PROFESSIONAL DOCTORATES

# The Influence of Community on Adjustment and Resilience in Childhood and Fatherhood

Barker, James

*Award date:*
2018

*Awarding institution:*
Bangor University

# The Influence of Community on Adjustment and Resilience in Childhood and Fatherhood

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This thesis is submitted in partial fulfilment of the regulations for the Doctorate in Clinical Psychology

August 2018

**Acknowledgements**

I would like to particularly thank the fathers who gave their time to take part in the research study. Your openness and honesty around sharing some of your most personal experiences with a commitment to make a difference for other fathers is admirable.

I would also like to extend my gratitude to the health visitors and community workers who supported fathers to take part and offered their facilities to enable the research interviews to take place. Your dedication to support and make a difference to the families and the local area is inspiring.

Thank you to Dr Liz Mear for our numerous fascinating conversations. I cannot thank you enough for your support throughout this process. Dr Elizabeth Burnside for helping me to focus my thoughts and develop my thesis in one of many areas which I find fascinating. And Dr Mike Jackson, for your research support and calming influence.

Finally, I would like to dedicate this thesis to my wife, Abi, and my three sons. Without your understanding and support, this thesis would not have been possible.

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**Thesis Summary**

This thesis focuses on the influence of community on adjustment and resilience during childhood and fatherhood.

A systematic literature review explored contextual sources of resilience outside of the family home for children and adolescents who have experienced adverse childhood experiences (ACEs). Thirty-four studies met the inclusion criteria and were narratively reviewed. Six protective factors were identified, including peer relationships, the school environment, relationships with adults, activity involvement, religiosity/spirituality and neighbourhood. Studies were critically reviewed in terms of their methodological quality, operationalisation of resilience and measurement of adverse childhood experiences. Areas for further research are outlined and recommendations made for the development of community-based interventions to support resilience in children and adolescents after ACEs.

A qualitative empirical study used interpretative phenomenological analysis to explore the psychological adjustment to fatherhood in a socioeconomically deprived community in Wales. The study utilised semi-structured interviews with nine fathers. Four superordinate themes offer an insight into the complex processes that fatherhood entails in terms of the adjustment to the new role, finding a position within the family unit, fathers roles in co-creating their children's childhood and futures, and the sources of influences on the father from family and society. Limitations and recommendations for future research are discussed. Clinical recommendations are made for tailored support in order to meet fathers' needs.

Finally, implications for theory and clinical practice arising from the systematic literature review and empirical study are discussed, along with personal reflections of the research process.

# Chapter 1:

# Systematic Review

**Community based sources of resilience for children and adolescents following adverse childhood experiences: A systematic narrative review**

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**Journal details**

Journal: Clinical Psychology Review

Publisher: Elsevier

Author Guidelines: https://www.journals.elsevier.com/clinical-psychology-review

**Abstract**

Adverse childhood experiences (ACEs) frequently occur and are associated with a range of negative outcomes across the life span. However, some individuals seem to live relatively well functioning lives despite ACEs, this is often referred to as resilience. The purpose of this systematic review is to identify contextual factors outside of the family home that promote resilience for children and adolescents with experience of physical, verbal and sexual abuse, physical and emotional neglect, and exposure to violence. Four databases were searched (PsycINFO, Web of Science, PubMed and CINAHL). Thirty-four studies met the inclusion criteria and were narratively reviewed. Methodological quality together with measurement and definitions of ACEs and resilience was assessed. Six categories of protective factors were linked to resilience including peer relationships, school environment, relationships with other adults, activity involvement, religiosity/spirituality and neighbourhood. This review highlights the need for further research, particularly using longitudinal designs to explore resilience across time and developmental periods, along with qualitative approaches to deepen understanding of individual processes and additional protective factors. Interventions should be developed and rigorously evaluated based on the protective factors identified within this review to support childhood resilience after ACEs within the community context.

**Keywords:**

Resilience, Protective, Community, Adverse Childhood Experiences, Child Maltreatment

**Highlights:**

- Community-based resilience factors after adverse childhood experiences are reviewed.
- Operationalisation of resilience and adverse childhood experiences is examined.
- Community-based interventions based on trauma informed models are recommended.
- Further research is required to replicate findings and build on current literature.

## Introduction

Adverse childhood experiences (ACEs) frequently occur across society, with recent prevalence estimates of experiencing one or more ACE at 50% in the UK (Hughes, Ford, Davis, Homolova & Bellis, 2018) and 46% in the USA (Sacks, Murphey & Moore, 2014). Defined as traumatic and/or stressful events, ACEs are generally agreed to include direct child maltreatment such as physical and verbal abuse, emotional and physical neglect, sexual abuse, along with a range of family factors including parental separation, exposure to domestic violence, parental mental illness, parental substance misuse and parental incarceration (Felitti et al, 1998). Previous studies show that ACEs frequently co-occur (Hughes et al 2018) with greater exposure related to increased negative outcomes and higher likelihood of individuals engaging in harmful behaviours through the life span (Anda et al, 2006; Bellis et al, 2017).

A range of negative outcomes have been identified across the life span for those who have experienced ACEs. These include increased risk of mental health difficulties (Hughes et al, 2018), suicidal behaviour (Dube et al, 2001), substance misuse (Dube et al, 2003), involvement with the criminal justice system (Reavis, Looman, Franco & Rojas, 2013) and poor academic and occupational achievement (Bellis, Lowey, Leckenby, Hughes and Harrison, 2014), along with an increased risk of physical health conditions and obesity (Springer, Sheridan, Kuo & Carnes, 2007). Significantly, four or more ACES have been associated with a significantly increased risk of premature mortality (Bellis et al, 2014).

Historically, research into ACEs has tended to focus on their maladaptive consequences however not all people with ACEs experience ongoing negative outcomes within their life course (Walsh, Dawson & Mattingly, 2010). In fact, some individuals continue to live well functioning lives despite ACEs (Domhardt, Münzer, Fegert & Goldbeck, 2015). This positive adaptation in the context of significant adversity is often referred to as *resilience* (Rutter, 2006;

Sciaraffa, Zeanah & Zeanah, 2018), however debate continues around the definition and assessment of this concept (Walsh et al, 2010).

Resilience is generally defined in the literature as the presence of a positive outcome and the absence of a negative outcome after experiencing some form of adversity (Marriot, Hamilton-Giachritsis & Harrop, 2014). More widely, resilience has been conceptualised as a dynamic and interactive process which occurs in three different ways. First as a relative resistance to the adverse effects of environmental risk experiences, second by means of overcoming stress or adversity and 'bouncing back' to baseline functioning, and third adapting positively in the context of adversity which may involve an element of positive growth (Cicchetti, 2013, Bensimon, 2012).

Within primary research, the concept of resilience has been operationalised using varying methods, often including one or more of the following conceptualisations: a lack of negative outcome (e.g. absence of psychopathology, or externalising and internalising behaviour), performance in the normal peer average range on domains of psychosocial functioning (e.g. educational, occupational or social function), self-reported subjective psychological wellbeing (Walsh et al, 2010; Haskett, Nears, Ward & McPherson, 2006) or as a separate trait (Hu, Zhang & Wang, 2015). Studies have attracted some criticism in terms of the lack of consensus in definition and the depth and breadth of measurement required to accurately capture resilience. Individuals classed as resilient due to normal functioning in one domain may not have developed resilience across all areas of life (Afifi & MacMillan, 2011), therefore demonstration of cross-domain competence is required (Walsh, et al, 2010). In addition, the World Health Organisation defines mental health as a state of wellbeing rather than the absence of psychopathology (WHO, 2014). Consequently, individuals may exhibit positive wellbeing with the presence of a mental health diagnosis or poor wellbeing with the

absence of a mental health diagnosis (Cheung et al, 2017). Psychological functioning should therefore be measured in greater depth than merely the absence of a psychiatric diagnosis or behaviour difficulties.

In an attempt to further understand the mechanisms of resilience and develop opportunities for intervention, researchers have focused on identifying protective factors that potentially inhibit the effect of risk and vulnerability factors and enable the person to develop a positive life trajectory (Perez-Gonzalez et al, 2017). It is generally accepted that protective factors occur at varying levels of the individual's context and can be specific to and vary across time, environments and the individuals' stage of development (Cicchetti, 2013). An ecological-transactional model has been employed as a conceptual framework to understand the protective factors relevant to resilience (Lynch & Cicchetti, 1998; Gartland, Bond, Olsson, Buzwell & Sawyer, 2011). This model suggests that both risk and protective factors occur within different levels of an individual's context, from wider society, to local communities, to the family and at the individual level (Cicchetti & Lynch, 1993).

Despite a wealth of recent studies, reviews exploring the protective factors associated with resilience following child maltreatment are limited. Published reviews have focused on subtypes of abuse i.e. childhood sexual abuse (Marriott et al, 2014; Domhardt, Munzer, Fegert & Goldbeck, 2015) or ACEs in general (Heller, Larrieu, D'Imperio & Boris, 1999; Haskett et al, 2006; Afifi & MacMillan, 2011; Ben-David & Jonson-Reid, 2017; Meng, Fleury, Xiang, Li & D'Arcy, 2018). These reviews have identified a range of protective factors which reduce the negative outcomes of ACEs, including abuse related factors such as disclosure, meaning making and coping, individual factors such as personality traits, supportive family relationships and some community factors such as school and peer support. Studies have explored factors related to children and young people's community and social contexts which may offer

resilience after ACES, however no review has set out to directly explore the mechanisms of resilience within these contexts. This has substantial clinical and public health significance, if protective factors present during childhood and adolescence within community and societal contexts can be identified, these can be capitalised upon in targeted community interventions to enhance the resilience and life trajectory of individuals who experience ACEs.

