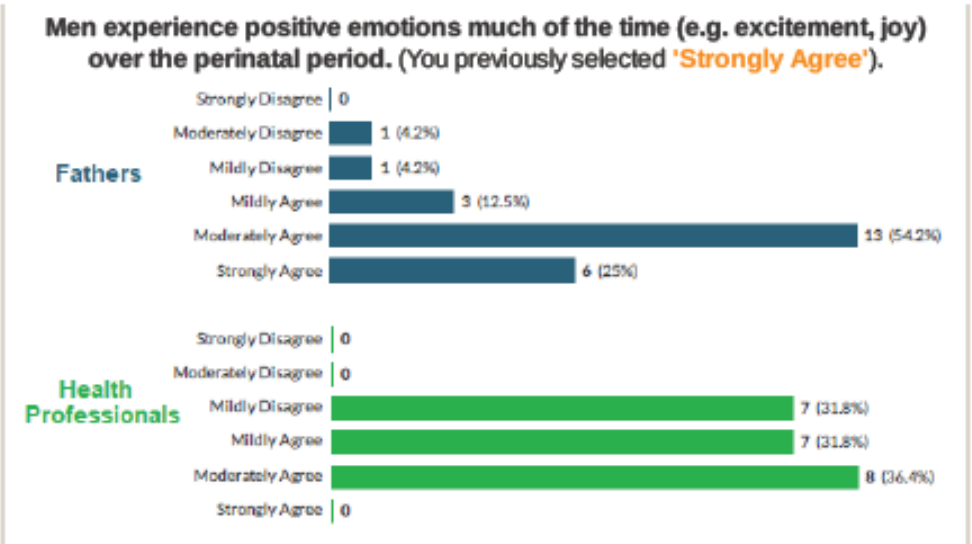
During pregnancy, men anticipate and build expectations about different aspects of what fatherhood might bring. (You previously selected 'Strongly Agree').



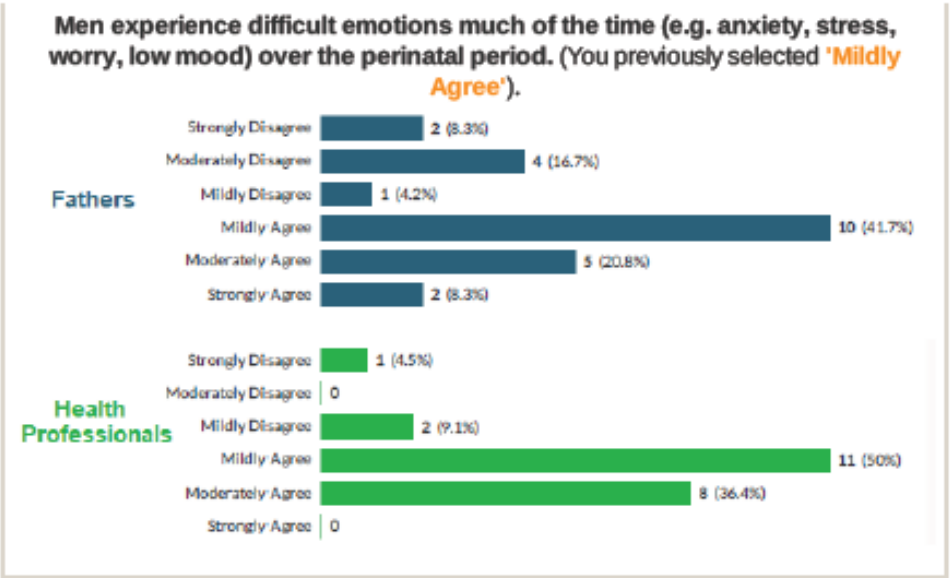
	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐



	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐



	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐



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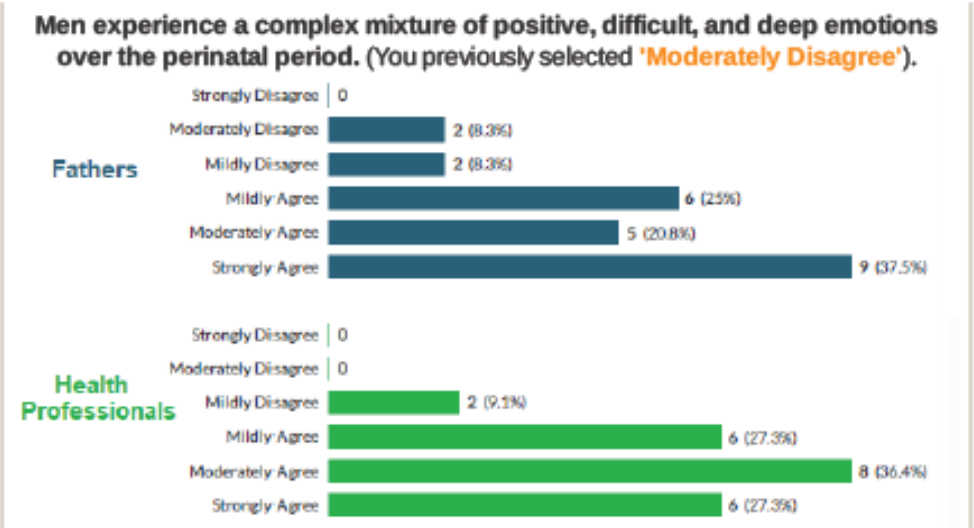

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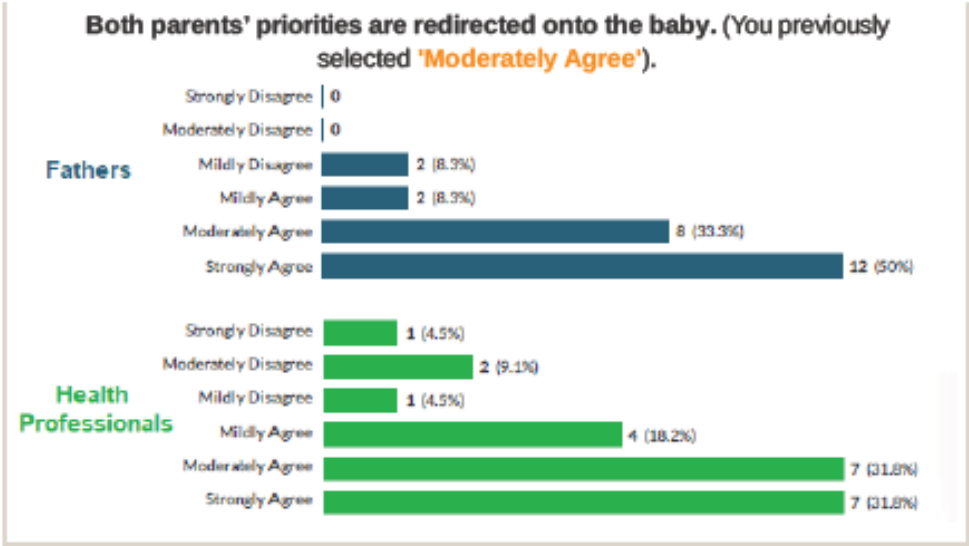
In the first year of the baby's life...



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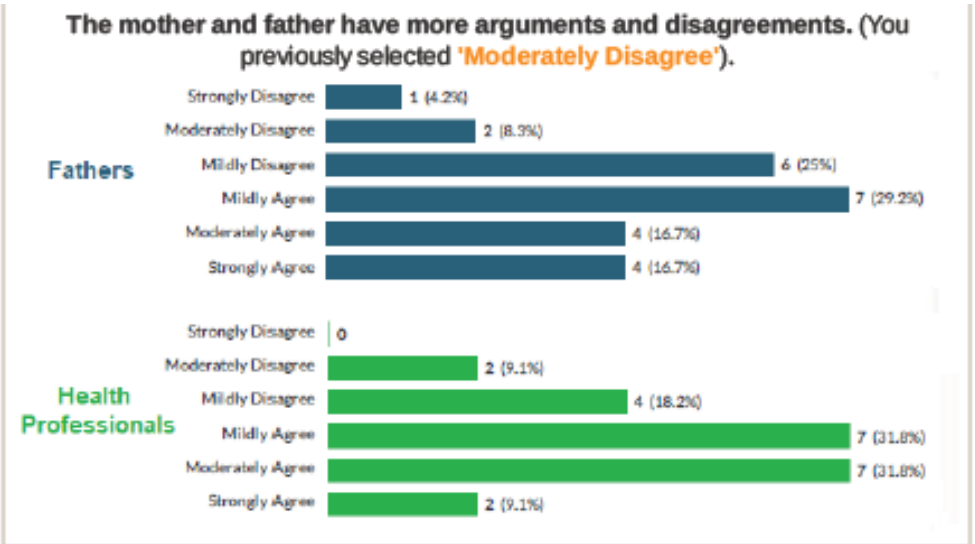

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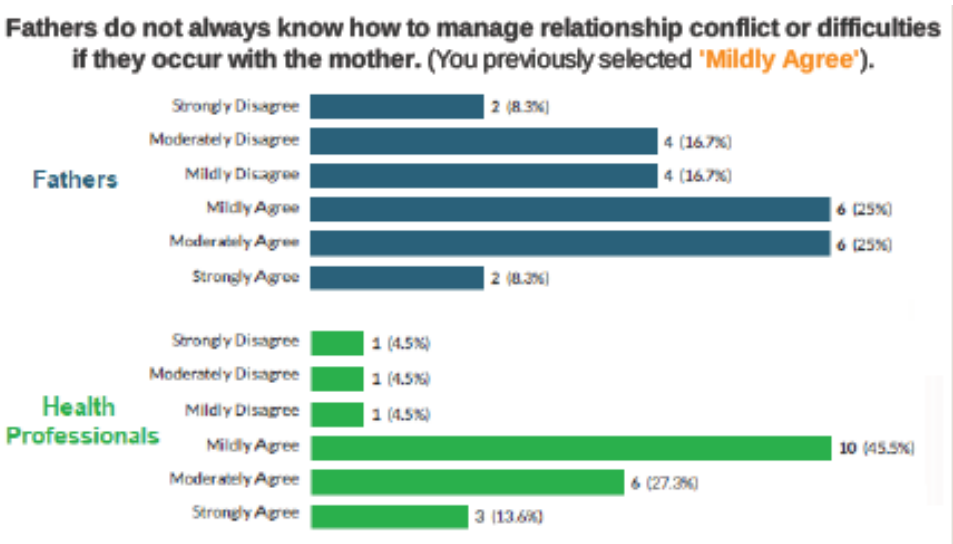

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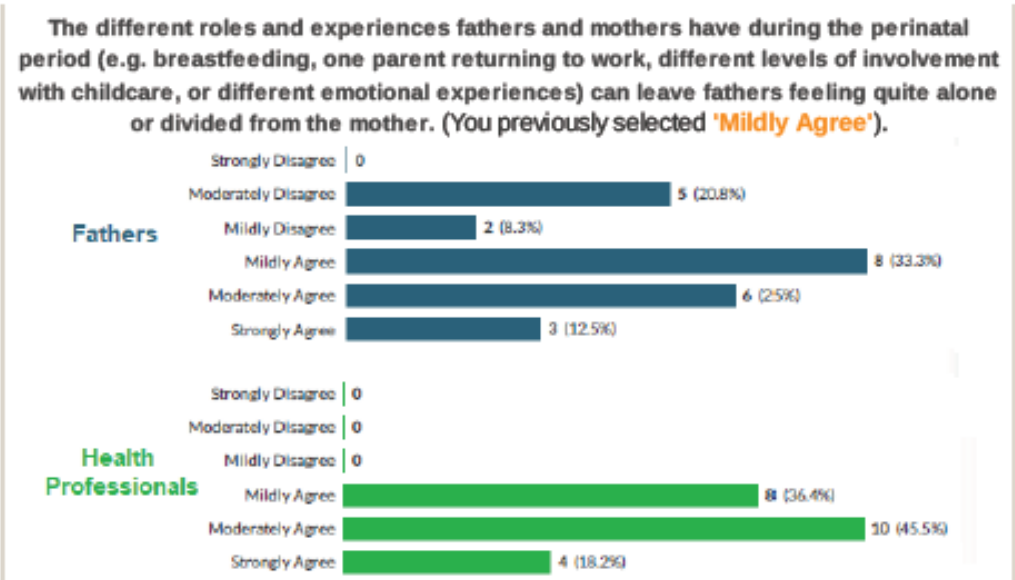

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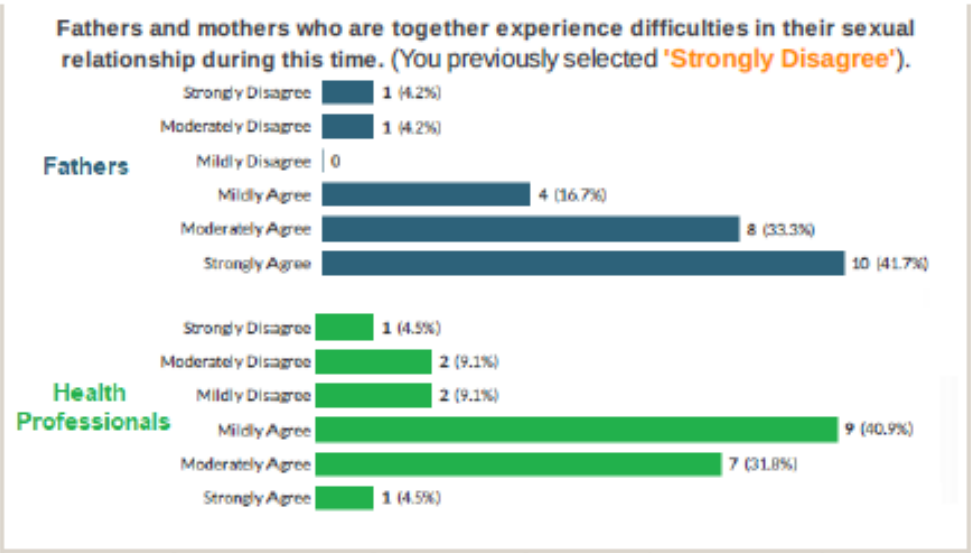

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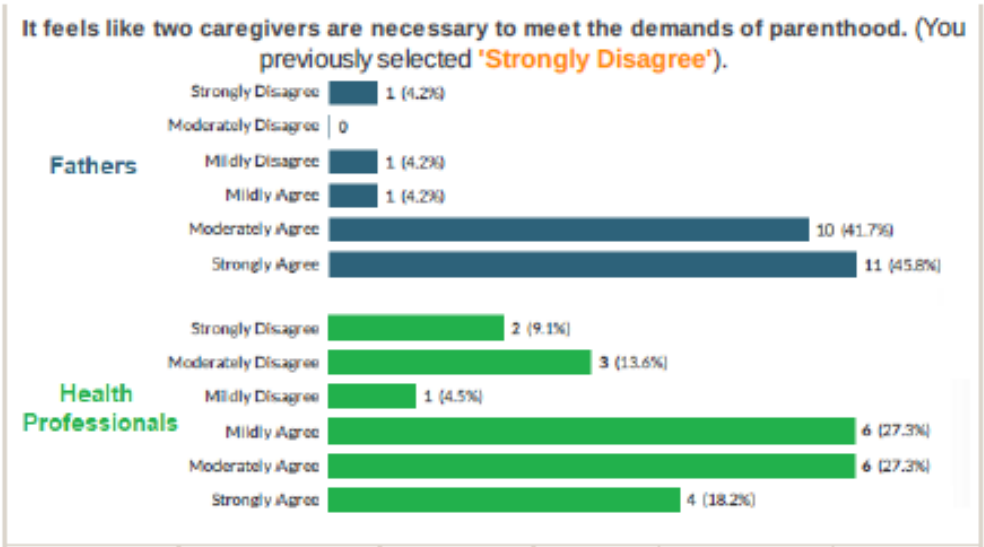