### *Aim of the review*

This review has two aims. First to identify contextual factors outside of the family home which build resilience in children and young people after adverse childhood experiences and can be targeted by community and public health services for intervention. Second, to explore the quality of current research and identify gaps in the literature to inform the needs for further research with a focus on the operationalisation of resilience and measurement of ACEs. The review will focus on direct forms of child maltreatment, including physical, verbal and sexual abuse, physical and emotional neglect, and exposure to domestic violence as directly harmful risk factors to children and young people's future outcomes.

## Method

### *Eligibility Criteria*

Studies included were English language with participants reporting one or more incidences of physical, emotional or sexual abuse, emotional or physical neglect and/or exposure to domestic abuse before the age of 18 years of age. Studies were excluded if they did not report factors of resilience outside of the home or if these factors were not experienced before 18 years of age. Adult samples were included if they measured factors of resilience in childhood and adolescence. Both quantitative and qualitative studies were included. Commentaries, editorials, dissertations, case reports and books were excluded from the review.

### *Search*

To systematically identify relevant published peer-reviewed studies for narrative review, four electronic databases (PsycINFO, Web of Science, PubMed and CINAHL) were searched by the lead author in March 2018. Specific search terms relating to childhood (c*hild OR childhood OR adolescen* OR teenage*),* resilience (*resilience OR resilient OR invulnerability OR hardiness OR protective factors OR positive outcomes*) and types of childhood abuse (*adverse childhood experience OR ACE OR maltreatment OR physical abuse OR sexual abuse OR verbal abuse OR neglect OR exposure domestic violence, OR exposure family violence OR exposure household violence*) were entered. No restrictions were set on date, age of participants or methodology used. Reference lists of studies selected for review were then searched to identify any further relevant articles.

### *Data Extraction and Synthesis*

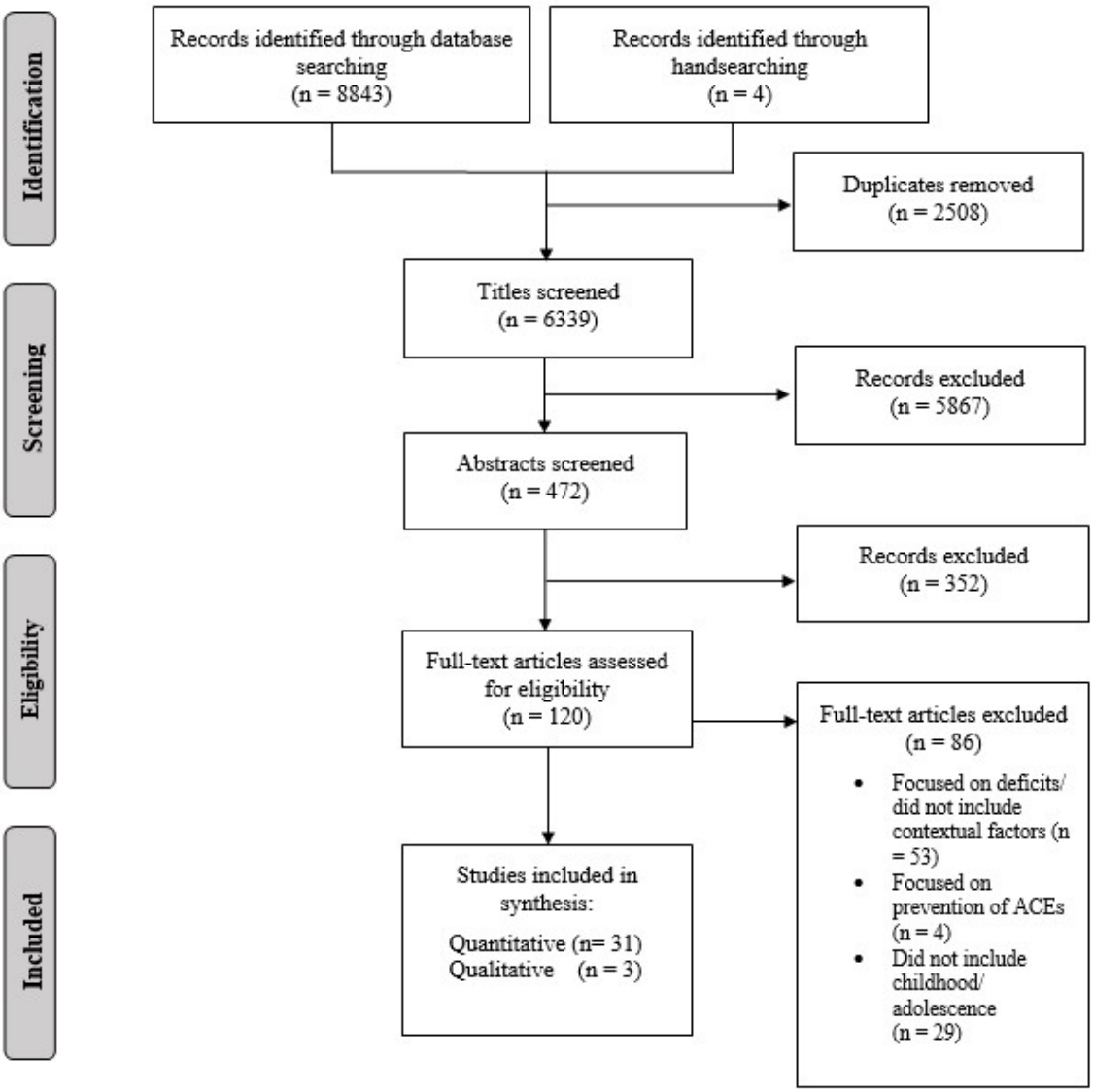
A range of data was systematically extracted by the first author including publication year, country, study design, sample characteristics, ACE subtypes, measurement of ACEs, definition of and measurement of resilience along with external protective factors and key findings (Tables 1-6).

To enable a broad but critical review of the current literature a structured narrative approach to data synthesis was taken (Hong, Pluye, Bujold & Wassef, 2017). This enabled the inclusion of both qualitative and quantitative studies using a variety of samples, methods and outcome measurement. Subsequently, as the review included a heterogenous range of studies, this precluded the use of a structured tool to assess quality (Sanderson, Tatt & Higgins, 2007). Instead quality was appraised by the first author as data was extracted with a focus on design, methodology, sampling, analysis and bias.

## Results

Selection followed the Preferred Reporting for Systematic Reviews and Meta-Analyses guidance (PRISMA; Moher, Liberati, Tetlzaff & Altman, 2009). After the removal of duplicate articles, 6339 titles and 472 abstracts were then screened, 120 articles were read in full and assessed for eligibility (Figure 1). Thirty-four relevant articles were identified, consisting of 30 quantitative, 3 qualitative and 1 mixed method studies.

Figure 1: PRISMA 2009 Flow Diagram for Systematic Search



This section initially comments on the methodological quality of the studies with a focus on the definition and measurement of resilience and ACEs. It then moves on to identify and explore protective factors related to the community and society around children and adolescents with direct forms of ACEs, presenting key information in tabular form with a critical summary of the strength of the evidence for each factor.

### *Quality appraisal*

Study characteristics are outlined in tables 1-6. To capture the varying nature of resilience over time a longitudinal approach is considered the most appropriate methodology (Cicchetti, 2013), however the majority of studies are cross sectional focusing on current outcomes with only nine studies utilising longitudinal designs. Within cross sectional designs the direction of causality is often unclear. For example, resilient children may be better at making friendships, friendships may support resilience in children, or both. Studies tend to focus on the adolescent period (18 studies), infant, early and middle childhood samples are rare (4 studies), although potentially difficult to access due to the close connection between young children and their family unit. Three studies used samples across the span of childhood. Nine studies utilised an adult population with retrospective childhood measures of ACEs and protective factors, which may be susceptible to a positive reporting bias, affecting the validity of protective factors identified. Qualitative studies are essential to bringing a sense of depth to the quantitative studies identified in the review. However, there were no qualitative studies with children or adolescents, only three studies are included in the review and these utilise adult participants reflecting on their childhood. Again, this may present bias as participants were reporting through an adult lens which may detract from what was important at the time for their childhood self. The emphasis on quantitative designs risks research only exploring variables identified by researchers rather than being informed by survivors.

The majority of studies used data from large surveys, although this strengthened their designs by using large representative samples, these studies were often weak on their measurement of ACEs, resilience and protective factors, often relying on single survey questions rather than robust empirically supported measures with added depth and breadth to variable measurement. Sample sizes ranged from 65 to 131,862 for quantitative studies and between 12 and 19 participants for qualitative studies. In terms of reliability and validity all three qualitative studies used participant verification and only two studies used cross validation with researchers.