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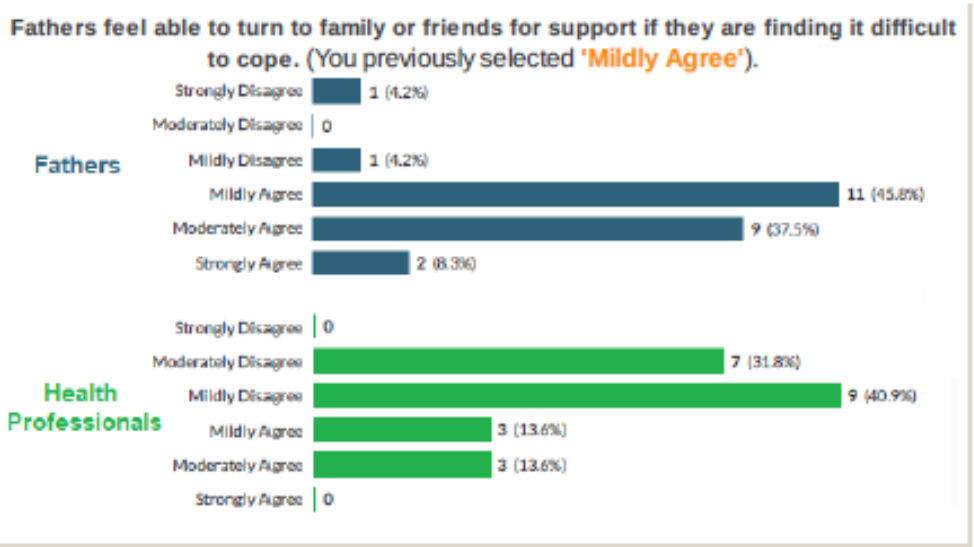

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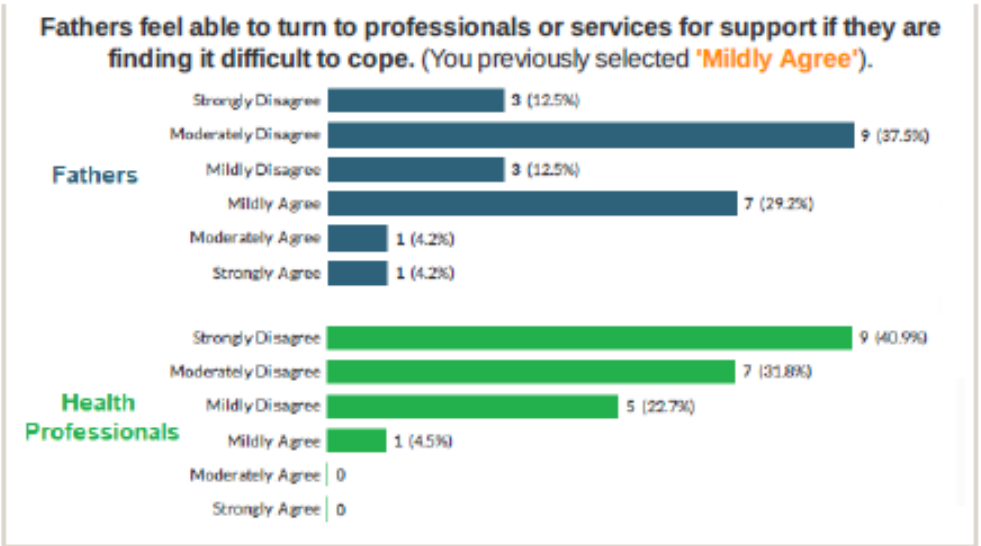

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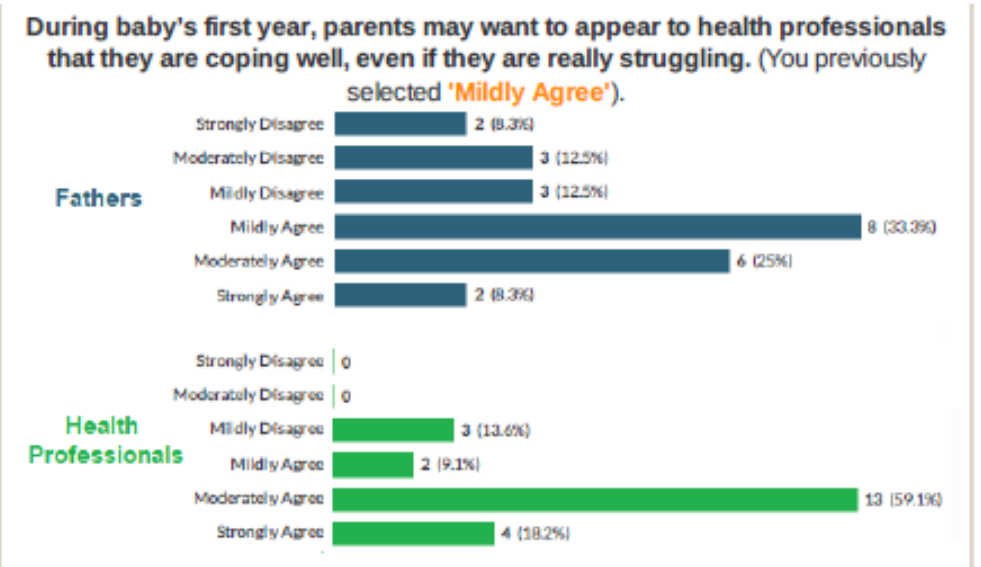

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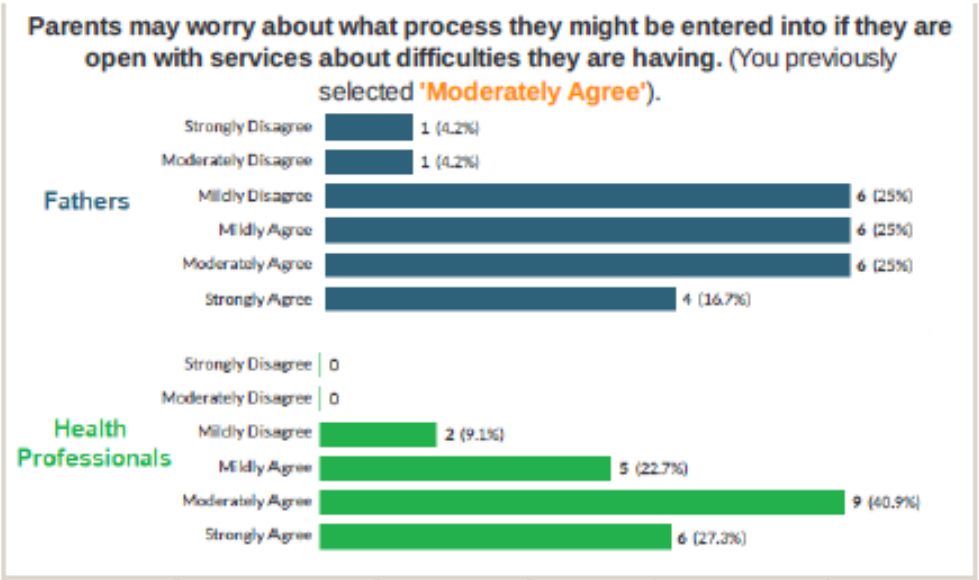

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If you have anything you would like to say about your answers, please write this in the box below. *Optional*

Page 3: The position that fathers can find themselves in

Fathers' comments from the previous round:

"paternity leave for fathers is far too short to have any real impact on support fo the mother and for bonding time with the child."

"Men are still trying to juggle work during these phases for time off for appointments and longer paternity leave would help."

"During most sessions I have been unaddressed as a father or role player in care. I have involved myself rather than been involved by health professionals."

"I was virtually ignored at UCLH during our birthing. Many midwives and consultants pointedly failed to address me with even a greeting... It was an uncomfortably sexist (as in anti-male) experience."

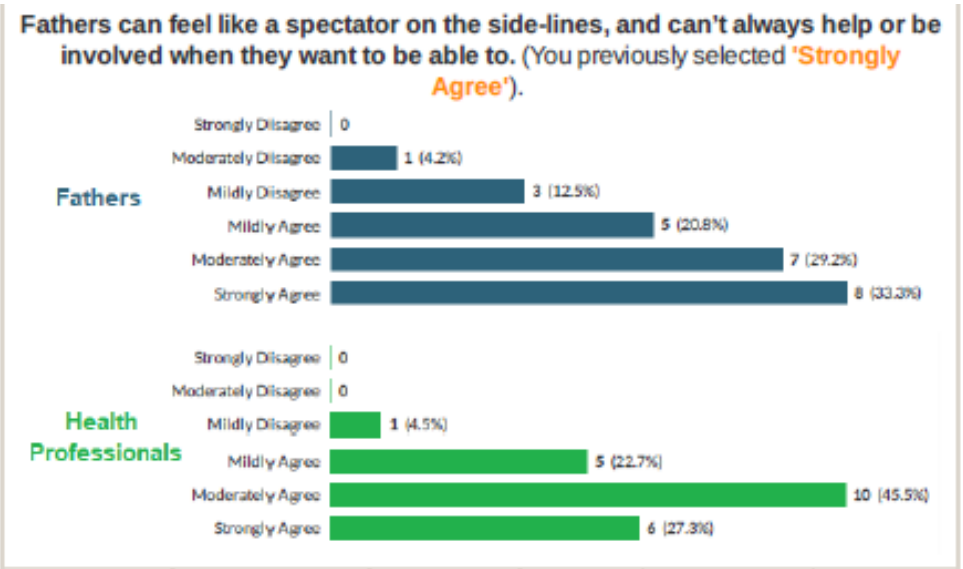
"Had some very negative experiences of psychiatric services during and after pregnancy - they made a hugely negative contribution to my partner's well being. No effort at all to engage with me in the care process, if anything, seemed to actively work to prevent that."

Health professionals' comments from the previous round:

"It is difficult to generalise about fathers...their response to becoming a father is different for each person."

"I think the mother and father should be supported as a family unit and their joint and individual needs addressed within this."

During the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year)...



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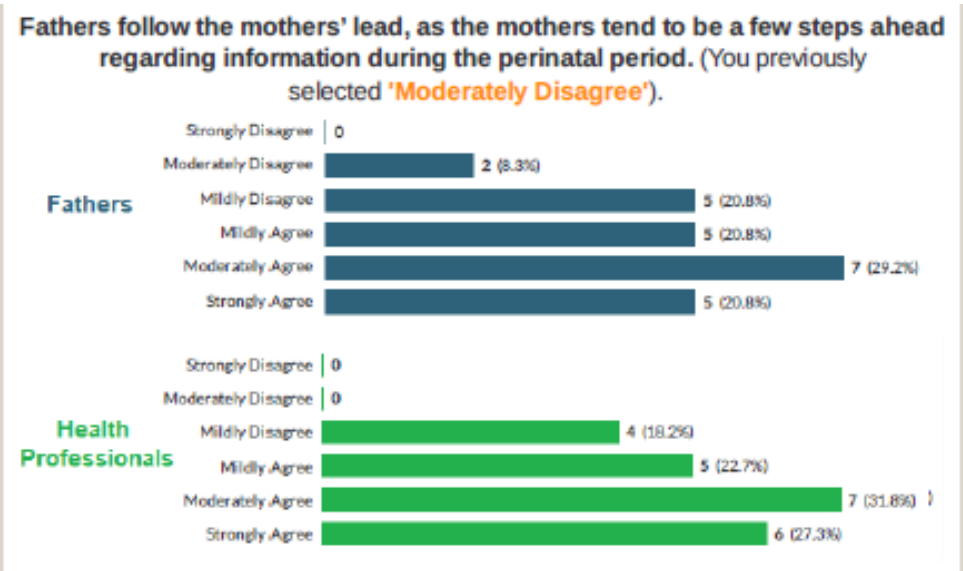

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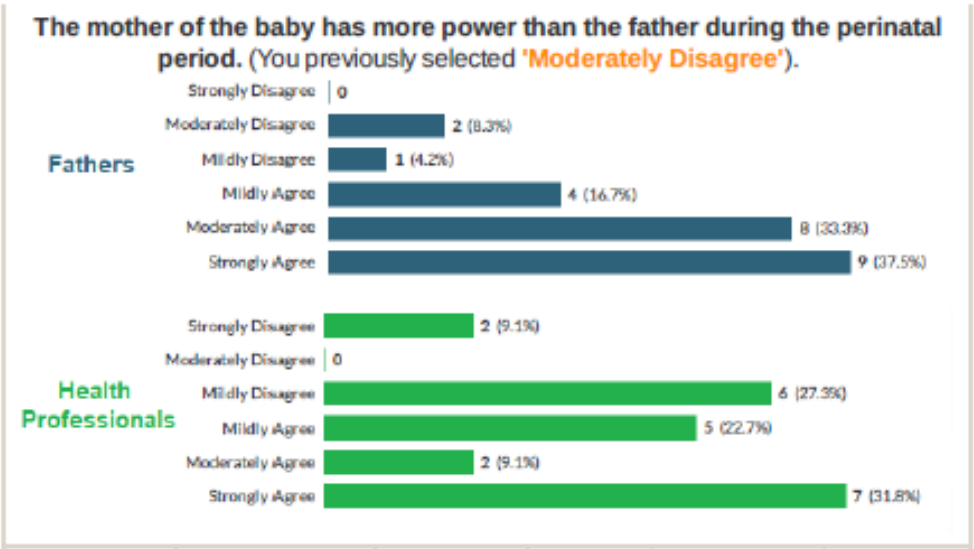

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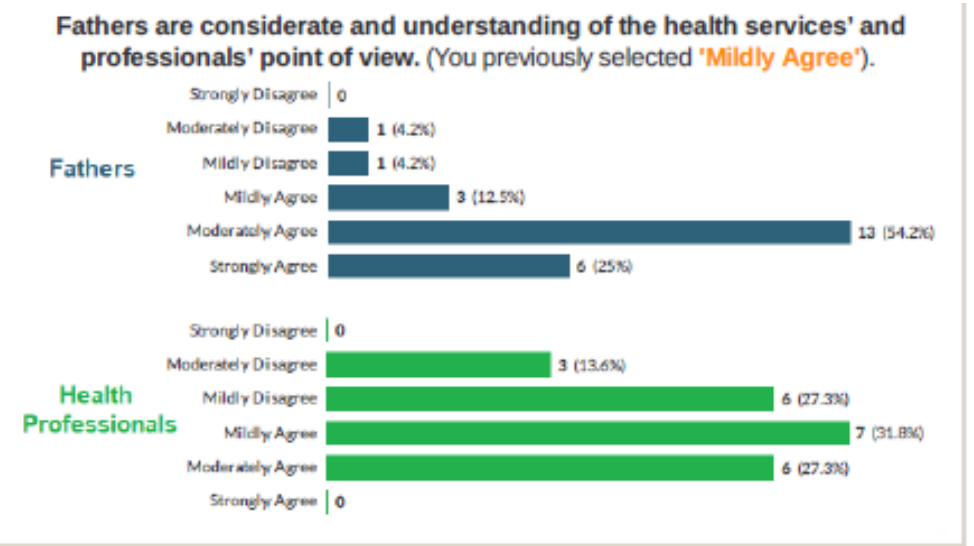

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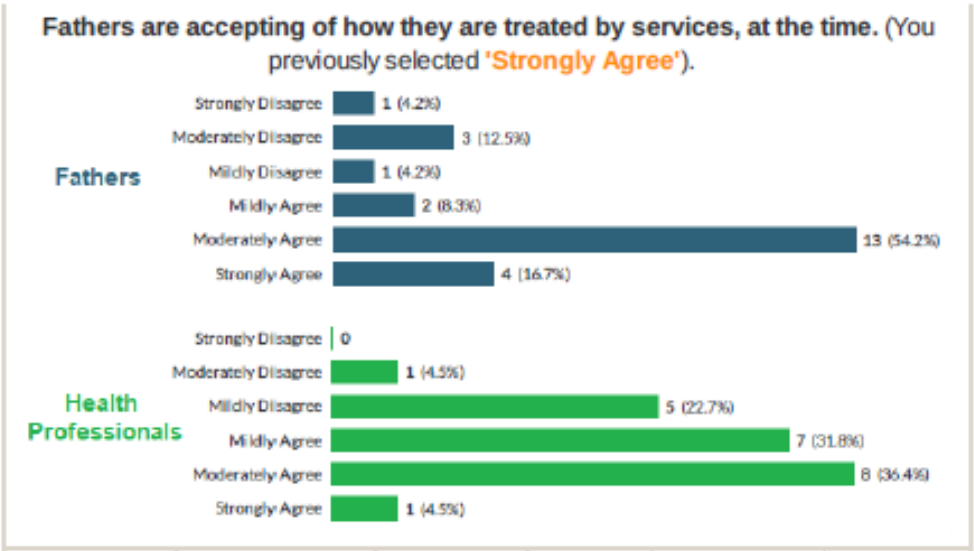

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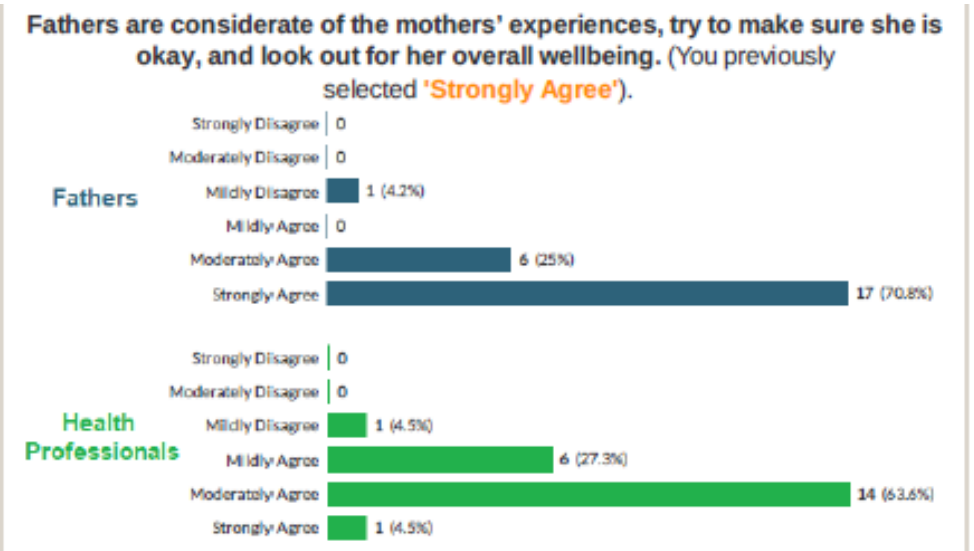

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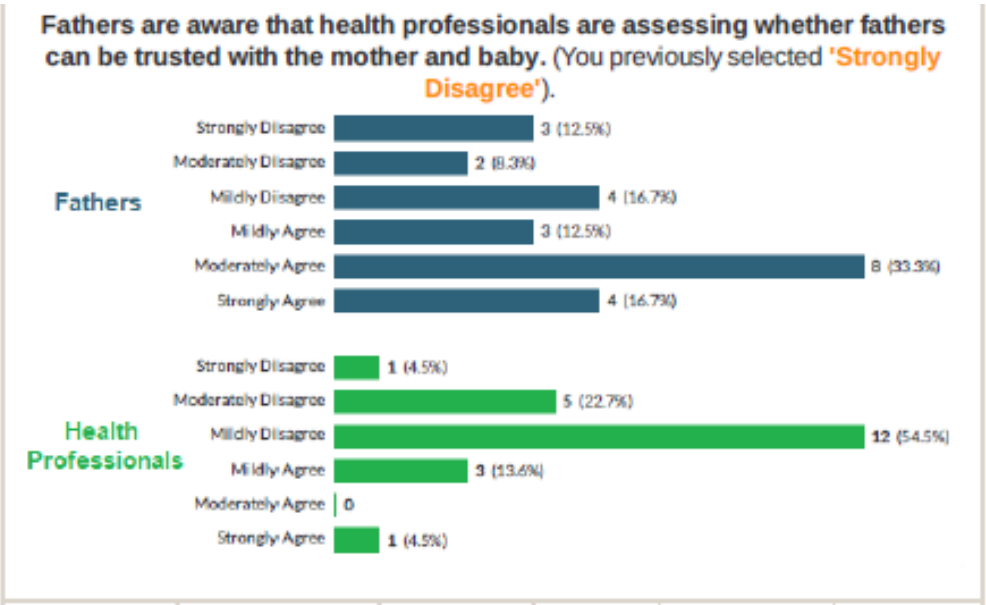

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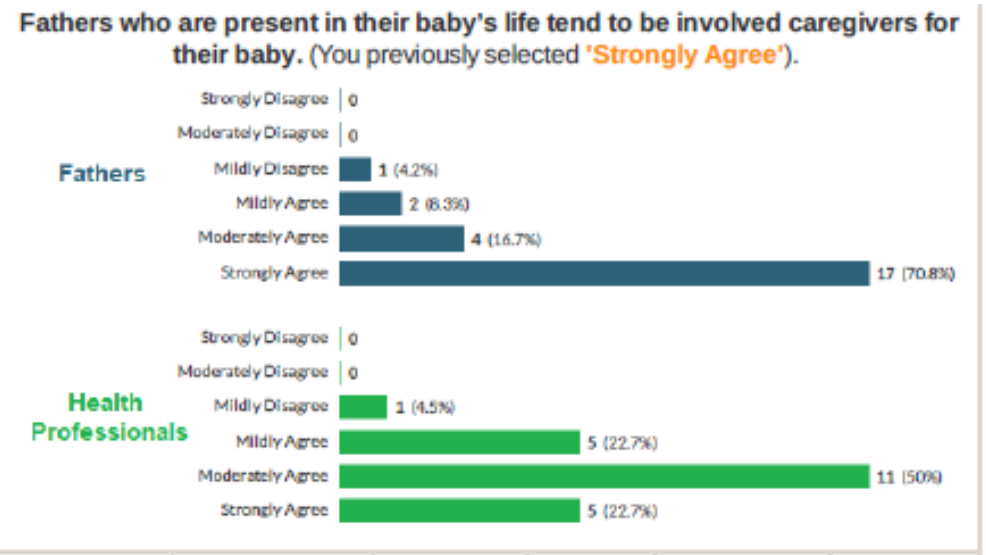

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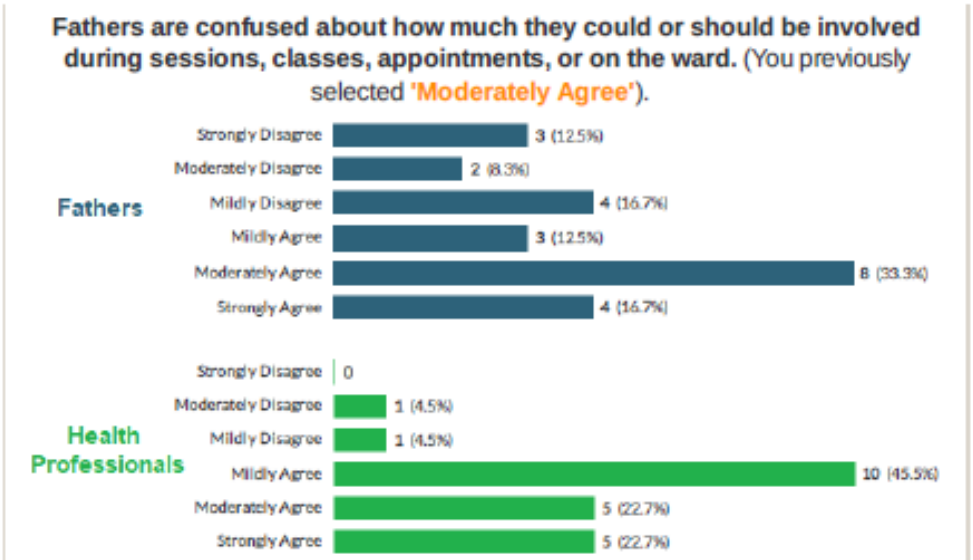

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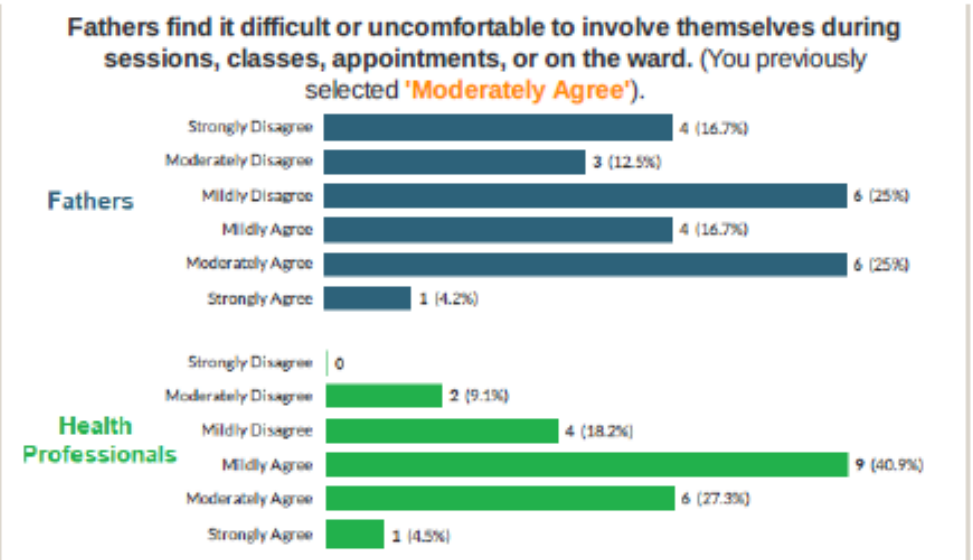

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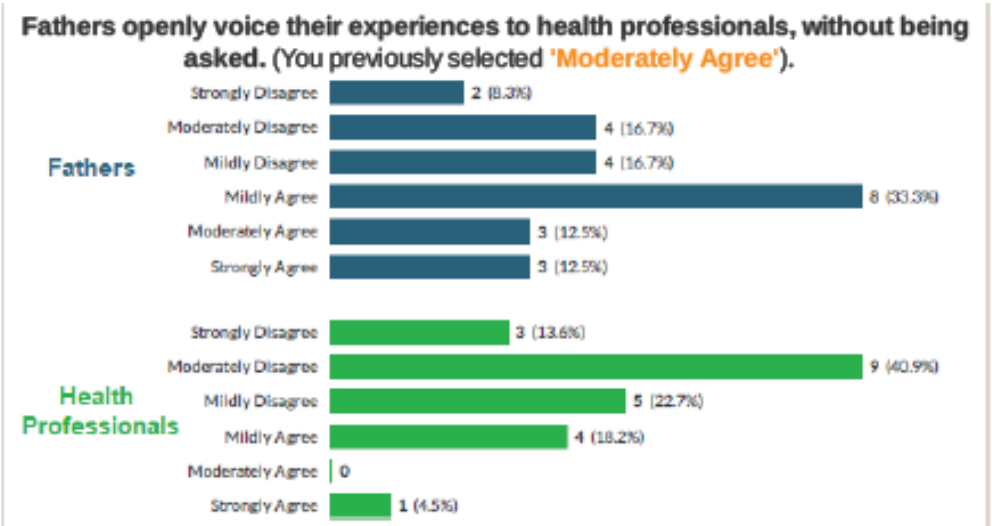

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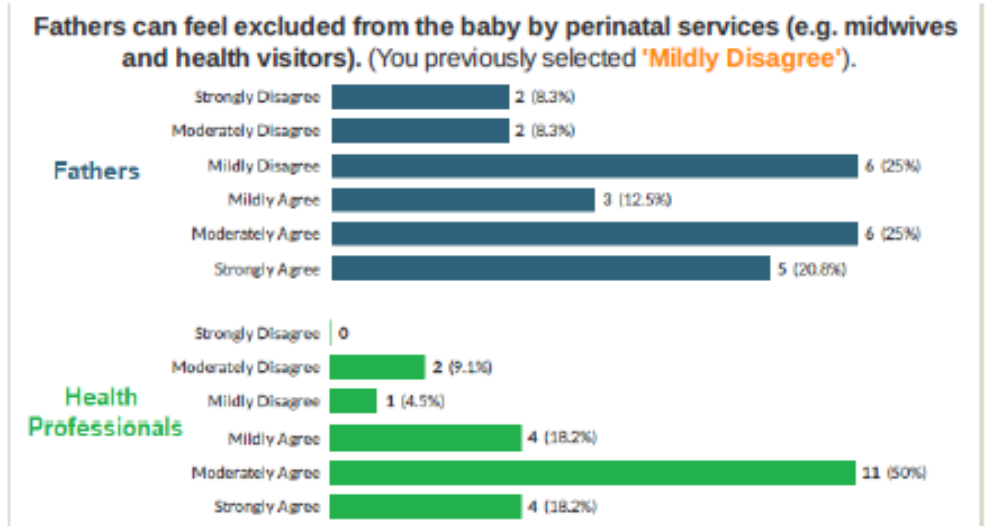

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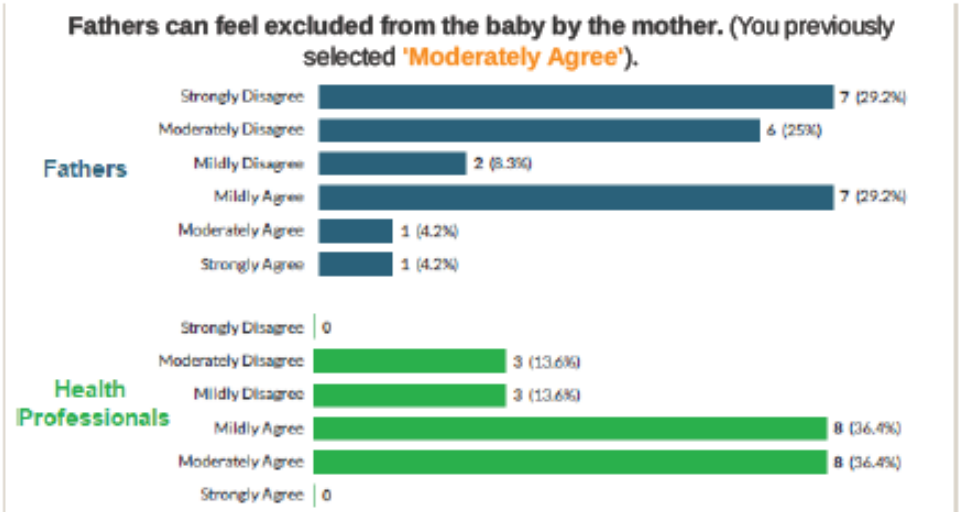