The review includes a wide range of geographically disparate studies, although the majority comprise of American participants (25 studies), four from the UK, two from Canada, two from Spain, and one from New Zealand. This highlights the need for further studies in countries other than America. However, it is possible that studies are published in a different language and therefore were not identified by this review.

*Definition and measurement of resilience*

Quantitative studies conceptualised resilience in a range of ways, most frequently as the absence of psychopathology or internalising/externalising behaviour (23 studies), the majority using formal questionnaires (i.e. Child Behaviour Checklist, Achenback, Thomas & Edelbrock, 1991) or diagnostic criteria, however some studies relied on non-validated survey questions. Other studies measured functioning within psychosocial domains, with only seven studies measuring two or more domains, however these often relied on binary questions limiting validity. Another approach employed was the use of psychometric measures of resilience as a concept (i.e. Adolescent Resilience Questionnaire, Gartland, Bond, Olsson, Buzwell & Sawyer, 2011), which tend to aggregate scores related to individual, family, peer, school and community factors (3 studies).

*Definition and measurement of ACEs*

ACEs were measured in varying ways with many studies relying on single questions from previous survey data or interviews (12 studies) which lack depth and validity. Other studies used more empirically supported measures such as scales rated by the child or parent (13 studies). Self-report methods are subjective and may lack validity due to fears of disclosing being a perpetrator or victim of abuse, particularly in parents. Other studies have attempted to use a more objective approach by searching child protection records (5 studies).

Most studies explored samples with multiple ACEs (21 studies), often aggregating the subtypes within their analyses, this limited the exploration of outcomes and protective factors for different types of ACEs. Further, there is a lack of investigation into the factors surrounding ACEs such as timing, frequency, severity, and relationship to abuser. Research has yet to explore the relationship between these factors and resiliency in depth.

***Community and Societal Factors Promoting Resilience***

A range of factors related to the wider social and community environment of the individual (Lynch & Cicchetti, 1998) were found within the selected articles and clustered into six categories: peers, school, relationships with other adults, activity involvement, religiosity/spirituality and neighbourhood. Some studies address multiple protective factors and subsequently appear in multiple tables.

**Peers.** Fifteen studies examined the protective effect of friendships on a range of outcomes following ACEs, including five longitudinal studies (Table 1).

**Table 1.** Peers - Summary of study characteristics

| Author, year, country | Design and sample demographics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Moses and Villodas (2017) USA** | **Longitudinal**<br>831, 10-16, 47.4% male<br>Outcomes and protective factors measured cross-sectionally at 16 years old. | Peer relationship quality (companionship, satisfaction, intimacy and conflict) (Networks of Relationship Inventory, Furman & Buhrmester, 1985) | **Multiple -** Parent report – measured biannually throughout childhood | Self-report survey questions - Prosocial activity engagement, school engagement – grade completion, dropout contemplation, perceived school importance | High intimacy with peers predicted increased prosocial activity engagement, peer companionship predicted increased perceptions of school importance only when peer conflict was low, low levels of peer conflict was protective against school dropout. |
| **Dion et al (2016) Canada** | **Longitudinal**<br>605, 14-18, 55.6% female<br>Outcomes measured at 16,18, 24years protective factors at 14 years. | Self-rated friend support (adapted from Bellerose et al, 2002) | **Multiple -** Self-report survey question | Self-report psychological distress Psychological Distress Index (Deschesnes, 1998) | Perceived greater friend support predicted less psychological distress at 16, 18 and 24 years old. |
| **Schultz et al (2009) USA** | **Longitudinal**<br>5504, 0-14, 47.28% female<br>Outcomes measured 36 months after protective factors | Caregiver-rated: social competence (Social Skills Rating System, Gresham & Elliott, 1990), adaptive functioning (Vineland Adaptive Behaviour Screener, Sparrow, Carter & Cicchetti, 1993), self-rated satisfaction in peer relationships (Loneliness&Social Dissatisfaction Questionnaire; Asher & Wheeler, 1985) | **Multiple -** Child protection data | Child Behaviour Checklist (Caregiver rated) Reading competence - Mini-Battery of Achievement | Social competence, adaptive functioning skills and satisfaction in peer relationships predicted normal levels of externalising behaviour, social competence predicted normal levels of internalising behaviour. |
| **Collishaw et al (2007) UK** | **Longitudinal**<br>364, 42-46, Not reported<br>Protective factors measured in adolescence, outcome measures between ages 42-46 years. | Peer relationships judged by researchers as normal or abnormal based on peer and parental accounts in adolescence. | **CSA, PA -** Retrospective self-report at 42-46 years old-Childhood Experience of Care & Abuse Interview (Bifulco, Brown & Harris, 1994) | Current presence of psychiatric disorder - Schedule for Affective Disorders and Schizophrenia (Harrington et al, 1988). | Peer relationships in adolescence predicted less psychopathology in adulthood. |

**Table 1.** Cont.

| Author, year, country | Design and sample demographics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Criss et al (2002) USA** | **Longitudinal**<br>517, 5-8, 52% male<br>Protective factors measured at kindergarten and grade 1, outcome at grade 2. | Peer-rated acceptance and number of friends at kindergarten and grade 1. | **Multiple -** Parent-report questionnaire Violent marital conflict– Conflict Tactics Scale (Straus, 1979). Interviewer rated - Harsh discipline. | Child Behaviour Checklist (Teacher rated) at grade 2. | High peer acceptance predicted reduced externalising behaviour. Number of friends only predicted less externalising behaviour in children who had experienced physical abuse. |
| **Perez-Gonzalez et al (2017) Spain** | Cross-sectional<br>1105, 12-17, 590 male | Self-report - availability to peers and connectedness to peers(Adolescent Resilience Questionnaire, Gartland et al,2011) | **SA -** Self-report– Juvenile Victimisation Questionnaire (Finkelhor, Hamby, Ormrod & Turner, 2005) | Youth Self Report (Achenbach & Rescorla, 2001) | Availability to peers associated with fewer internalising behaviour difficulties. Connectedness to peers associated with increased externalising behaviour. |
| **Cheung et al (2017) USA** | Cross-sectional<br>10148, 13-17, Not reported | Self-rated supportive friendships, two questions. | **Multiple -** Self-report– Conflict Tactics Scale (Straus et al, 1998) | Past and present mental disorder -DSM diagnostic criteria.Self-report -Past & present suicidal ideation & perceived mental health | Feeling able to open up to friends to talk about worries associated with reduced mental health difficulties and suicidal ideation, no association for reliance on support from friends. |
| **Segura et al (2017) Spain** | Cross-sectional<br>127, 12-17, 53.7% female | Self-rated peer connectedness and availability (Garland et al, 2006) | **Multiple -** Self-report – Juvenile Victimisation Questionnaire (Finkelhor et al, 2005) | Youth Self Report – (Achenbach & Rescorla, 2001) | Greater peer support associated with fewer internalising but not externalising symptoms. Higher ACEs - greater peer support predicted increased externalising symptoms. |
| **Williams & Nelson-Gardell (2012) USA** | Cross-sectional<br>237, 11-16, 80% female | Peer relationships – Loneliness and Social Dissatisfaction Questionnaire for Young Children (Asher, Hymel & Renshaw, 1981) | **SA -** Case worker report | Child Behaviour Checklist (Rater not reported) | Peer relationships not predictive of internalising and externalising problems. |
| **Edmond et al (2006) USA** | Cross-sectional<br>351, 15-18, 54% female | Self-report- positive and negative peer behaviour, peer substance use (based on Stiffman, Dore, Cunningham and Earls, 1995 and Baker et al, 1993) | **SA -** Self-report survey questions | Youth Self Report (Achenbach & Rescorla, 2001) | Those without current mental health difficulties more likely to have prosocial peers – in terms of antisocial behaviour and substance use. |

**Table 1.** Cont.

| Author, year, country | Design and sample demographics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Perkins and Jones (2004) USA** | Cross-sectional<br><br>16313, 12-17, 53.3% female | Peer group characteristics – 5 items related to frequency of alcohol use, substance use, getting into trouble at school, doing well at school and helping others. | **PA -** Self-report survey question | Single self-report question - frequency of suicide attempts Self-report - Substance use, sexual activity, antisocial behaviour, success in school and helping others | Prosocial peer group characteristics negatively associated with alcohol, tobacco and substance misuse, sexual activity, antisocial behaviour and suicide. |
| **Feiring et al (1997) USA** | Cross-sectional<br><br>154, 8-15, 63 female | Social support – number of people and satisfaction – My family and Friends Interview (Reid & Landesman, 1988) | **SA -** Child protection data | Depressive symptoms – Child Depression Inventory (Kovacs, 1983), PTSD, Social Reactions, Abuse Attributions, Eroticism - The Children's Impact of Traumatic Events Scale – Revised (Wolfe et al, 1991), Self-esteem - The Self-Perception Profile for Adolescents (Harter, 1985) | No effect of friendships on behavioural outcomes, less support from friends was related to higher self-esteem. |
| **Chandy et al (1996b) USA** | Cross-sectional<br><br>1959, 12-17, 49.4% male | Feeling able to discuss problems with friends | **SA -** Self-report – The Adolescent Health Survey | Self-report survey - Body image, suicide risk, substance misuse, school performance | Able to discuss problems with friends, along with a perceived helpfulness increased likelihood of normal functioning in all variables |
| **Anderson & Danis (2006) USA** | Qualitative - Grounded theory<br>12 females | - | **PA, EA -** Not reported | - | External connections with peers as positive coping strategy. |
| **Gonzales, et al (2012) USA** | Qualitative - Grounded theory<br><br>12 men | - | **Exposure to parental violence** - Initial screen and interview disclosure | - | Quality time with peers in childhood as positive coping strategy. |

Overall, studies suggest that the quality of emotional connection between friends, such as high intimacy, feeling accepted, satisfied and able to open up to discuss their problems (Chandy, Blum & Resnick, 1996b; Cheung et al, 2017; Moses and Villodas, 2017) is a key

mechanism for enhancing resilience, rather than the quantity or availability of friends (Segura, Pereda, Guilera & Hamby, 2017; Cheung et al, 2017). In addition, associating with prosocial peers is associated with positive outcomes such as reduced substance misuse and antisocial behaviour, sexual activity and suicidality (Perkins and Jones, 2004; Edmond, Auslander, Elze & Bowland, 2006). Longitudinal studies report a protective effect on mental health continuing into early (Dion et al, 2016) and mid adulthood (Collishaw et al, 2007).