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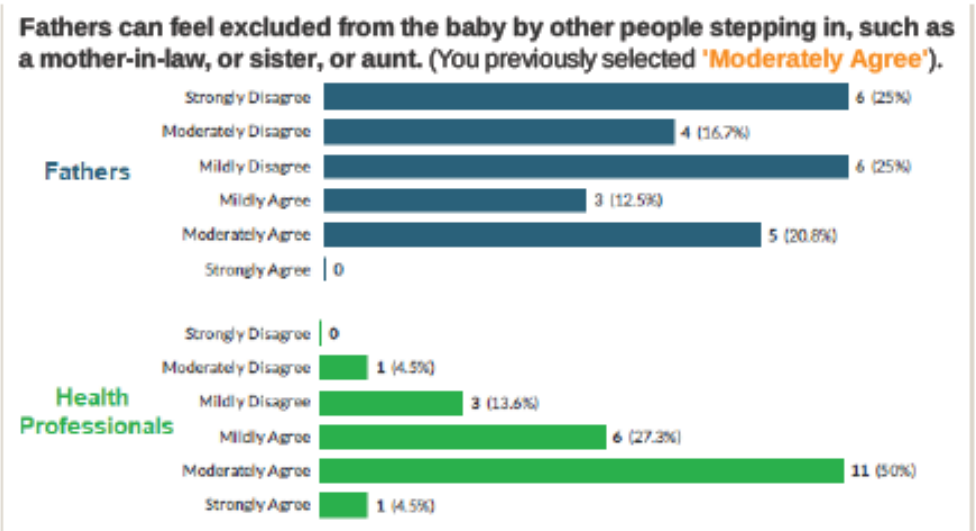

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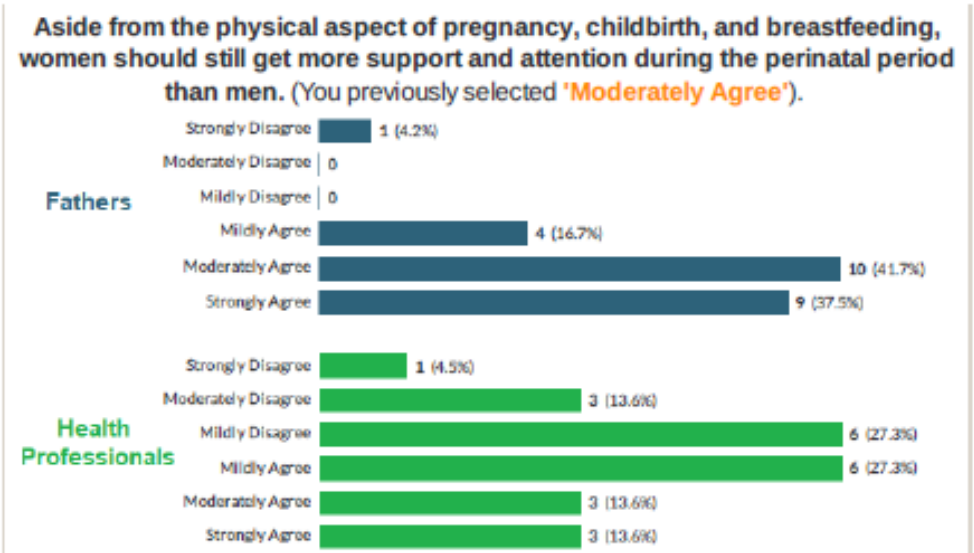

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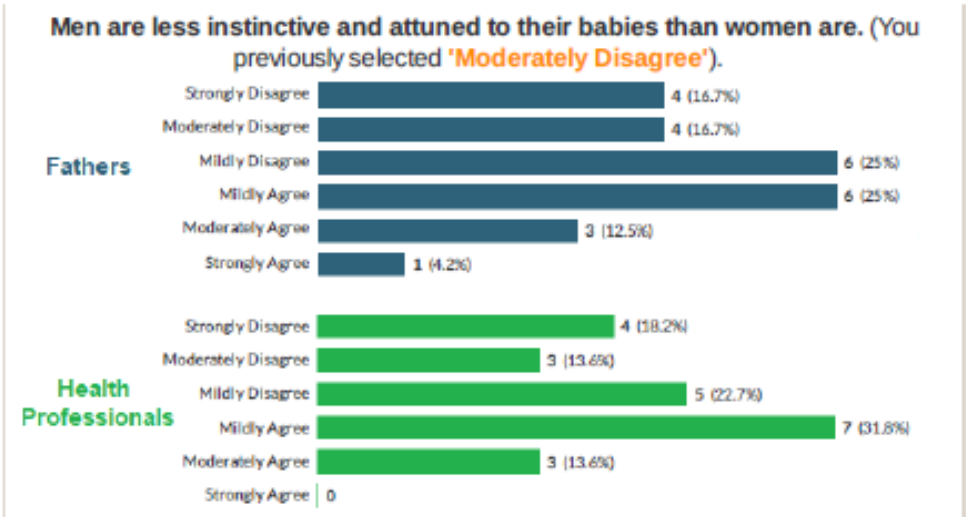

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If you have anything you would like to say about your answers, please write this in the box below *Optional*

Page 4: Fathers' and health visitors' perceived strengths and weaknesses of perinatal services

Fathers' comments from the previous round:

*"We had staggeringly good support, from the midwifery team - they were fantastic at involving and supporting me. My partner was severely ill with ante & post natal depression. There were no services that offered me any support to help me deal with that, or support me in supporting her. The services that existed to support *her* completely failed in that, and their consistent effort to keep me out made it more difficult for me to identify that this was happening."*

"No opportunity for men to speak separately to any health professionals at any time."

"I do not feel the role of a father is in any way adequately covered by health professionals. I received little to no advice on what my role should be (other than doing the housework once the baby is born - a message received via an NHS video). This has caused problems post birth, but significantly during labour itself. I did not fully appreciate the mental and physical state my spouse would be in during labour and the significant role I would have in supporting her throughout"

Health professionals' comments from the previous round:

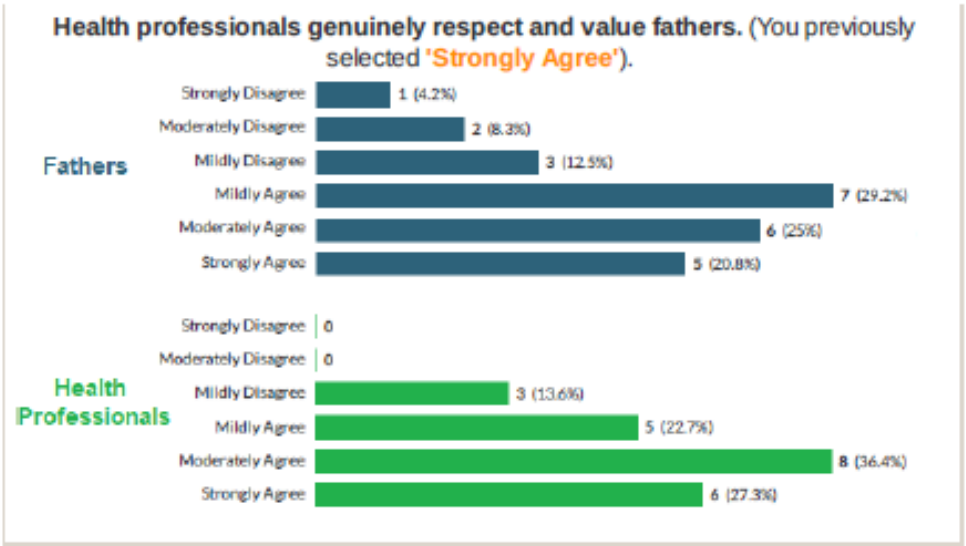
"The service is not balanced for women and men, because we are concentrating so much on how the woman is coping/feeling. Men often can't attend all appointments although they are welcome."

"A woman has a right to privacy... Fathers should be involved, but the initial encouragement and consent should come from the woman herself. Men should be demanding time off and paid paternity leave so they can be more actively involved - men have the power to be vocal and make this change... my job is making sure two lives are kept healthy and alive for aprox 40 weeks."

"fathers are invited to groups etc, however they would need to take A/L to attend and leave tends to be kept for other family occasions than appointments"

"I always try and include fathers... I understand the importance of involvement of fathers for the health and wellbeing of the family and quality of the relationship with the mother and child / children. I always talk to parents about PN depression, mental health and wellbeing, as a new parent. I always offer fathers the option to contact me if they have any worries or questions (they never do!) I try hard to de stigmatize MH issues, especially in fathers and be realistic about the challenges of parenthood as well as the rewards."

During the perinatal period (i.e. pregnancy, labour, birth, and/or baby's first year)...



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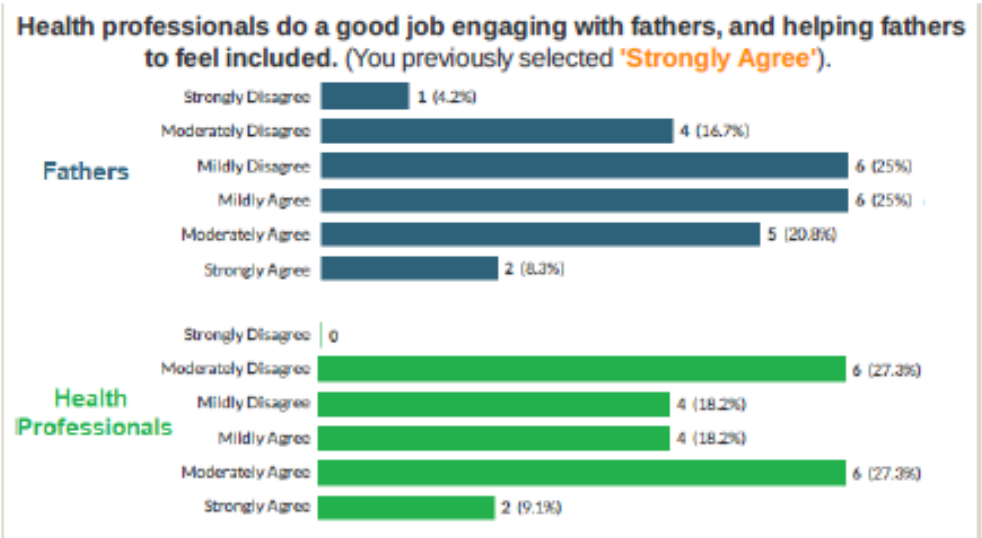

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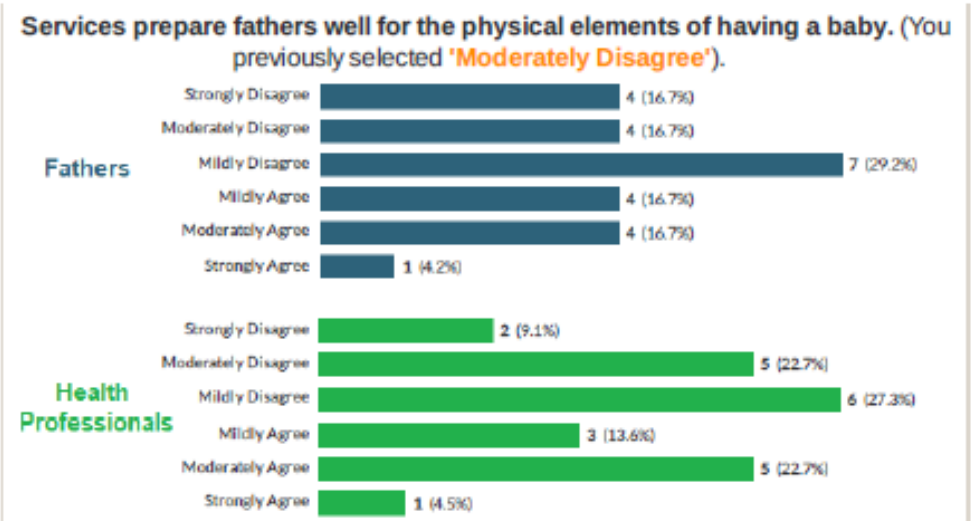

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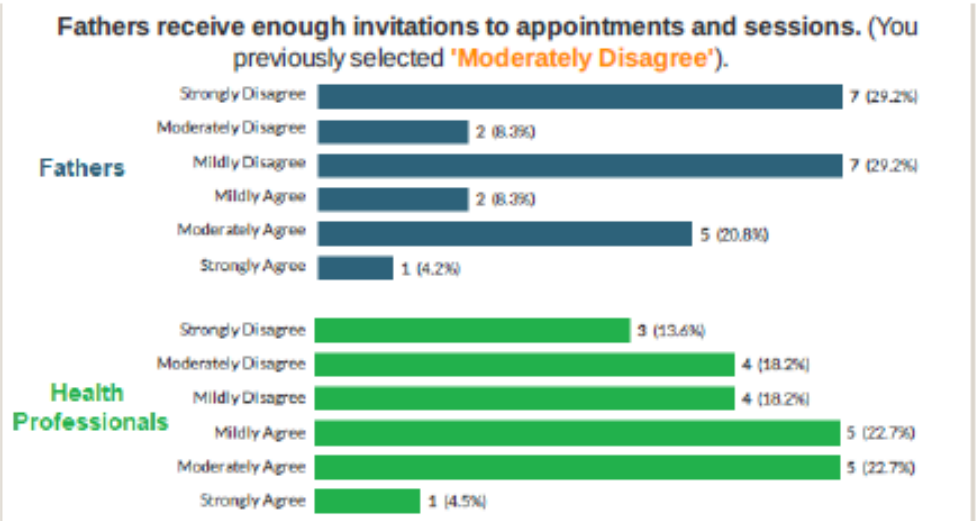

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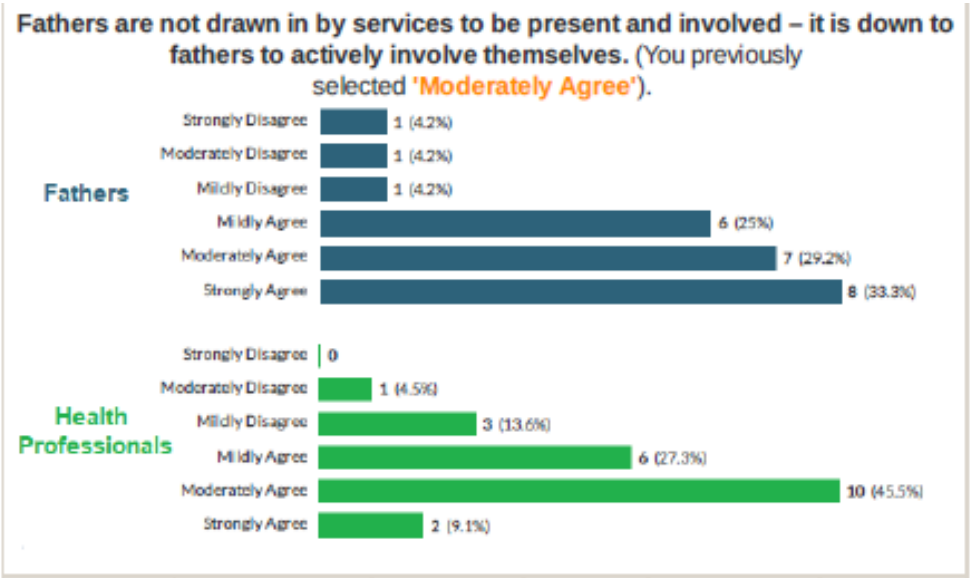

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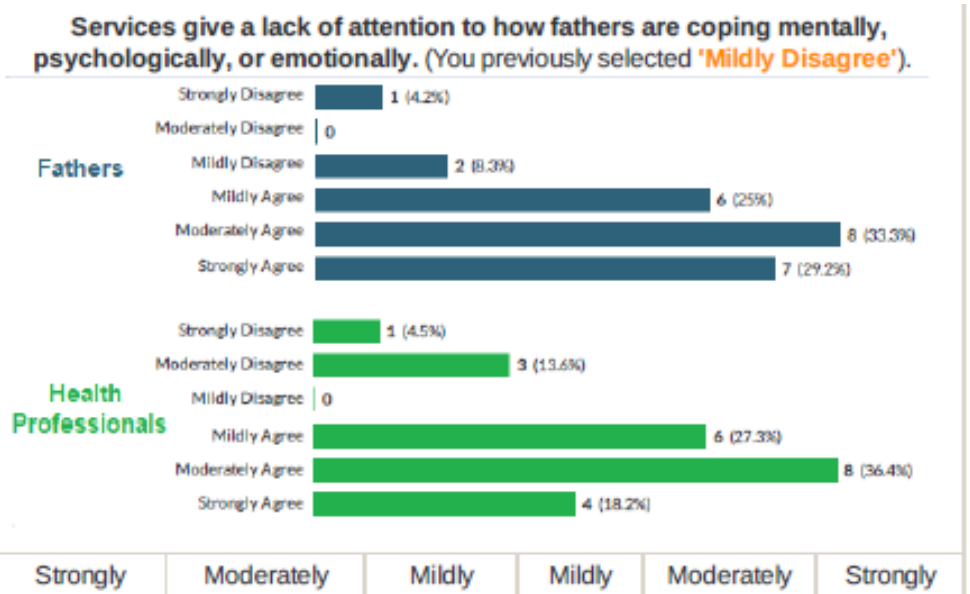