Protective effects of peer relationships on externalising behaviour have been demonstrated in longitudinal studies in childhood and adolescence (Criss, Pettit, Bates, Dodge & Lapp, 2002; Schultz, Tharp-Taylor, Haviland & Jaycox, 2009). However, Perez-Gonzalez et al (2017) found peer support can have a detrimental effect on externalising behaviour in adolescence. One potential explanation is the negative influence of some peers that adolescents may connect with. Two studies found no effect of friendships on behavioural outcomes (Feiring, Taska & Lewis, 1997; Williams & Nelson-Gardell, 2012), in fact Feiring et al (1997) found that less support from friends was related to higher self-esteem.

Studies are limited by their lack of robust measurement of friendship and outcomes, often using single self-report questions rather than empirically supported measures or objective observation. Further research is required to explore the mechanisms of peer relationships, particularly the characteristics of relationships engaged in at different ages, ideally across childhood using longitudinal designs measuring a range of domains of functioning.

**School.** Eleven cross-sectional studies have related factors within the school environment with positive outcomes, there are no longitudinal studies (Table 2).

**Table 2.** School - Summary of study characteristics

| Author, year, country | Design and sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Perez-Gonzalez et al (2017) Spain** | Cross-sectional<br>1105<br>12-17<br>590 male | Self-report connectedness and supportive environment at school – Adolescent Resilience Questionnaire (Gartland et al, 2011) | **SA -** Self-report questionnaire – Juvenile Victimisation Questionnaire (Finkelhor, Hamby, Ormrod & Turner, 2005) | Youth Self Report (Achenbach & Rescorla, 2001) | Feeling a connection to school but not support from teachers associated with reduced externalising but not internalising behaviour |
| **Cheung et al (2017) USA** | Cross-sectional<br>10148<br>13-17<br>Not reported | Self-report - fair treatment from teachers, caring what teachers thought about them, liking school, importance of good grades, liking teachers, school effort. | **Multiple -** Self-report questionnaire – Conflict Tactics Scale (Straus et al, 1998) | Past and present mental disorder using DSM diagnostic criteria.<br>Past and present suicidal ideation<br>Perceived mental health. Aggregated to classify mental health. | Fair treatment from most teachers, caring a lot about what teachers think of them and liking their teacher associated with increased likelihood of 'good mental health' |
| **Moore & Ramirez (2015) USA** | Cross-sectional<br>34152<br>12-17<br>Not reported | School engagement – measurement not reported | **Multiple -** Parent-report questionnaire | Brief 5-point scale self-rated questions related to- health status, calm and controlled behaviour, task completion, school engagement, interest and curiosity, and internalizing | School engagement in terms of caring about school work mediated the relationship between ACEs and overall child wellbeing. |
| **Williams & Nelson-Gardell (2012) USA** | Cross-sectional<br>237<br>11-16<br>80% female | Disposition towards school - Drug Free Schools outcome study questions (Drug Free Schools and Community Act,1986) | **SA -** Case worker report | Child Behaviour Checklist (Rater not reported)- | Positive disposition towards school and learning associated with decreased behavioural difficulties and psychological distress. |
| **Eisenberg et al (2007) USA** | Cross-sectional<br>131862,<br>11-17,<br>66,584 female | Self-report - Feeling safe on the journey to school and in the bathrooms. | **SA -** Self-report survey question | Suicidal attempts and ideation - two self-rated questions | Perception of school as a safe environment related to reduced suicidal behaviour. |
| **Edmond et al (2006) USA** | Cross-sectional<br>351<br>15-18<br>54% female | School status, stability, problems and plans -self-rated questionnaire from Slonim-Nevo,Auslander & Ozawa(1995) | **SA -** Self-report survey questions | Normal scores on Youth Self Report (Achenbach & Rescorla, 2001) | Greater certainty of educational and future plans negatively associated with psychopathology and internalising and externalising behaviour. |

**Table 2.** Cont.

| Author, year, country | Design and sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Perkins and Jones (2004) USA** | Cross-sectional 16313 12-17 53.3% female | Self- rated - School climate – teacher caring, teacher attention, encouragement at school and liking school. | **PA -** Self-report survey question | Single question-frequency of suicide attempts. Self-report questions - substance use, sexual activity, antisocial behaviour, success in school and helping others | Positive school climate provided by teachers negatively associated with alcohol, substance or tobacco use, sexual activity, antisocial behaviour and suicide attempts. |
| **McKnight & Loper (2002) USA** | Cross-sectional 2850 10-19 All female | School fairness and acceptance, attitudes concerning future college attendance. Self-rated 5 questions. | **SA -** Self-report survey question | Presence of 15 delinquent behaviours – not all specified | Perceiving teachers as fair associated with reduced self-reported delinquency, no association for future college attendance. |
| **Perkins et al (2002) USA** | Cross-sectional 25463 12-18 46.7% female | School climate – Self-rated – teacher caring, teacherattention, encouragement at school and liking school. | **PA -** Self-report survey question | Self-reported - Purging (one question from Attitude and Behaviour Questionnaire) | Having positive experiences at school associated with reduced purging behaviour. |
| **Pharris, Renick & Blum (1997) USA** | Cross-sectional 13923 12-17 50.7% female | Positive feelings about school – Modified Adolescent Health Questionnaire | **SA -** Self-report survey question | Self-reported hopelessness and suicidal ideation - single questions | Positive feelings about school associated with reduced hopelessness, suicidal ideation and suicide attempts in females, only suicide attempts in males. |
| **Romans et al (1995) New Zealand** | Cross-sectional/ mixed methods 138 Adults All female | Retrospective enjoyment of high school – interview. | **SA -** Self-report questionnaire – no details | Current (adulthood) and past psychiatric disorder – Present State Examination (Wing et al, 1974) Level of self-esteem - Self-esteem scale (Robson, 1988) | Positive mediating effect of enjoyment of high school on adult psychopathology and self-esteem. |

Positive relationships with teachers characterised by fairness, care and encouragement are supported by five cross-sectional studies to be negatively associated with delinquency after childhood sexual abuse (CSA) and physical abuse (McKnight & Loper, 2002; Perkins & Jones, 2004), suicidal ideation and attempts after CSA and physical abuse (Eisenberg, Ackard & Resnick, 2007; Perkins & Jones, 2004), and purging behaviour after physical abuse (Perkins, Luster & Jank, 2002). Three studies related a perceived positive connection with school with a

range of positive outcomes for adolescents with CSA including, reduced self-reported hopelessness, suicidal ideation and suicide attempts in females but only suicide attempts in males (Pharris, Resnick & Blum, 1997), reduced current psychopathology and increased self-esteem in adult females when school was retrospectively rated as positive (Romans, Martin, Anderson, O'Shea & Mullen, 1995) and decreased behavioural difficulties and psychological distress (Williams & Nelson-Gardell, 2012). Moreover, perception of school as a safe environment was related to reduced self-reported suicidal behaviour (Eisenberg et al, 2007). These studies only explored children with experience of CSA, generalisability to other ACE subtypes is unclear and requires further investigation.

Moreover, four studies have related academic achievement and focus on education with reduced mental health difficulties (Pharris et al, 1997; Edmond et al, 2006; Moore & Ramirez, 2015; Cheung et al, 2017). Perez-Gonzalez et al (2017) reported that commitment and connection to school predicted reduced self-reported externalising but not internalising behaviour in Spanish adolescents with history of CSA, no effect was found for support from teachers. It may be that children who are committed to school have an internal locus of control and self-motivation to manage their behaviour or are less likely to report externalising behaviour.

These studies consistently associated positive teacher-pupil relationships, connection with school and focus on education with improved functioning. However, methodological challenges weaken their findings, such as relying parent report which may present a self-serving bias (Moore and Ramirez, 2015), poor measurement of outcome relying on single questions (e.g. Pharris et al, 1997, Eisenberg et al, 2007) and aggregation of outcome variables preventing understanding of associations between different factors (Moore and Ramirez, 2015; Cheung et al, 2017). These require addressing in further research. In addition, all studies focus

solely on adolescence, the protective impact of the school environment in younger children requires investigation. Further, all studies are cross sectional, it is not clear whether resilient children are more likely to report these protective factors or whether they have a direct influence on developing resilience. To address this, longitudinal research including control groups is required across the span of childhood.

**Relationships with other adults.** Seven studies explore the protective effect of relationships with other adults, there are no longitudinal studies (Table 3).

**Table 3.** Relationships with other adults- Summary of study characteristics

| Author, year, country | Design and sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Hughes et al (2018) UK** | Cross-sectional<br><br>2497, 18-69, 45.3% male | Trusted childhood relationships with adults retrospectively rated. | **Multiple -** Self-report questionnaire - Centers for Disease Control and Prevention & World Health Organization's Short Child Maltreatment Questionnaire (Meinck et al, 2016). | Lifetime and current mental health problems, suicide and self-harm – single self-report survey questions | Trusted adult relationship in childhood associated with reduced current mental health difficulties regardless of number of ACEs experienced but not lifetime psychopathology, suicidal ideation or self-harm. |
| **Bellis et al (2017) UK** | Cross-sectional<br><br>7047, 18-69, 54.1% female | Trusted childhood relationships with adults retrospectively rated. | **Multiple -** Self-report questionnaire - ACE questions from the Centers for Disease Control and Prevention short ACE tool | Current adult self-report - Wellbeing – Short Warwick Edinburgh Mental Wellbeing Scale Current adult self-report - Presence of health harming behaviours – poor diet, daily smoking and alcohol use | Having a trusted adult relationship in childhood associated with reduced health harming behaviours including smoking, poor diet and heavy drinking in adulthood. |
| **Brown & Shillington (2017) USA** | Cross-sectional<br><br>1054, 11-17, 55.3% female | Protective adult relationships – 5 items from resilience scale as part of LONGSCAN study | **Multiple -** Multiple reporting sources – questionnaire (Felliti et al, 1998) | Substance use – Self-report -Youth Risk Behavior Survey Delinquency – Self-report -Denver Youth Survey - Modified | Trusted adult relationship in childhood associated with reduced substance misuse but not delinquency. |

**Table 3.** Cont.

| Author, year, country | Design and sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Flores et al (2005) USA** | Cross-sectional<br><br>133, 8.68 mean, 69.2% male | Student-Teacher Relationship Scale (Pianta & Steinberg, 1992) – quality of relationship from counsellors' perspective. | **Multiple -** Child protection data | Child Behaviour Checklist (rated by camp counsellor) | Forming a positive relationship with head counsellor related to greater social competence and reduced behavioural symptomology. Children with ACEs struggled to form and maintain relationships, rated as less warm & less open communication. |
| **Perkins and Jones (2004) USA** | Cross-sectional<br><br>16313, 12-17, 53.3% female | Self-report – two items from Attitude and Behaviour Questionnaire (Benson, 1990) | **PA -** Self-report survey question | Self-report question - frequency of suicide attempts<br>Self-report questions related to -Substance use, sexual activity, antisocial behaviour, school success & helping others | Adult support related to increased alcohol, tobacco and substance use, sexual activity, suicidal ideation and attempts, and poor school performance, but positively related to helping others. |
| **Perkins et al (2002) USA**<br>25463, 12-18, 46.7% female | Cross-sectional | Self-report – (Attitude and Behaviour Questionnaire, Benson, 1990) - number of 'good conversations' with adult in last month, no. of adults available for support. | **PA -** Self-report survey question | Single self-report question measuring purging behaviour. | Support from other adults associated with increased purging behaviour. |
| **Pharris, Resnick & Blum (1997) USA** | Cross-sectional<br><br>13923, 12-17, 50.7% female | Perceived care from tribal leader - questions not reported. (Adolescent Health Questionnaire) | **SA -** Self-report survey question | Self-reported hopelessness and suicidal ideation - single questions | Perceived care from a tribal leader associated with reduced hopelessness in females and suicidal ideation in both sexes, no effect found for suicide attempts in either sex. |
| **Anderson & Danis (2006) USA** | Qualitative Grounded theory<br>12 females | - | **PA & EA -** Not reported | - | Participants discussed developing support systems around them which included teachers and coaches |

Trusted adult relationships in childhood are associated with a range of positive outcomes across the lifespan, including reduced suicidal ideation, behavioural difficulties and

substance use in childhood (Brown & Shillington, 2017; Flores, Cicchetti & Rogosch, 2005; Pharris et al, 2007) and reduced psychopathology, suicidal behaviour, health harming behaviour in adulthood (Bellis et al, 2017; Hughes et al, 2018). The studies exploring outcome in adulthood use large representative samples which strengthens their generalisability, however they are limited by their cross-sectional designs and use of short retrospective survey questions. Although a protective link is demonstrated across the studies, it is not clear whether resilient children are more able to access adult relationships or whether adult relationships build resilience. In addition, participants without mental health difficulties may present a positive bias when retrospectively reporting childhood relationships.

This protective link is not straight forward, two studies have identified relationships with adults other than parents to be deleterious in adolescents with history of physical abuse, increasing alcohol, tobacco and substance use, sexual activity, suicidal ideation and attempts, and poor school performance (Perkins & Jones, 2004) and purging behaviour (Perkins et al, 2002). In both studies, measurement of adult support was limited to the number of good conversations with an adult in the last month and the number of adults available for support, this may not fully capture the relational connection. In addition, it is not certain whether this negative link applies to other ACE types other than physical abuse. Flores et al (2005) found children with ACEs struggled to form and maintain relationships with peers and counsellors. Due to relational trauma, children and adolescents may have difficulties within relationships with adults, furthermore, not all adult relationships are positive and adolescents may be susceptible to relationships which encourage harming behaviours.

Further research is required to explore the mechanisms and effects of differing types of adult relationships in respect to different ACE subtypes. Hughes et al's (2018) participants identified neighbours, friends and professionals (including teachers, sports coaches, police,

health professionals and religious leaders) as positive relationships, in addition those with higher ACE counts were less likely to report support. This is a starting point for future research to begin to explore the effect of these relationships on building children's resilience. The current evidence relies on cross-sectional research, as described in previous sections longitudinal research is required to explore the direction and effects of adult relationships over the course of childhood and into adulthood.

**Activity Involvement.** Nine studies have related activity involvement with resilience, including one longitudinal study (Table 4).

**Table 4.** Activity involvement- Summary of study characteristics

| Author, year, country | Design and sample demographics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main Findings |
|---|---|---|---|---|---|
| **Leon et al (2008) USA** | **Longitudinal**<br>142<br>10.4-17.9<br>27% female<br>Outcomes measured at two time points (Mean 1.5 years apart) | Foster parent rated – binary question "Is your youth involved in clubs?" | **Multiple -** Self-report (Conflicts Tactics Scale, Sexual Abuse Scale of Youth Self Report) | Negative affect, sexually ruminative thoughts, non-sexual rumination - Trauma Symptoms Checklist (Briere, 1996) | Involvement in clubs was protective against self-reported sexually ruminative thoughts, only for low severity of CSA, effect diminished with increased exposure to CSA |
| **Hughes et al (2018) UK** | Cross-sectional<br>2497<br>18-69<br>45.3% male | Retrospective rating of childhood involvement in clubs. | **Multiple -** Self-report (Centers for Disease Control and Prevention and World Health Organization's Short Child Maltreatment Questionnaire, Meinck et al, 2016). | Lifetime and current mental health problems, suicide and self-harm – single self-report survey questions | Compared those who did and did not report regular childhood sports participation, observing a decrease in current mental health problems in adulthood (defined as depression, anxiety or other) from 25% to 19% in those who engaged in sport. |
| **Afifi et al (2016) Canada** | Cross-sectional<br>23395<br>15 plus<br>Not reported | Self-report-binary question asking whether they had engaged in moderate to vigorous physical activity in the past 7 days. | **Multiple -** Self-report (Childhood Experiences of Violence Questionnaire) | Wellbeing (Mental Health Continuum – Short Form), Presence of mental condition (CIDI) Suicidal ideation | Involvement in moderate to vigorous levels of physical activity associated with improved mental health in adolescents with and without ACEs. |