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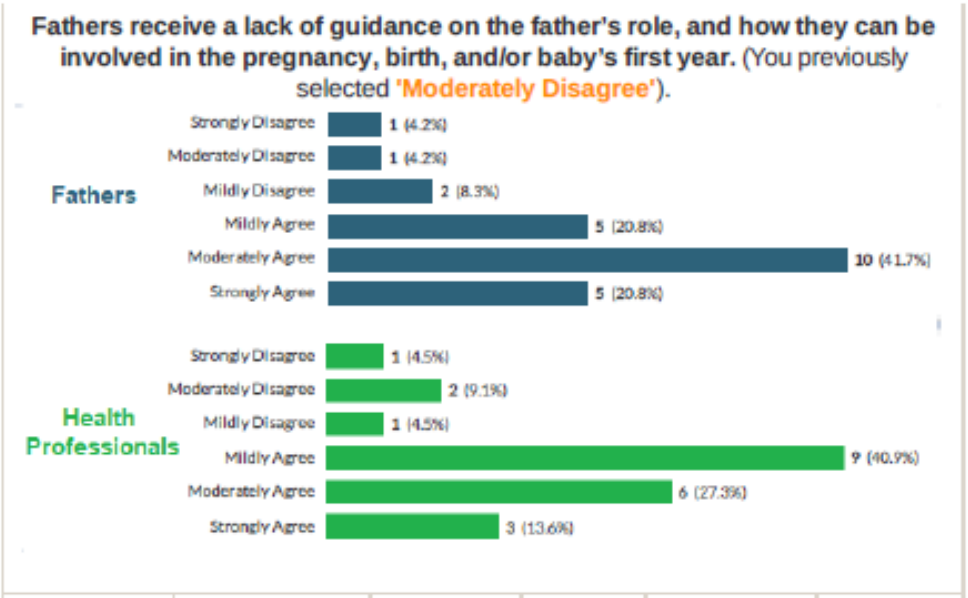

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
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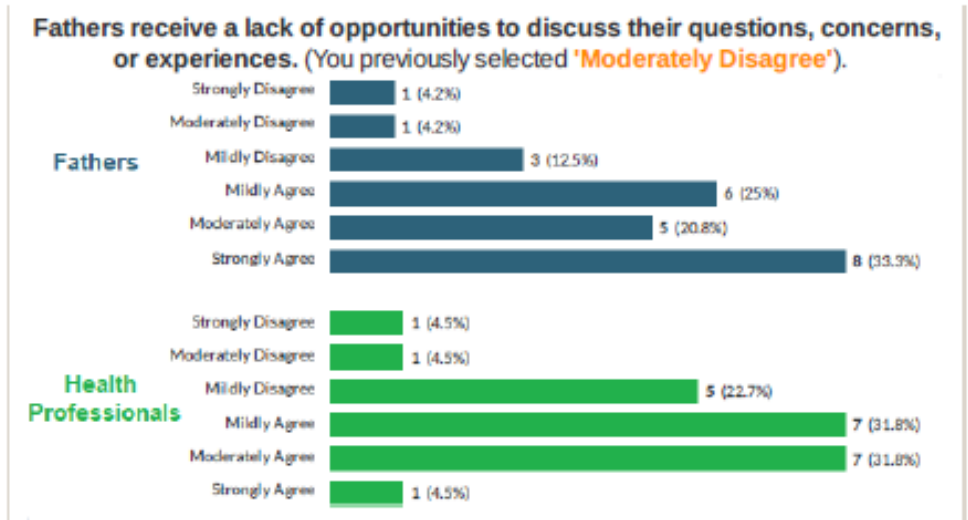

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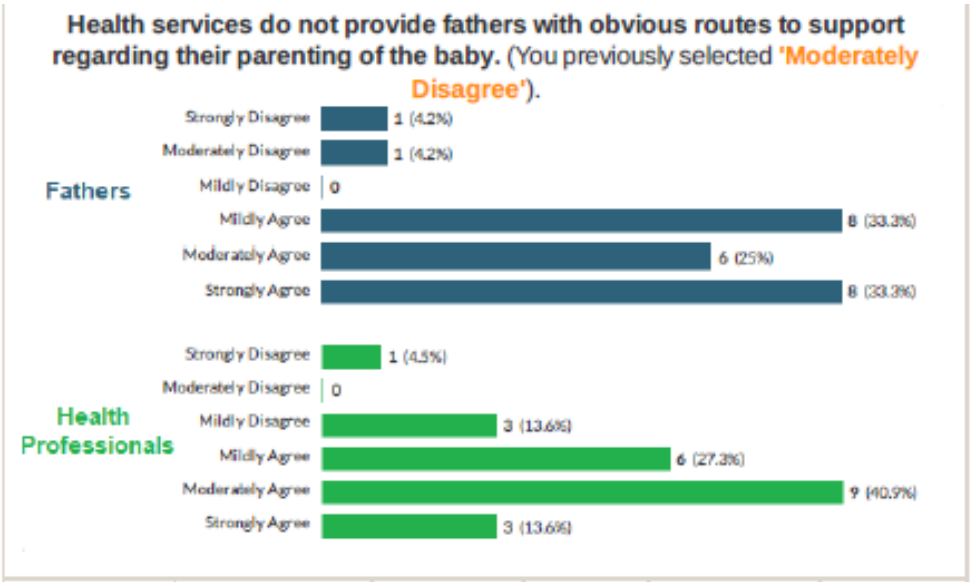

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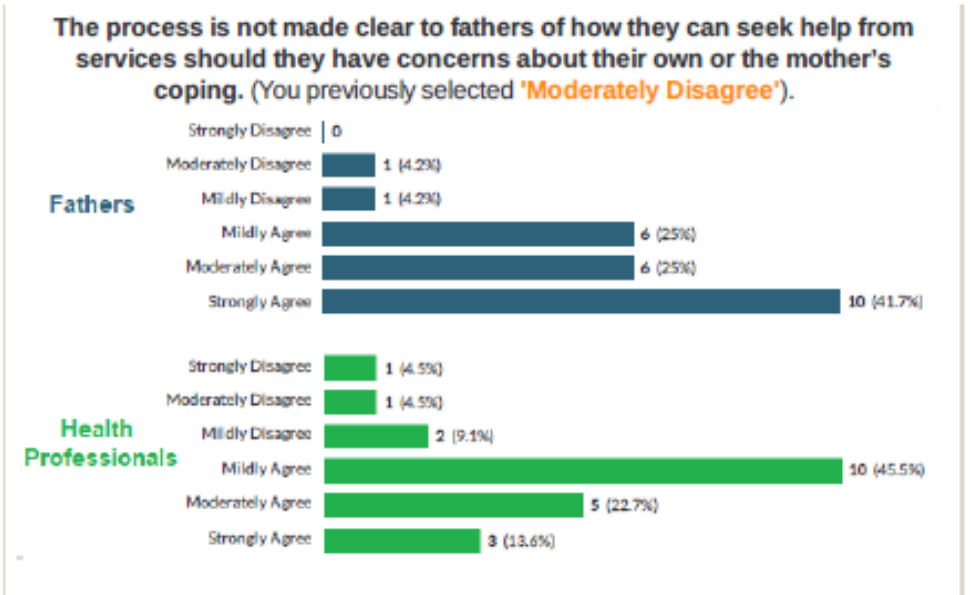

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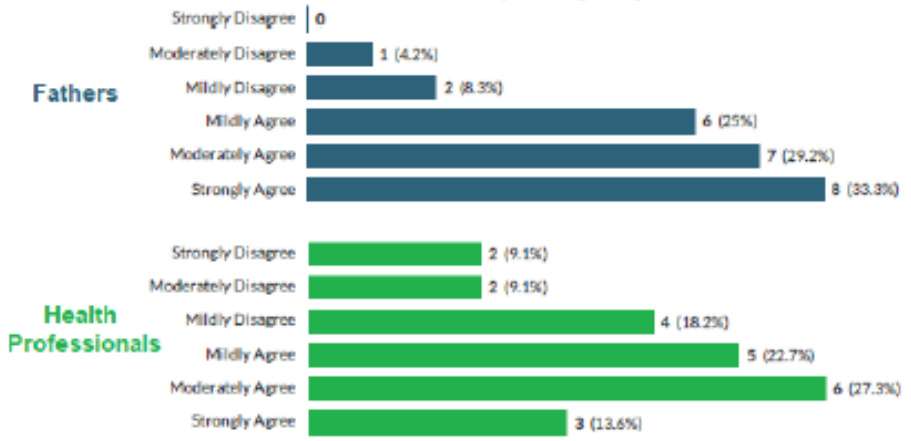
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐

Health professionals sometimes provide information and advice according to their personal opinions regarding matters where there are several possible evidence-based options that parents could consider. (You previously selected 'Moderately Disagree').



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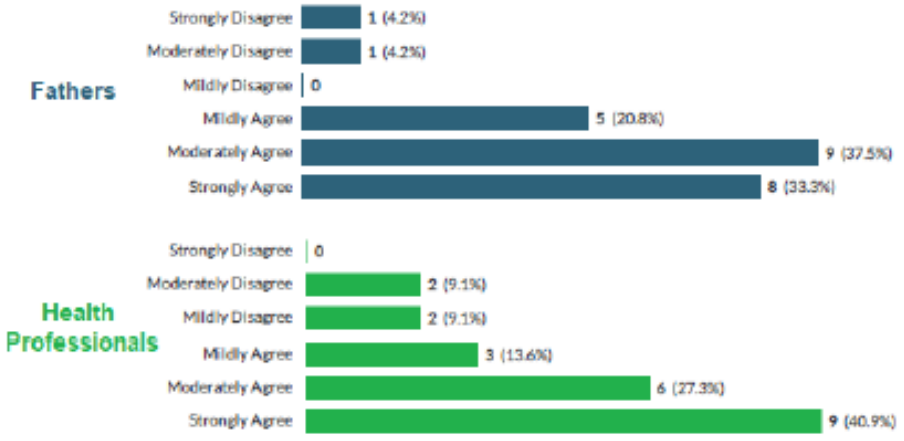
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐

Support for fathers provided by health professionals varies a lot between different members of staff. (You previously selected 'Moderately Disagree').



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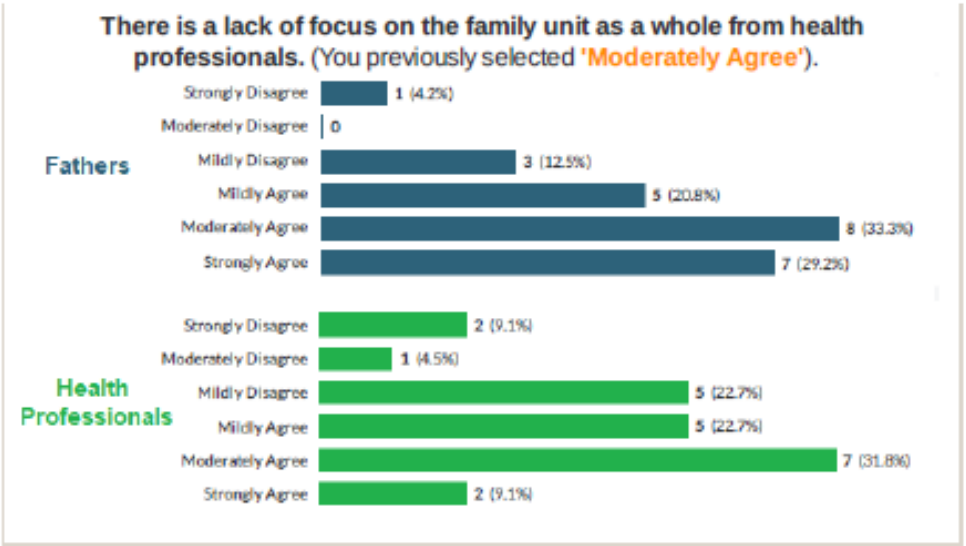

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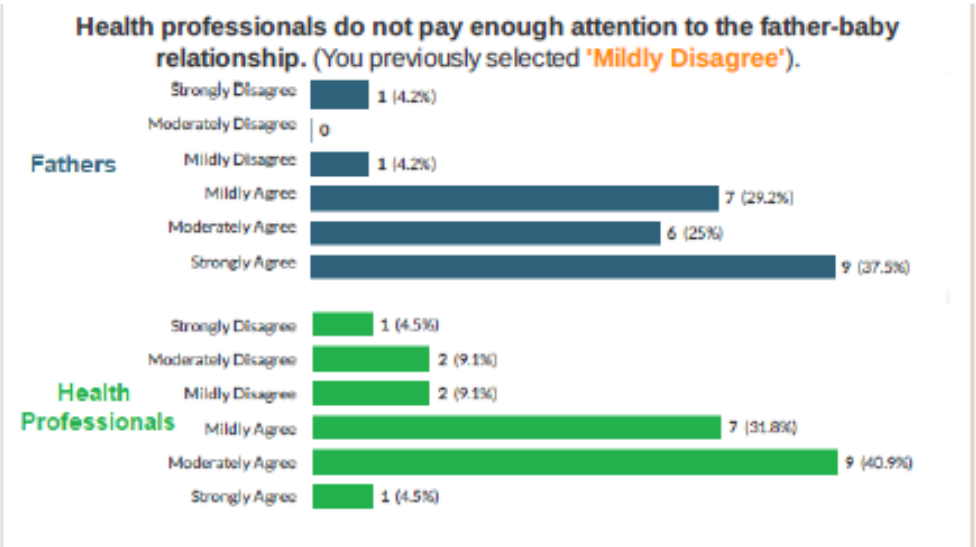

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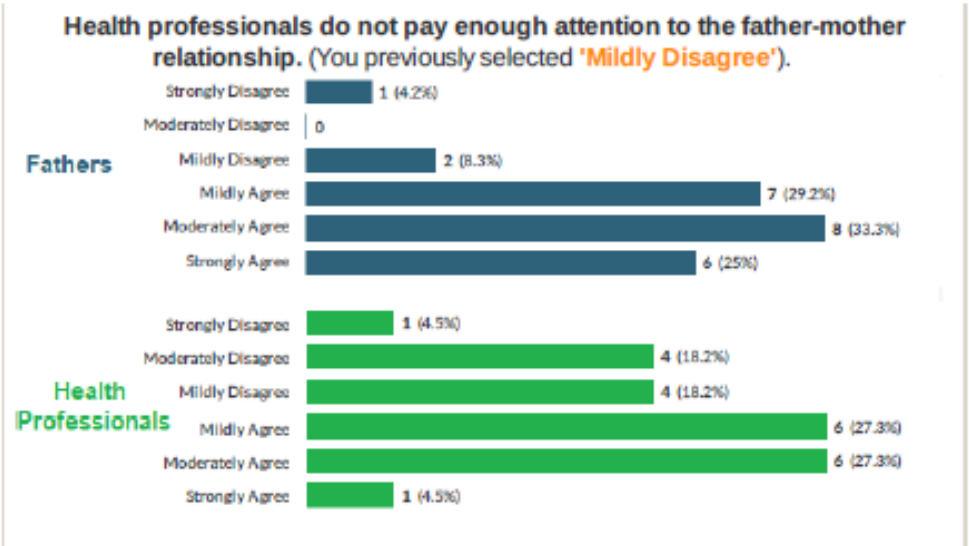

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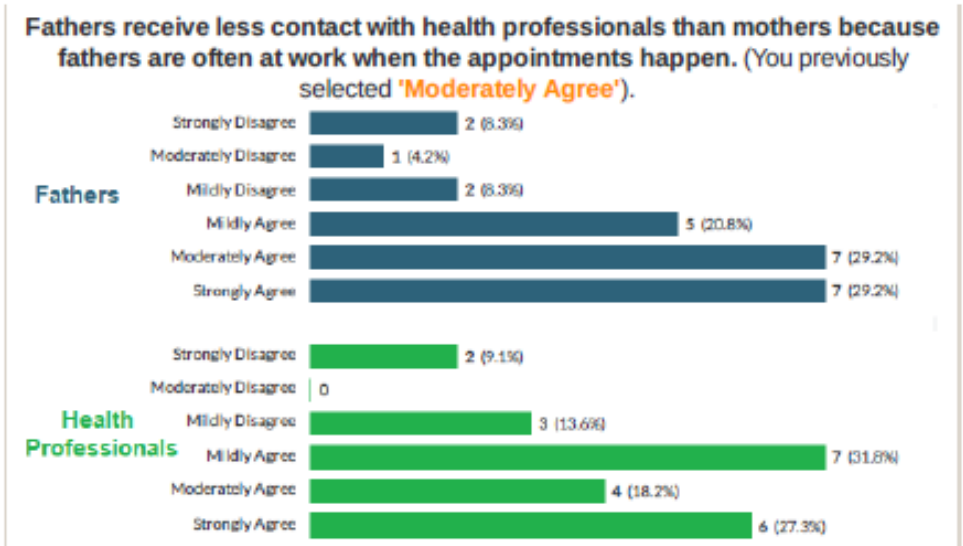

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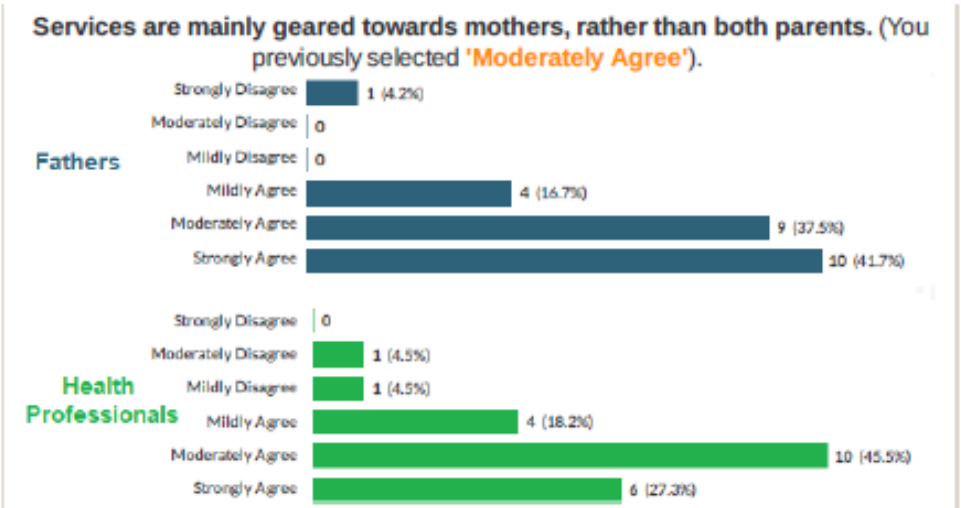

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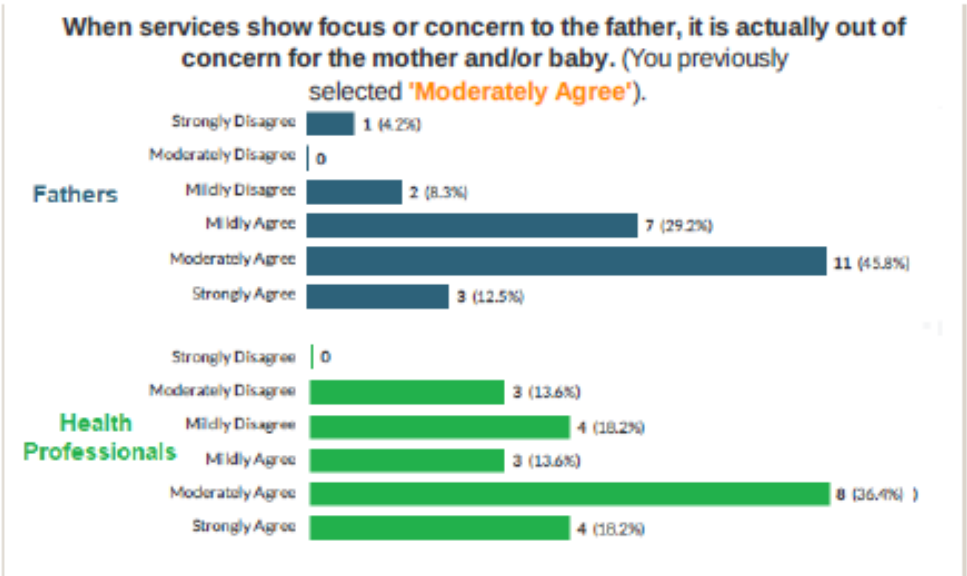

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If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

Page 5: Ideas of what services should continue, enhance, or improve to benefit fathers' experiences

Fathers' comments from the previous round:

"i found a emptty bed on myb third day in the hospital amd was literally shouted at by a midwife to get off the bed... just needed a short sleep. Wanted to cry"

"MW team fantastic at supporting skin to skin and all that stuff (which I believe is hugely important). Think it is very important that when thinking about 'services' here, that what's needed isn't a rebalancing, such that mothers get less, but addition."

"The ideas [below] for dad focused sessions are good. Quite right that when mum and baby are in the room health professionals arent focusing on the dad. Just need to include him."

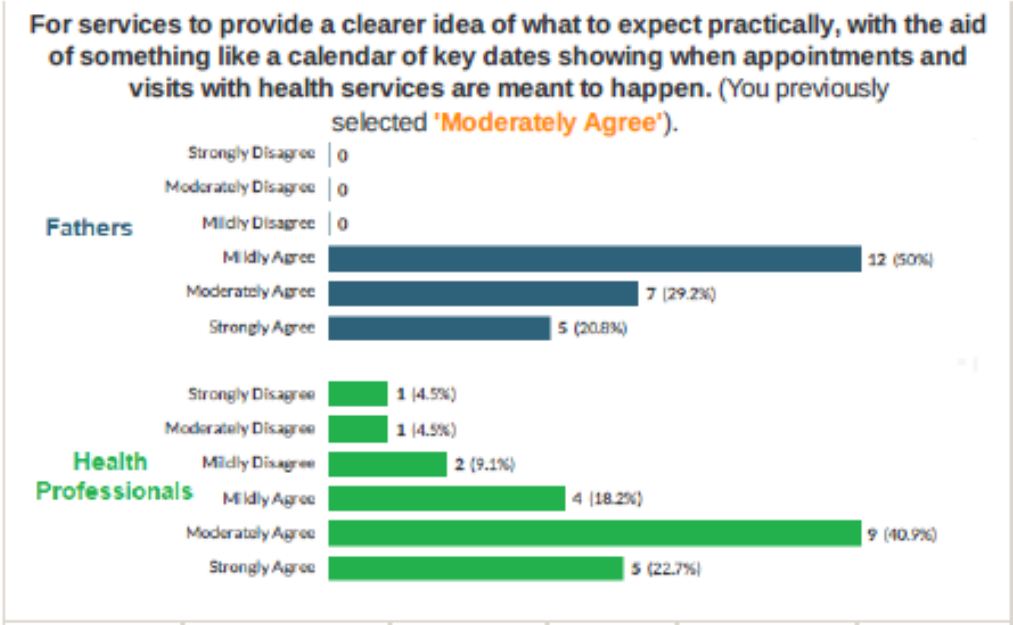
"A family-based service is a much bette or approach. Currently roles feel very isolated with little conjunction between them"

"Health professionals will need more time and resources to be able to provide additional services. They are doing a good job given the resources (or lack of)"

Health Professionals' comments from the previous round:

"if midwives and health visitors provided 'dad-only' time, it would be at the expense of time they could have spent with pregnant women, which is unacceptable. If the father is having skin-to-skin... the baby is not having it with the mother, which interrupts the natural process... Skin-to-skin after the mother has had it however is a good idea."

"we have tried to offer many of the [below] to fathers/but have withdrawn due to the poor uptake and challenge of offering what appears not to be wanted. parents are overloaded with information"



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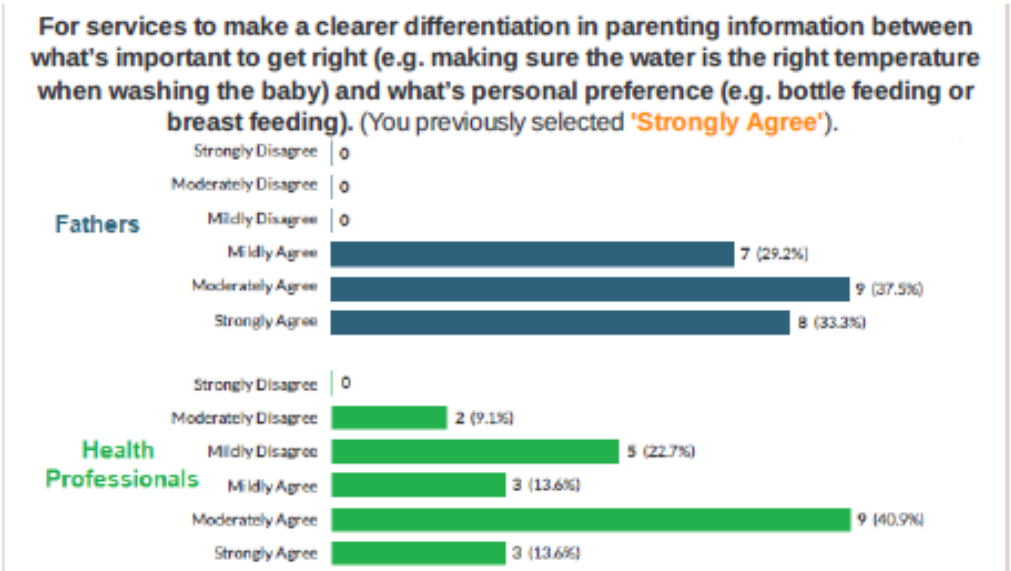

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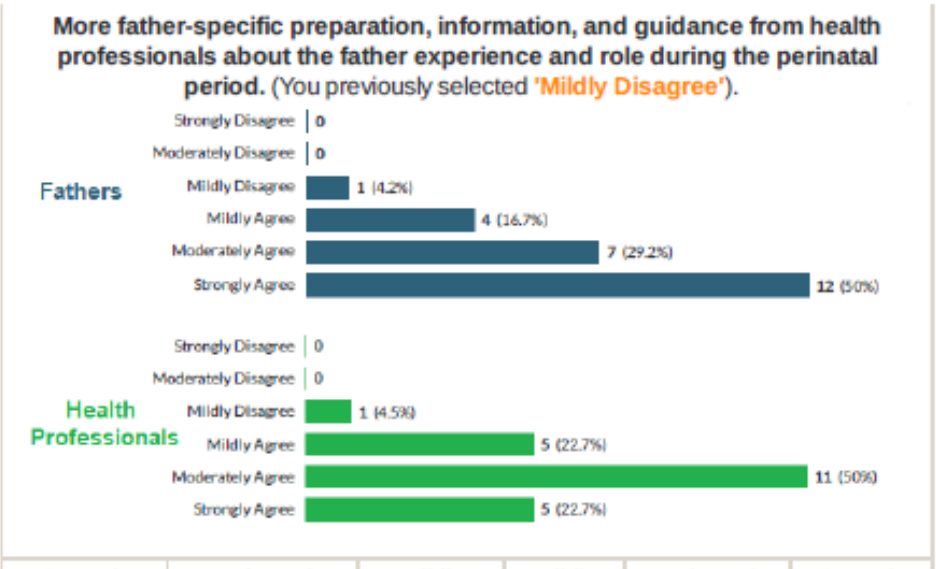

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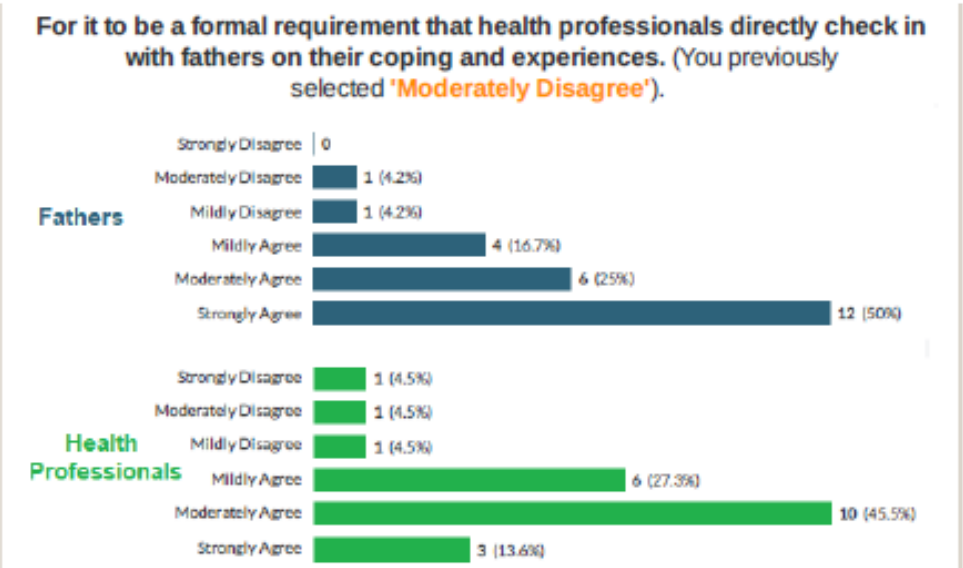

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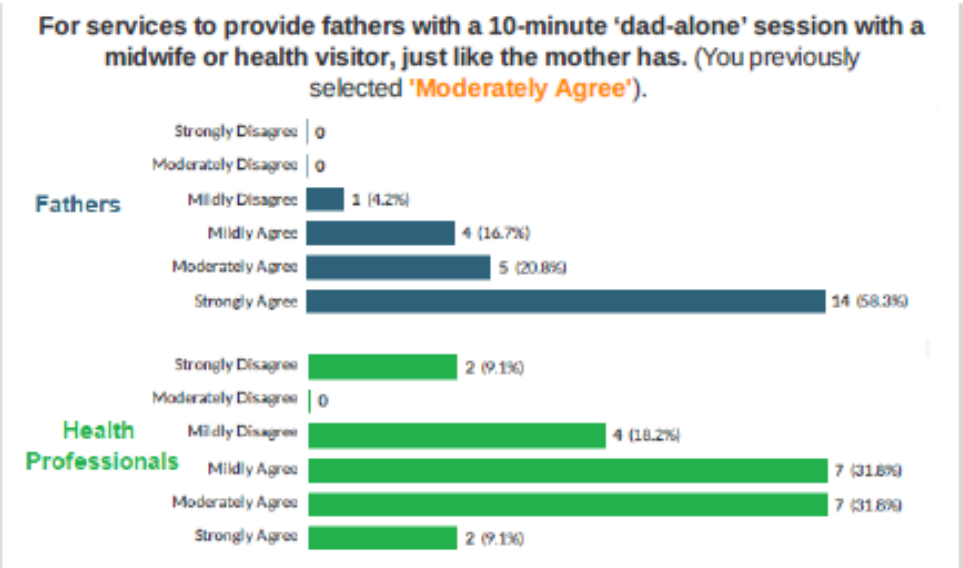