**Table 4.** Cont.

| Author, year, country | Design and sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Moore & Ramirez (2015) USA** | Cross-sectional<br><br>34152<br>12-17<br>Not reported | Average participation across sports clubs and other organisations | **Multiple** - Parent-report questionnaire | Self-report questions - health status, controlled behaviour, task completion, school engagement, interest & curiosity, and internalizing | Participation in extra-curricular activities had no effect on measures of child wellbeing. |
| **Perkins and Jones (2004) USA** | Cross-sectional<br><br>16313<br>12-17<br>53.3% female | Activity involvement - self-reported average weekly hours spent in music tuition, clubs within and outside of school and sports teams | **PA -** Self-report survey question | Self-report questions - frequency of suicide attempts, substance use, sexual activity, antisocial behaviour, success in school and helping others | Activity engagement associated with reduced tobacco use, increased high grades and helping of others, no effect on alcohol and substance misuse, positively associated with antisocial behaviour. |
| **Pharris, Renick & Blum (1997) USA** | Cross-sectional<br><br>13923<br>12-17<br>50.7% female | Involvement in traditional activities – (Adolescent Health Questionnaire) | **SA -** Self-report survey question | Self-reported hopelessness and suicidal ideation - single questions | Traditional activities reduced suicide attempts in males, no effect on suicidal ideation or hopelessness. |
| **Romans et al (1995) New Zealand** | Cross-sectional/ mixed methods<br><br>138<br>Adults<br>All female | Retrospective self-assessment as good at sport in adolescence - interview | **SA -** Self-report questionnaire – no details | Current (adulthood) and past psychiatric disorder (Present State Examination; Wing et al, 1974)<br>Self-esteem (Self-esteem scale, Robson,1988,1989) | Self-assessment as good at sport in adolescence positively mediated the development of current adult psychiatric disorders and self-esteem. |
| **Gonzales et al (2012) USA** | Qualitative - Grounded theory<br><br>12<br>All men | - | **Exposure to parental violence**<br>Screen and disclosure in interview | - | Cinema, burying self in video games, afterschool activities, personal hobbies, sports culture helped children cope. |
| **Meyers (2016) USA** | Qualitative - Hermeneutic phenomeno-logical analysis 19, 16 female | - | **Sibling abuse**<br><br>Telephone interview | - | Creative outlets such as music and theatre provided an escape from everyday life, emotional release and a sense of community |

Studies exploring the link between activity involvement and resilience are limited with inconsistent findings. Some positive associations have been identified however studies are limited by methodological flaws. One longitudinal study found club involvement predicted reduced sexually ruminative thoughts approximately 1.5 years later, this effect diminished as

severity of CSA increased (Leon, Ransdale, Miller & Spacarelli, 2008). However, club involvement was poorly operationalised using a single caregiver-rated binary variable and variables were only measured over a short time period. Two cross sectional studies demonstrate a link between activity involvement and resilience, including traditional activities reducing suicide attempts in male adolescents with history of CSA but not suicidal ideation or hopelessness in either sex (Pharris et al, 1997). Similarly, weekly hours of activity predicted reduced tobacco use and increased likelihood of high grades and helping of others, had no effect on alcohol and substance misuse and was positively associated with antisocial behaviour (Perkins & Jones, 2004). In contrast, Moore and Ramirez (2015) found no effect between number of extracurricular activities and an aggregation of child wellbeing measures. Current studies often rely on frequency and/or duration of activity. Operationalisation of activity involvement requires extending in future research, exploring types of activity or subjective experiences of activity involvement. Particularly as participants in qualitative studies reported activities within and outside of school were coping strategies during childhood (Gonzales, Chronister, Linville & Knoble, 2012; Meyers, 2016).

The protective effect of sport involvement is promising, Romans et al (1995) and Hughes et al (2018) both found retrospectively-rated sports involvement in childhood was related to reduced current mental health difficulties in adulthood. However, the reliance on adult retrospective reporting presents some bias, it is not clear whether participants are reporting on their childhood experience or current self-concept. Due to the limited research, it is not certain whether internal positive self-judgement (Romans et al, 1995), physiology of exercise (Afifi et al, 2016) or the social aspect of sport (Gonzales et al, 2012) is the mechanism between sport and resilience.

Evidence is limited by cross-sectional designs, it is not clear whether resilient children are more likely to engage in activities or vice versa. Further research should utilise a range of outcome measures and activity related variables, longitudinal and control group designs should be used to ascertain efficacy of activity and sports.

**Religion/Spirituality.** Eight studies report on religiosity/spirituality as related to resilience, there are no longitudinal studies (Table 5).

**Table 5.** Religion/Spirituality - Summary of study characteristics

| Author, year, country, | Design and Sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Moore & Ramirez (2015) USA** | Cross-sectional<br>34152<br>12-17<br>Not reported | Participation in religious activities – measurement not reported | **Multiple -** Parent-report questions | Child Wellbeing - Self-rated -health status, controlled behaviour, task completion, school engagement, interest and curiosity and internalizing | Participation in religious activities positively mediated the relationship between ACEs and overall child wellbeing. |
| **Kim (2008) USA** | Cross-sectional<br>384<br>6-12<br>185 female | Freq. of attendance at church & prayer, importance of faith, (Gunnoe & Moore, 2002) | **Multiple -** Child protection data | Child Behaviour Checklist (Rated by camp counsellors) | Importance of faith was related to reduced internalising behaviour in girls but not boys, no effect was found for externalising behaviour. |
| **Edmond et al (2006) USA** | Cross-sectional<br>351, 15-18<br>54% female | Two questions – what is your religion? How often do you go to religious services? | **SA -** Self-report survey questions | Normal scores on Youth Self Report (Achenbach & Rescorla, 2001) | Frequency of attendance at religious services not protective of psychopathology or internalising/ externalising behaviour |
| **Perkins and Jones (2004) USA** | Cross-sectional<br>16313<br>12-17<br>53.3% female | Self-reported attendance at a place of worship, number of hours per week, importance of religion. | **PA -** Self-report survey question | Frequency of suicide attempts. Self-report questions- Substance use, sexual activity, antisocial behaviour, success in school, helping others | Frequency/duration of attendance and perceived importance of religion was related to reduced alcohol, tobacco and substance misuse, sexual activity and antisocial behaviour & increased helping others. |
| **McKnight & Loper (2002) USA** | Cross-sectional<br>2850<br>10-19<br>All female | One self-report question – How important is religion to you? | **SA -** Self-report survey question | Presence of 15 self-reported delinquent behaviours – not all specified | Perceived importance of religion associated with less engagement in delinquent behaviours |

**Table 5.** Cont.

| Author, year, country, | Design and Sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Perkins et al (2002) USA** | Cross-sectional<br>25463<br>12-18<br>46.7% female | Self-report - attendance at place of worship, no. of hours per week, importance of religion. | **PA -** Self-report survey question | Self-reported - Purging (one question from Attitude and Behaviour Questionnaire) | Perceived importance of religion but not attendance at a place of worship related to reduced self-reported purging behaviour |
| **Chandy et al (1996a) USA** | Cross-sectional<br>1011, 12-17<br>All female | Self-perception as religious – measurement not reported. | **CSA** - Survey question | Self-report survey - Suicide risk, substance use, school performance, pregnancy, suicide | Self-perception as a religious or spiritual person predictive of resilience. |
| **Chandy et al (1996b) USA** | Cross-sectional<br>1959<br>12-17<br>49.4% male | Self-perception as religious – measurement not reported. | **SA -** Self-report - Adolescent Health Survey | Body image, suicide risk, substance misuse – survey questions. School performance – survey questions | Self-perception as a religious or spiritual person predictive of average self-reported functioning in resilience factors |
| **Anderson & Danis (2006) USA** | 12<br>All female | Qualitative - Grounded theory | **PA, EA -** Not reported | - | Making external connections with God or a higher power. |

Self-perception as a religious or spiritual person has been shown to be predictive of average self-reported functioning in school performance, reduced suicide risk and substance use in female adolescents with CSA and/or parental substance use (Chandy et al, 1996a; 1996b) and less engagement in delinquent behaviours in female adolescents with CSA (McKnight & Loper, 2002). However, these studies rely on a single question to measure religiosity and although they measure a range of domains of functioning, measurement is not fully reported, limiting the reliability and validity. Kim (2008) used an empirically supported observation rating scale and did not repeat this finding in 6-12-year olds, rather value of faith was only associated with reduced internalising behaviour in girls who had experienced multiple ACEs but not boys. No effect was found for externalising behaviour. One qualitative study found that making a connection with God or a higher power was supportive in childhood by adult females with multiple ACEs (Anderson & Danis, 2006).

Perkins and Jones (2004) expanded their definition of religiosity finding frequency and duration of worship attendance and perceived importance of religion, was related to reduced alcohol, tobacco and substance misuse, sexual activity and antisocial behaviour, and increased helping others in adolescents who had experienced physical abuse. Other studies have found mixed effects of attendance in religious activities on outcome, Moore and Ramirez (2015) found participation in religious activities mediated the relationship between ACEs and overall child wellbeing. However, as they aggregated a range of outcome variables individual effects cannot be determined. Two studies found no effect of frequency of attendance on psychopathology, externalising or internalising behaviour in adolescents with history of CSA (Edmond et al, 2006) or purging behaviour in female adolescents with history of CSA and physical abuse (Perkins & Jones, 2002).

Due to the lack of longitudinal research and poor operationalisation of religion and spirituality, the strength of evidence is weak. It is inconclusive whether religion provides a source of resilience through providing a sense of meaning or by facilitating connection and identification with a social group. In addition, all studies were in the USA limiting generalisability to other geographical regions.

**Neighbourhood.** Four studies have set out to explore the relationship between neighbourhood characteristics and resilience, including three longitudinal studies (Table 6).