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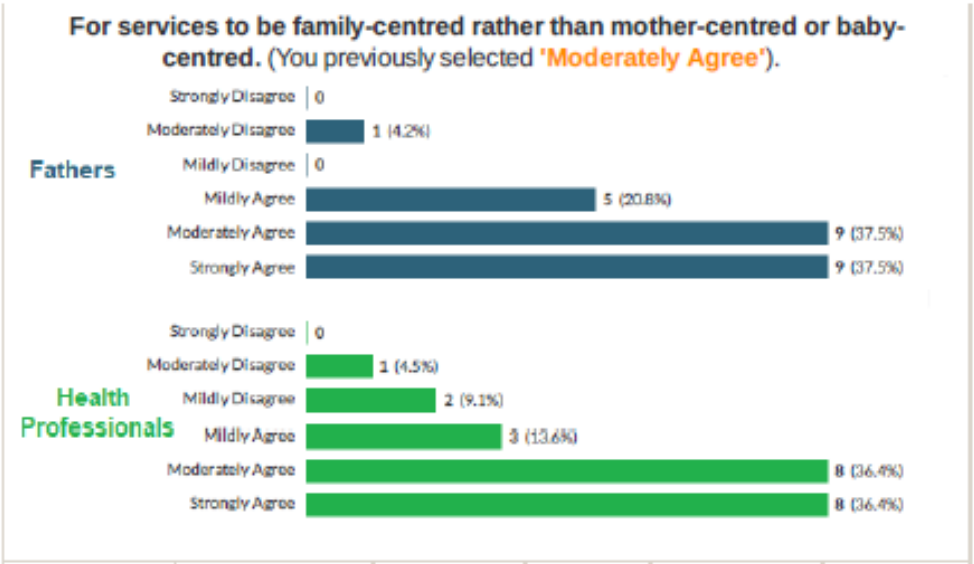

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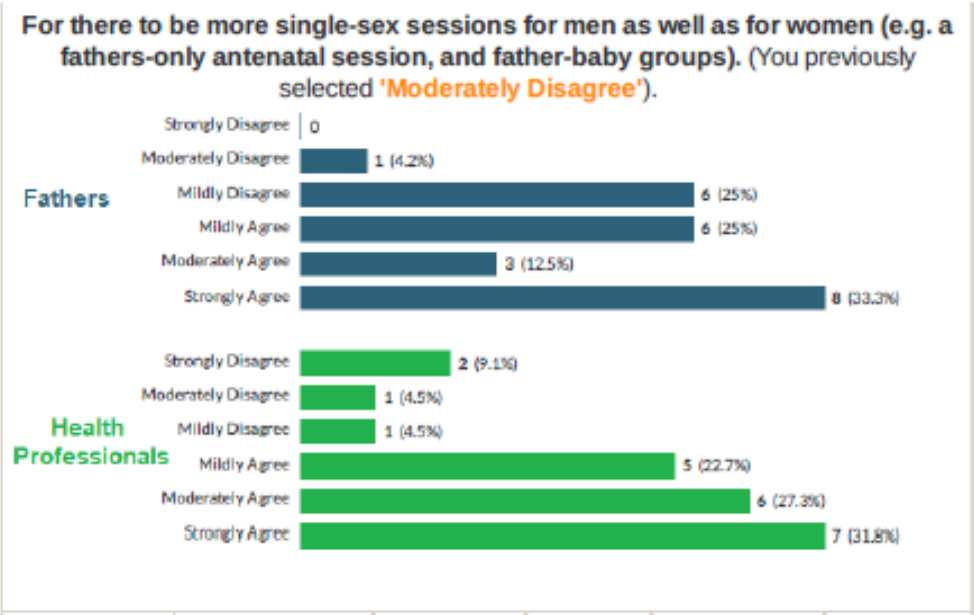

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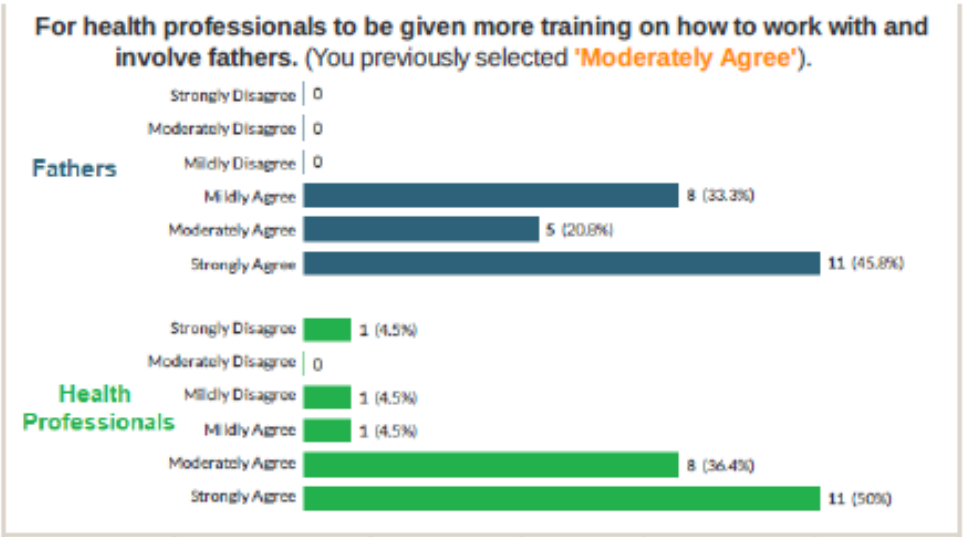


	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

Page 6: Social and cultural context of men as fathers, and for health professionals working with fathers

Fathers' comments from the previous round:

"Families are more isolated now. Father's have to do the role that grandmothers /. Aunts etc did in previous generations"

"I'm aware that I'm unusually lucky to have been able to work part time and flexibly to spend more time with my child - this has been massively positive for all three of us."

"Government need to force business to give expectant dad's same rights as mothers... dad's need same protection."

"Fathers are obviously very important, but they aren't intrinsic to the act of having and raising a child. Health services are also stretched. For the above reasons, while it would be ideal for there to be more involvement of fathers in the perinatal process, it is clearly a priority to focus upon the needs of the mother, who is more emotionally and physically involved in all aspects of pregnancy, birth and child-raising."

Health professionals' comments from the previous round:

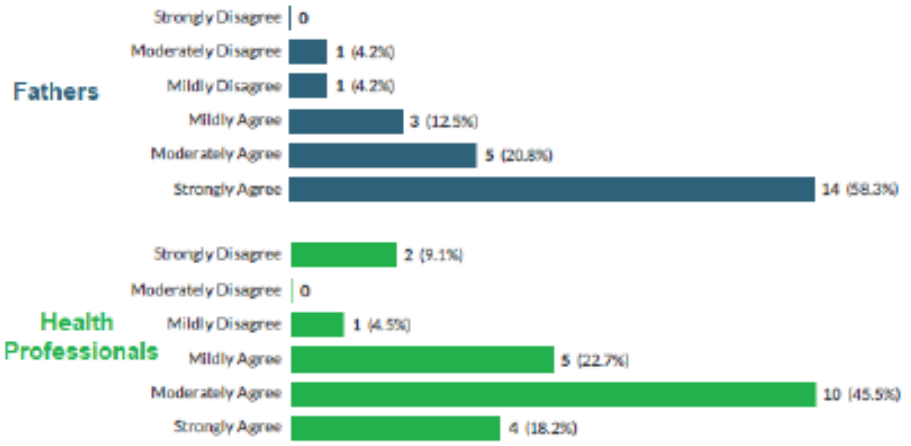
"I feel that both women and men are becoming less prepared for birth and the lifestyle change than ever. This, I think, is due to societal changes such as career becoming a priority and women having children older, less experience with children/babies at a young age, all leading to increased anxiety around pregnancy and birth"

"Women should not be penalised for having a baby and a partner when it comes to maternity leave. Men should have paternity leave in their own right. Then yes, all relationships should benefit."

"services dependant on area, resources available and training of professionals, groups and time not available due to tme constraints and overworked health professionals."

"I try to include the father as much as possible...There is not always a father present."

Today's fathers were raised by a generation in which the mothers were more involved in childcare than the fathers were. (You previously selected 'Moderately Disagree').



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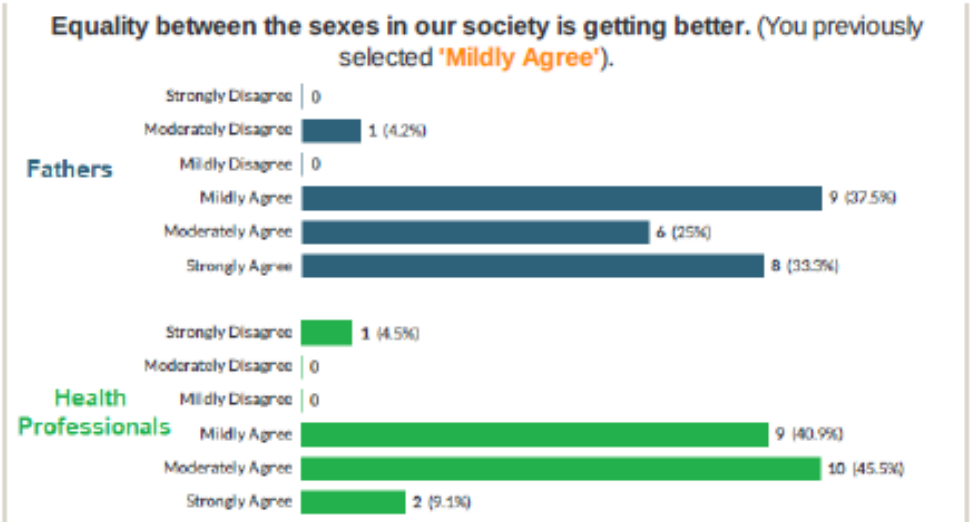

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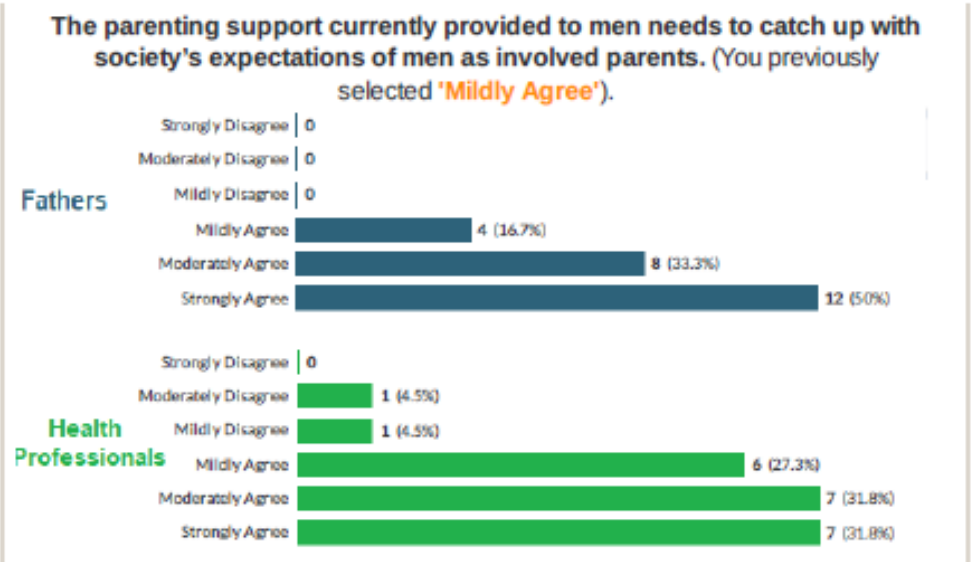

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
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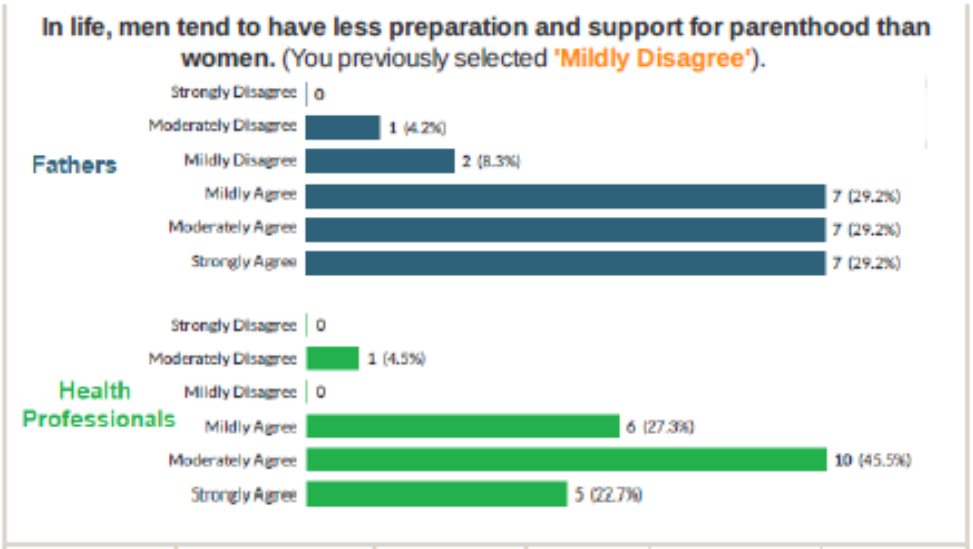

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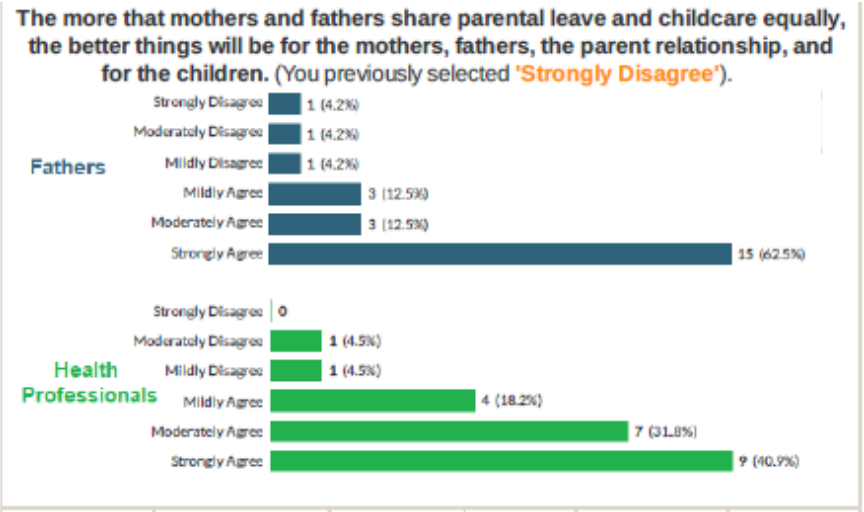

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If you would like to change your response, please select your new rating.	☐	☐	☐	☐	☐	☐

If you have anything you would like to say about your answers, please write this in the box below *Optional*

Would you like to be emailed a copy of the final findings for this study?

- ○ Yes
- ○ No

If you would like to submit your responses, please tick "Yes" below before clicking "Finish".

- ○ Yes, I would like to submit my survey responses

Page 7: THANK YOU

Thank you for completing the final round of this study. Your contribution to this research exploring experiences of fathers and health professionals and their views of NHS perinatal support for fathers, is greatly appreciated!

The hope is that this project will provide greater insights into how fathers experience perinatal support during the transition to parenthood, and how health professionals experience giving support to fathers. Furthermore, by gathering an idea of the level of consensus within and between the different groups regarding paternal perinatal support, this research has the potential to inform NHS service improvements.