**Table 6.** Neighbourhood - Summary of study characteristics

| Author, year, country | Design and sample demo-graphics | Protective factors measured | Type and measurement of ACEs | Definition and measurement of resilience | Main findings |
|---|---|---|---|---|---|
| **Riina et al (2014) USA** | **Longitudinal**<br>Outcomes rated 3, 6 and 9 years apart.<br>2810<br>3-15<br>50.5% male | Parented rated neighbourhood cohesion based on 5 questions about neighbourhood | **Multiple**<br><br>Parent-report questionnaire | Child Behaviour Checklist<br>(Parent rated) | Living in a high cohesion neighbourhood was protective against internalising for children aged over but not under 11, no effect on externalising behaviour. |
| **Jaffee et al (2007) UK** | **Longitudinal**<br>1116, 5-7<br>51% female<br>Protective factor rated at 5 years, outcomes at 5 & 7 years | Mother reported crime, informal social control and social cohesion.<br>-5 years old | **Multiple**<br><br>Interview with parent | Child Behaviour Checklist<br>(Teacher rated) at ages 5, 7. | Lower crime neighbourhoods with higher levels of social cohesion/informal social control predicted age appropriate internalising and externalising behaviours at ages 5&7. |
| **Dumont et al (2007) USA** | **Longitudinal**<br><br>676<br>Adults<br>50.4% female<br><br>Protective factors measured in adolescence, outcomes measured (mean) 22 years later. | Neighbourhood advantage-income, home ownership, education and occupation – data from 1970 US Census | **Multiple**<br><br>Child protection data | Psychiatric disorder and substance misuse– NIMH Diagnostic Interview Schedule<br>Self-report of violent behaviour<br>Resilient if successful in 4/5 domains – high school graduation, psychiatric diagnoses, substance abuse or dependence diagnosis, arrests, and self-reported violence | No direct effect of neighbourhood advantage on resilience in adolescence but increased likelihood of resilience in adulthood |
| **Segura et al (2017) Spain** | Cross-sectional<br><br>127<br>12-17<br>53.7% female | Community connectedness – Self-report Adolescent Resilience Scale (Gartland et al, 2006) | **Multiple**<br>Self-report – Juvenile Victimisation Questionnaire (Finkelhor et al, 2005) | Youth Self Report – (Achenbach & Rescorla, 2001) | Community connectedness mediated the relationship between ACEs and self-reported internalising symptoms, no effect on externalising. |

High cohesion neighbourhoods with informal social control have been found to be predictive of normal internalising and externalising behaviour across early childhood (Jaffee, Caspi, Moffit, Polo-Toms & Taylor, 2007). Riina, Martin and Brooks-Gunn (2014) in a longitudinal study only found an association between neighbourhood cohesion and reduced

internalising in children over 11, there was no effect on externalising behaviour. This finding is supported by one cross sectional study (Segura et al, 2017). However, these studies defined resilience merely as the absence of internalising and externalising behaviour. In contrast, Dumont, Widom and Czaja (2007) explored neighbourhood advantage across a wider range of domains of functioning, finding no association with resilience in adolescence but increased likelihood of resilience in adulthood.

Research exploring neighbourhood characteristics is minimal. Further research is required to explore a range of neighbourhood characteristics with a more robust measurement of resilience across a range of domains. However, it must be noted that this review did not set out to explore the prevention or predictors of adverse childhood experiences, many of the studies exploring neighbourhood characteristics may be within these literature bases.

**Discussion**

The aim of this systematic narrative review was to identify protective factors within the social and community environments of children and adolescents with history of child maltreatment. A broad review was undertaken to map current findings as a basis for clinical intervention and further research. Overall, six categories of protective factors were identified, including peer relationships, school environment, relationships with other adults, activity involvement, religiosity/spirituality and neighbourhood characteristics, each was critically examined.

Associating with peers who engage in prosocial behaviours and having emotionally supportive relationships with friends, rather than the quantity and availability of friendships, were key mechanisms for resilience. Longitudinal studies demonstrated this effect continued through parts of childhood and protected against mental health problems in adulthood. However, for some children peer support had a detrimental effect, with increases observed in

externalising behaviour, suggesting some children may be susceptible to the negative influence of some peers. Features of friendships are well established as protective in childhood and particularly adolescence (Bukowski, Motzoi & Meyer, 2009). Further research is required to explore the mechanisms within peer relationships, particularly the characteristics of relationships engaged in at different ages and ideally across time using longitudinal designs.

Positive relationships with teachers, connection with school and focus on education were identified as protective factors in the school environment. These factors form essential components of a trauma informed environment (Wiest-Stevenson & Lee, 2016), highlighting that the school environment offers a unique opportunity to offer safety and stability for children with ACES. However, resilience was often measured solely as the absence of psychopathology rather than across a range of domains of functioning. Evidence would be strengthened through longitudinal examination across childhood utilising measurement of resilience across a range of domains of functioning.

Having a positive relationship with an adult was generally protective for mental health and health harming behaviour, although in some cases this relationship was linked to an increase in adverse outcomes. As with peer relationships it could be that children and adolescents access a range of positive and negative adult relationships which influence resilience, some which have an adverse effect on their functioning. Research has yet to explore the mechanisms and effects of different types of adult relationships across a range of domains of functioning.

Mixed findings were apparent for activity involvement, with positive effects reported e.g. reduced substance misuse, sexually ruminative thoughts, suicide attempts in males and increased school attainment. However, some risk effects were noted, including an increase in antisocial behaviour. In future studies, the operationalisation of activity involvement should

include type of activity and subjective experience rather than relying merely on frequency and duration. In addition, despite engagement in sports activity reducing the likelihood of mental health problems, it is not clear whether internal positive self-judgement, physiology of exercise or the social aspect of sport is the mechanism between sport and resilience. This warrants further research, particularly as sport has established benefits for mental health and social interaction (Eime, Young, Harvey, Charity & Payne, 2013), even for children developing in adverse contexts (Massey & Whitley, 2016).

Identification as a religious or spiritual person was generally associated as a protective factor across a range of outcomes. This effect has been found in the general population and associated with better coping with stress and less depression, anxiety, suicide and substance abuse (Koenig, 2009). Due to the poor operationalisation of religion and spirituality in the reviewed literature, it remains inconclusive as to whether religion provides a source of resilience through the sense of meaning it gives to people or by facilitating social connection through connection and identification with a social group.

Finally, low crime, social cohesion and informal social control were identified as protective neighbourhood factors in longitudinal studies, no effect was found for neighbourhood advantage until adulthood. Further studies may be contained in the literature exploring prevention or predictors of adverse childhood experiences. These are areas in which this review did not set out to explore. Further research is required within communities to explore the links between community functioning and resilience, particularly as intervening at a neighbourhood level is likely to have significant effect on life outcomes. Neighbourhood characteristics have been found to account for 10% variation in health outcomes after controlling for individual and family variables (Sellstrom & Bremberg, 2006).

Comparing findings across studies was difficult due to the range of designs and samples utilised. Most studies used samples that were either not representative or are drawn from a clinical population (Edmond et al, 2006; Collishaw et al, 2007), others used retrospective designs (Hughes et al, 2018, Bellis et al, 2017; Roman's et al, 1995). Most research was cross-sectional and focused on the adolescent period. These cross-sectional designs placed limitations on ascertaining the direction of causation within the identified protective factors, robust evaluation of interventions which promote these protective factors would be useful to determine causality. Resilience is variable over time and context and points in which individuals can either take a positive or maladaptive developmental trajectory are highly frequent across the various developmental stages in childhood and adolescence (Cicchetti, 2013; Rutter, 2012; Sapienxa & Marsten, 2011). To accurately capture this, studies with longitudinal designs are required covering the span of childhood into adolescence. There are no qualitative studies using child or adolescent samples, although limited in generalisability, qualitative methods would allow a deeper understanding of the complex processes of resilience after ACEs and could generate further protective factors which can be quantitatively investigated in larger samples. Mixed method approaches may be a solution allowing investigation in larger samples whilst exploring individual meaning and perception in a subgroup (Ben-David & Jonson-Reid, 2017).

There is general consensus that resilience is a multidomain and multidimensional construct (Cicchetti, 2013). However, within studies included in this review, resilience was most frequently operationalised solely as the absence of psychopathology, studies exploring functioning within a range of domains were rare or limited by using self-report survey questions rather than empirically supported measures. This severely limited the conclusions as to whether protective factors associated with resilient functioning are truly generalisable across other domains of functioning within an individual's life.

In addition, studies focused either on one type of ACE or included participants with multiple ACEs without completing separate analyses on ACE subtypes. This prevented exploration of the effects of different types of ACEs and their interactions with different protective factors. It was rare for studies to measure and explore factors surrounding ACES, such as onset, severity, chronicity, and relationship to perpetrator. For example, perpetration of physical and sexual abuse by caregivers is known to result in fewer mental health and behaviour problems than abuse by non-caregivers (Kiser et al, 2014). This specificity should be captured and analysed in future research allowing individual differences to be explored which may influence resilience processes and outcome. Further exploration and analysis are required in future studies to explore the differing effect of protective factors on gender. More research is required within different geographical regions considering different cultural processes.

One limitation of this review is that it did not explore the interlinks between protective factors occurring internal and external to the person. It is not conclusive as to whether internal factors e.g. self-esteem or attributional style increase an individual's use of community protective factors or vice versa. This warrants further investigation.

Despite these limitations, understanding of resilience has significantly developed over recent years and this review explored studies over a 22-year period. The studies included provide an indication of various factors which have encouraged positive functioning within at least one domain of functioning within a child or adolescents life and should not be dismissed. Services should start to explore mental health at an ecological level within communities and develop applied community interventions for children with ACEs. These would be required to undergo appropriate evaluation such as controlled trials. Developing protective factors within the community context will not only support resilient functioning in individuals with ACEs but

may support societal education of the impact of ACEs with a likely by product of supporting ACE prevention but this must not be the focus to prevent stigmatisation (Ko et al, 2008).