If you have any questions or comments regarding this study, please contact Sophie Fenton (lead researcher) at s.e.fenton383@canterbury.ac.uk. Or if you would like to make a complaint, please contact Professor Paul Camic (research sponsor) at paul.camic@canterbury.ac.uk.

Many thanks for making a valuable contribution to this area of research.

(Prize draw winners will be contacted in due course).

These are the statements which reached high levels of agreement in the previous round by both fathers and health professionals:

- Men experience personal changes in themselves, and observe personal changes in the baby's mother too.
- The relationship dynamic between the mother and father changes when there is the baby in the relationship too.
- Communication, negotiation, and compromise between the father and mother is important during the perinatal period.
- Becoming a parent is just as important to fathers as it is to mothers.
- Fathers are equally as able as mothers to be good primary caregivers for their children.
- Fathers are important for the physical health of the baby (e.g. bottle feeding, supporting breastfeeding, being aware of the baby's physical health and what to look out for).
- Fathers are important for the psychological wellbeing of the baby (e.g. being an attachment figure for the baby, and supporting the mother's bond with the baby).
- Fathers are important for the psychological wellbeing of the mother (knowing about her mood and coping, and providing support).

- Fathers may have important information to share about their experiences or coping, which health professionals are unlikely to find out unless they ask fathers directly.
- Fathers are important for being the baby's main caregiver if the mother is not able.
- Fathers are important for being an overall source of help and support.
- When the father has difficulty coping, it makes things more difficult for the mother too.

The following is important to fathers' experiences during the perinatal period:

- For health professionals to signpost fathers to a clear and reputable source of parenting information.
- For services to provide more information and preparation regarding the psychological, emotional and relational aspects of parenthood.
- For antenatal classes to have more content on the father-mother relationship, raising awareness of the impact that having a baby can have on the relationship, how to nurture the parent relationship, and what can be helpful in managing conflict.
- For fathers to receive invitations to appointments, parent education sessions, and classes.
- For health professionals to encourage fathers to have skin-to-skin contact with their baby straight after the birth.
- For health professionals to involve fathers in communication with body language, direct questions, and prompts for them to speak.
- For health professionals to open up conversations between parents about the choices they have (e.g. who to have in the birth room, or whether to have the father stay the night on the ward with the mother).
- For fathers to be better accommodated for staying overnight on the ward (e.g. having the option of staying overnight, having a mat to sleep on, a microwave to heat food, somewhere to wash).

Statements specific to health professionals that reached a high level of agreement:

- Attitudes towards how much health professionals should involve fathers varies between different midwifery or health visiting colleagues.
- The workload is stressful.
- There is a constant pressure of people waiting to be seen.
- Health professionals are often not able to offer consistent continuity of care to families.
- There ae not quite enough health professionals to meet the demands on the service.
- Health professionals do not receive enough training on fathers or how best to include fathers (e.g. what fathers want, what their expectations are, or how to address their needs).
- Health professionals find it difficult to fulfil their roles to their full potential due to time pressure and stretched resources.
- Health professionals do not have as much time as they feel is needed to talk with parents about their psychological experiences or coping.
- For families where the father is involved, it is not a formal service requirement for health professionals to meet with the fathers.

Appendix AA: End of study notification letter to HRA, REC, and R&D departments

To whom it may concern,

I am writing to briefly summarise a research project that I recently conducted for the partial fulfilment of my doctorate in clinical psychology. This research was sponsored by Canterbury Christ Church University, and received favourable ethical opinion from the Dulwich Research Ethics Committee, and approval from the Health Research Authority. A summary of the research and the results are detailed below.

Title: Fathers' and healthcare professionals' perceptions and experiences of paternal perinatal support and their views on improving services

Background: The UK has observed a shift in culture toward more involved fatherhood. Research has highlighted the importance of positive father-involvement to children's developmental outcomes and mothers' wellbeing. The transition to parenthood can create increased vulnerabilities to psychological distress in new fathers, which has been linked to greater risk of negative outcomes for fathers and their families. Perinatal healthcare services are in a key position to detect difficulties in fathers and facilitate early intervention. However, fathers report feeling marginalised and excluded during the perinatal period, and healthcare professionals report having limited support to work with fathers.

Research aims: This study aimed to: 1) explore fathers' experiences during the perinatal period and of support they receive from midwives and health visitors; 2) explore midwives' and health visitors' experiences and understanding of fathers; 3) explore both groups' ideas for how perinatal services could improve the support provided to fathers; and 4) identify important areas of agreement and disagreement between fathers and healthcare professionals.

Method: A three-round Delphi method was employed to explore the experiences and views of fathers and healthcare professionals (midwives and health visitors). Thematic analysis of first-round focus groups led to the development of a second-round online survey that was completed by 24 fathers and 22 healthcare professionals. A third-round online survey was used to finalise consensus within and between groups.

Results: There was overwhelming agreement from both groups for all statements relating to the importance of fathers (e.g. for the physical and/or psychological wellbeing of mother and baby), and both groups agreed that more sharing of parental leave would benefit the whole family. Participants agreed on the personal and relationship changes, and the complex mixture of emotions that fathers can experience during the perinatal period, and strongly agreed on the importance for communication and compromise with their partner during this time. There was moderate consensus among participants that fathers can feel side-lined, and both groups agreed that services tend to be mother-centred. Despite some shortfalls of services, fathers agreed that they do feel understanding and accepting of health services. Additional statements responded to by healthcare professionals highlighted the under-staffed, under-resourced, time-pressured, and often stressful environments that they are working in. Healthcare professionals also agreed that they do not receive enough training on how to best include fathers.

Table 1. displays the ideas for service improvements that came up in the focus groups, and received the most amount of agreement among fathers and healthcare professionals in the online surveys.

Table 1. Service improvement ideas agreed upon by fathers, midwives, and health visitors

Ideas that received strong consensus overall
For antenatal classes to have more content on the father-mother relationship, raising awareness of the impact that having a baby can have on the relationship, how to nurture the parent relationship, and what can be helpful in managing conflict.
For health professionals to signpost fathers to a clear and reputable source of parenting information.
For services to provide more information and preparation regarding the psychological, emotional and relational aspects of parenthood.
For health professionals to involve fathers in communication with body language, direct questions, and prompts for them to speak.
For services to be family-centred rather than mother-centred or baby-centred
More father-specific preparation, information, and guidance from health professionals about the father experience and role during the perinatal period
For health professionals to be given more training on how to work with and involve fathers
For fathers to be better accommodated for staying overnight on the ward (e.g. having the option of staying overnight, having a mat to sleep on, a microwave to heat food, somewhere to wash).
For health professionals to encourage fathers to have skin-to-skin contact with their baby straight after the birth.
For health professionals to open up conversations between parents about the choices they have (e.g. who to have in the birth room, or whether to have the father stay the night on the ward with the mother).
For fathers to receive invitations to appointments, parent education sessions, and classes.
Ideas that received moderate consensus overall
For it to be a formal requirement that health professionals directly check in with fathers on their coping and experiences
For services to make a clearer differentiation in parenting information between what's important to get right (e.g. making sure the water is the right temperature when washing the baby) and what's personal preference (e.g. bottle feeding or breast feeding)

Fathers strongly agreed on the idea for services to offer a 10-minute ‘dad alone’ slot. However, this reached low consensus among healthcare professionals, perhaps due to the time pressures and low resources that they are currently experiencing.

Conclusions: This research adds to the existing literature on fathers’ experiences during the perinatal period, and healthcare professionals’ experiences of working with fathers. Through collaboration and consensus-building between fathers and healthcare professionals, it has been possible to come to a shared understanding of the most important areas for attention agreed upon by these key stakeholders of perinatal services.

The findings highlighted the need for improved perinatal service involvement of fathers. Implications for practice include greater partnership working between perinatal and psychology services to inform clinical practice with including fathers, and supporting both parents with the relationship and psychological changes that can occur during the perinatal period, for example. The findings also draw attention to the need for wider organisational structures to provide healthcare professionals with the resources and support that they would need to implement the recommendations agreed upon by participants in this study. However, study limitations include a lack of participant diversity and potential for selection bias. Implications for further research are discussed.

A summary of the research findings has been disseminated to all participants who opted in to receive a summary. This research will be submitted to a relevant journal, which is yet to be decided. If you have any questions or would like to discuss the research, please contact me using the details provided below.

Yours sincerely,

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Appendix AB: End of study report for participants

Dear participant,

I would like to thank you for taking part in the research on fathers' and healthcare professionals' perceptions and experiences of paternal perinatal support and their views on improving services. Your interest and contribution to the study has been very much appreciated. Now that the study is complete, I am pleased to be able to provide you with a summary of the findings.

The aims of this research were to:

1) Gain an understanding of fathers' experiences during the perinatal period (from conception to first postnatal year), and support they received from healthcare professionals;
2) Understand healthcare professionals experience of working with, and understanding of, fathers;
3) Explore both groups' ideas for improving perinatal support and inclusion for fathers.

Overall, 27 fathers and 24 healthcare professionals (14 midwives, 10 health visitors) took part across the study's three stages (first-round focus groups followed by two online surveys). The findings are summarised below according to the research aims.

Research aims 1 & 2:

There was overwhelming agreement from both groups for all statements relating to the importance of fathers (e.g. for the physical and/or psychological wellbeing of mother and baby), and both groups agreed that more sharing of parental leave would benefit the whole family. Participants agreed that fathers can experience personal and relationship changes, and a complex mixture of emotions during the perinatal period, and strongly agreed on the importance for communication and compromise with their partner during this time. There was moderate consensus among participants that fathers can feel side-lined, and both groups agreed that services tend to be mother-centred. Despite some shortfalls of services, fathers agreed that they do feel understanding and accepting of health services. Additional statements responded to by healthcare professionals highlighted the under-staffed, under-resourced, time-pressured, and often stressful environments that they are working in. Healthcare professionals also agreed that they do not receive enough training on how to best include fathers.

Research aim 3:

Below are the ideas for service improvements that came up in the focus groups, and received the most amount of agreement among fathers and healthcare professionals in the online surveys

Ideas that received strong consensus overall
For antenatal classes to have more content on the father-mother relationship, raising awareness of the impact that having a baby can have on the relationship, how to nurture the parent relationship, and what can be helpful in managing conflict.
For health professionals to signpost fathers to a clear and reputable source of parenting information.
For services to provide more information and preparation regarding the psychological, emotional and relational aspects of parenthood.
For health professionals to involve fathers in communication with body language, direct questions, and prompts for them to speak.
For services to be family-centred rather than mother-centred or baby-centred
More father-specific preparation, information, and guidance from health professionals about the father experience and role during the perinatal period
For health professionals to be given more training on how to work with and involve fathers
For fathers to be better accommodated for staying overnight on the ward (e.g. having the option of staying overnight, having a mat to sleep on, a microwave to heat food, somewhere to wash).
For health professionals to encourage fathers to have skin-to-skin contact with their baby straight after the birth.
For health professionals to open up conversations between parents about the choices they have (e.g. who to have in the birth room, or whether to have the father stay the night on the ward with the mother).
For fathers to receive invitations to appointments, parent education sessions, and classes.
Ideas that received moderate consensus overall
For it to be a formal requirement that health professionals directly check in with fathers on their coping and experiences
For services to make a clearer differentiation in parenting information between what's important to get right (e.g. making sure the water is the right temperature when washing the baby) and what's personal preference (e.g. bottle feeding or breast feeding)

Fathers strongly agreed on the idea for services to offer a 10-minute 'dad alone' slot. However, this reached low consensus among healthcare professionals, perhaps due to the time pressures and low resources that they are currently experiencing.

Conclusions

This research adds to the existing literature on fathers' experiences during the perinatal period, and healthcare professionals' experiences of working with fathers. Through collaboration and consensus-building between fathers and healthcare professionals, it has been possible to come to a shared understanding of the most important areas for attention agreed upon by these key stakeholders of perinatal services.

The findings reflect a change in culture, whereby the importance of fathers and their involvement is widely acknowledged, yet there is still room for service development regarding the support provided to fathers in their transition to parenthood. The findings highlight how most healthcare professionals have stressful workloads within stretched services, and lack training or guidance on how best to involve fathers. This draws attention to the need for wider organisational structures to provide healthcare professionals with the resources and support that they would need to implement the recommendations agreed upon by participants in this study.

Further dissemination

As stated in the study information that you consented to before taking part, this research may be published in a journal, and your anonymous responses may be quoted to illustrate important points. If you would like to withdraw consent to this, or you would like to discuss this further, please contact me before July 2017.

Thank you very much for your participation in this study. Your contribution has been valuable. I hope that these findings will inform service changes that could improve fathers' experiences during the perinatal period in the future.

Kind regards,

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Appendix AC: BIRTH: Issues in Perinatal Care, Author Guidelines

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BIRTH ISSUES IN PERINATAL CARE

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Author Guidelines

Birth: Issues in Perinatal Care is an editorially independent, interdisciplinary journal published quarterly by Wiley Blackwell. *Birth* publishes original, peer-reviewed experimental research and review papers on clinical practice in the fields of perinatal medicine, perinatal nursing, maternal/newborn public health, and the social sciences.

Readers and subscribers of *Birth* are nurses in obstetrics, public health, and neonatology; midwives; physicians; childbirth educators; lactation counselors; doulas; psychologists; social scientists; epidemiologists; and other health workers and policymakers in perinatal care. Information on the Journal's aims and scope is available on the *Birth* website at wileyonlinelibrary.com/journal/birth.

Unlike the majority of obstetric and pediatric journals that have a heavy focus on the highest risk situations, the goal of *Birth* is to improve the birthing experience for the vast majority of women who are at low-risk for poor pregnancy outcomes. As such, we don't accept case reports or comparisons of drugs, products, or technologies. We accept articles about breastfeeding initiation, duration, and propensity, but not articles about the specific biochemical properties of breast milk, or those advocating formula feeding. Due to space constraints, we do not accept audits of maternity services or questionnaire validations.

Birth welcomes submission of original research articles, brief reports, and systematic reviews on current topics that address clinical and public health issues in perinatal care. A paper is considered for publication on the understanding that it has been submitted solely to *Birth* and is not being considered for publication elsewhere. A paper presented at a scientific meeting may be considered if it has not been published in full in a proceedings or similar publication. Authors have a responsibility to inform the Editor about potential conflicts of interest, and to send to the Editor any previous reports that might be regarded as prior or duplicate publications of the same data.

Types of Articles

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Manuscripts that report the results of original quantitative or qualitative public health research are published as original research articles. These articles generally are up to 3,500 words in length in the main text (exclusive of abstract and references), although articles up to 4,000 words in length may occasionally be permitted. The main text includes an Introduction, and separate sections for Methods, Results, and Discussion. These articles contain a structured abstract of up to 250 words, with Background, Methods, Results, and Discussion headings; up to 5 tables/figures; and no more than 50 references. Original research articles are the highest priority for *Birth* and the majority of papers published fall into this category.

Brief Reports
Preliminary or novel findings may be reported as brief reports (up to 1,500 words in the main text, an unstructured abstract of up to 150 words, and up to 2 tables/figures). The main text of briefs follows the standard format for original articles, with an Introduction and separate sections for the Methods, Results, and Discussion.

Systematic Reviews
Systematic Reviews are reviews of clearly formulated research questions that use systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the reviews. Metaanalysis (statistical techniques to integrate the results of included studies) may or may not be used to analyze and summarize the results. It is strongly recommended that authors follow the Preferred Reporting Items for Systematic Reviews and

MetaAnalyses (PRISMA) guidelines, available at: http://www.prisma-statement.org/ in the development of their reviews. Systematic reviews should not exceed 4,000 words.

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Commentaries are generally commissioned by members of the editorial team or, on occasion, reformatted as commentaries from other submitted papers. They are generally limited to 2,000 words or less.

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