Childhood and adolescence is a crucial period for determining long term mental and physical health, in addition resilience during childhood is strongly associated to resilience within adulthood (Ben-David & Jonson-Reid, 2017). Adolescence is a time when children separate from their parents, place value on relationships with peers and access community resources (Erikson, 1950; Feiring et al, 1997), suggesting children are particularly primed at this developmental stage to access protective community factors.

Accessing protective factors within a child or adolescents community ultimately requires forming and maintaining relationships with others. Children who experience ACEs often have difficulties developing positive connections with others due to the relational nature of their trauma (Bath, 2015), which can make accessing protective factors more difficult. A starting point for helping children and adolescents access community based protective factors would be to develop trauma informed relationship building skills in adults within the community context (Walkley & Cox, 2013), along with developing trauma informed groups, activities and environments which provide a supportive context for children with ACEs. This review highlights the evidence and significance of relational safety and security within schools, this warrants further investment and research.

Although the evidence for protective factors at the community and societal level is still emerging and further research is required to explore the mechanisms and processes underlying these protective factors, this review provides a basis from which community-based interventions can be developed within a trauma informed framework. Future research should focus on exploring community and societal protective factors related to resilience across time

and domains of functioning, ideally with longitudinal designs including control groups, and in-depth exploration of the association with factors surrounding ACEs.

**Acknowledgements** – None.

**Funding** – This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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# Chapter 2:

# Empirical Study

**Becoming and Being a Father Living in a Deprived Community – an Interpretative Phenomenological Analysis**

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**Journal Information**

Journal: Parenting

Publisher: Taylor and Francis

Link to author guidelines:

https://www.tandfonline.com/action/authorSubmission?journalCode=hpar20&page=instructions

**Abstract**

This article explores the experiences of early fatherhood for men living in an area associated with a high level of deprivation. Semi structured interviews were conducted with nine fathers of infants aged between three and eighteen months. Data was analysed using interpretative phenomenological analysis. Fathers described the processes of adjusting to the role, making sense of their new position within the family unit, co-creating their infants' childhood and future, and the sources of influence on their role including intergenerational reparation and sources of support. Recommendations are made for developing supportive interventions for fathers within early fatherhood. Research is needed to further understand the psychological processes of fatherhood across time, ideally using longitudinal designs, and to develop interventions tailored to fathers' needs.

**Key words:** fatherhood, transition, men, deprived, adjustment

**Funding.** This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

**Disclosure.** No potential conflict of interest was reported by the authors.

## Introduction

Over the past few decades, society has seen a significant shift in the concept of fatherhood (Draper, 2003). Moving from provider and authoritarian roles framed by hegemonic masculinity, to active participation in antenatal preparation, nurturing and caring tasks along with sharing domestic and employment activities (Chin, Hall & Daiches, 2011). There has been a corresponding shift in research into parenthood from a previous focus on the mother-infant dyad to looking at the roles of fathers.

Understanding the psychological processes underlying fatherhood has significant clinical importance. The perinatal period sees an increase in the prevalence of depression and anxiety in fathers of approximately 5-10% and 5-15% respectively (Paulson & Bazemore, 2010; Leach, Poyser, Cooklin & Giallo, 2016). This not only impacts on the wellbeing of fathers but is related to partner disharmony even when maternal depression is controlled for (Ramichandri et al, 2011). Anxiety and depression in fathers also detrimentally affects their ability to attune to their infant (Paulson, Dauber & Leiferman, 2006), which can negatively impact infants' future vulnerability to developing emotional and behavioural problems (Ramichandani et al, 2008). Conversely, research has also highlighted the positive impact of fathers on their children's emotional and behavioural development: children with consistent father presence or connectedness are better able to regulate their emotions (Bockneck, Brophy-Herb, Fitzgerald, Schiffman & Vogel, 2014); positive father involvement reduces the risk of adverse behavioural outcomes in the children of mothers experiencing depression (Chang, Halpern & Kaufman, 2007; Mezulis, Hyde & Clark, 2004); and adjustment to fatherhood and attuned emotional responses to their child, rather than quantity of direct involvement in childcare, is associated with positive behavioural outcomes in children at 11 years old (Opondo, Redshaw, Savage-Mcglynn & Quigley, 2016).

More recently there has been increased exploration of the underlying needs and experiences of fathers, although studies exploring men's personal experiences of fatherhood remain limited. In a metasynthesis, Chin et al (2011) reported three themes of psychological adjustment to fatherhood: emotional reactions to phases of transition - detached, surprise and confusion, identifying their role as father, and redefining self and relationship with partner.

Within the UK, there are limited qualitative studies that explore psychological processes around fatherhood. Two studies have focused on father's experiences of the transition to fatherhood. Bradley, Boath and Mackenzie (2004) explored the experience of ten first time fathers in Scotland, finding that fathers tended to reflect on the extent to which they experienced having a baby was congruous, or a significant upheaval, to their past life. Those who seemed least disrupted appeared to have spent time adapting their existing life to accommodate their baby. Fathers tended to focus on the mothers' support needs rather than their own and they experienced antenatal classes as patronising and women focused. This study has been criticised for lack of detail of the methodology used, the participants and their social context. Kowlessar, Fox and Wittkowski (2015a) interviewed ten first time fathers exploring the first year of fatherhood. They reported that fathers felt undervalued and unsupported through antenatal care, described learning through their partner and joining together as a team, and experienced a process of separating from their previous life with a change in their social networks. However, this sample was limited to white middle class men who were married and in full employment. No further research has assessed the generalisability of the findings of these studies.

Two further studies have explored aspects of the transition to fatherhood. Dolan and Coe (2011) explored the meanings and processes of masculine identity in first time fathers within the context of childbirth, finding that constructions of appropriate fatherhood practice

during pregnancy and childbirth were in opposition to traditional masculine values of power and control. However, they found that fathers sought resilience in utilising masculine constructed values of becoming stoic and self-reliant in the face of adversity. Whereas Darwin et al (2017) investigated father's mental health in the perinatal period finding that men described exhaustion, poor concentration and irritability. Fathers questioned the legitimacy of their needs and emphasised services were there to support mothers and often focused on the need to protect their relationship and the mothers' wellbeing.

The current evidence base lacks representation of fathers from different cultures, contexts and socioeconomic groups beyond white middle class populations. Despite public health funding often targeting parenting and early years support in areas of deprivation (i.e. Flying Start, Welsh Government, 2017), no study has explored fatherhood within deprived contexts in the United Kingdom. However, in the USA, two studies have explored fatherhood in men with low incomes. Summers, Boller, Schiffman and Raikes (2006) found fathers with low incomes articulated a strong sense of commitment and intentionality in their plans for interactions with their children through providing a stable environment, teaching their children, engaging in physical interaction and providing emotional support. Furthermore, Summers, Boller and Raikes (2004) explored barriers to fathering, finding that whilst many fathers reported no barriers and denied the need for support, the primary barrier reported was the difficulty of juggling work and family demands.

This study aims to explore the experiences of fatherhood within pregnancy and the first eighteen months of a child's life for men living in areas associated with high levels of social deprivation. Using the current literature as a basis, the similarities, differences, challenges and resilience of fatherhood within this demographic can be explored. It is hoped that findings will

support services to better understand men's experience of fatherhood and shape support and services they offer.

## Method

### Design

Interpretative phenomenological analysis (IPA) was chosen due to the focus on subjective lived experience. IPA's phenomenological stance explores the subjective meaning that individuals give to their experiences, whilst making an idiographic detailed examination of events and cases (Smith, Flowers & Larkin, 2009), appropriate for gaining insight into an understudied population. This study aims to offer a detailed exploration of individual cases whilst reporting on patterns of meanings within a homogenous group, rather than aiming for generalisability.

IPA acknowledges a double hermeneutic stance in which the researcher is interpreting participants' own interpretations of their experiences. As such, the researcher's thoughts, feelings and experiences can be instigated through the analytic process, and the use of this reflexive stance enables these elements of the self to be used to aid interpretation of the data (Smith et al, 2009). A reflexive stance was taken by the lead researcher, a father with children of a similar age to those of the participants within this study, who also has undertaken placements during clinical psychology training working clinically with children and families within the locality of the study.

### Participants

IPA studies aim for a small and fairly homogenous sample, which is purposely selected to enable idiographic analysis (Pietkiewicz & Smith, 2014). An urban area falling within the 10% most deprived areas of Wales was selected for recruitment, as measured by the Welsh

Index of Multiple Deprivation (comprised of income, employment, health, education, access to services, community safety, physical environment and housing data; Welsh Government, 2015).

Fathers living within the target area with at least one infant between the age of three to 18 months were invited to take part, including fathers with single and multiple children. Fathers were recruited through local community workers, posters placed in local community facilities and on the social media pages of local services.

Participants recruited via community workers were given information about the study and initially asked for verbal consent. Consenting participants were then contacted by the lead researcher and provided with further information and an opportunity to discuss the study. Participants recruited via posters and social media were given the same opportunity through direct contact with the lead researcher. 12 participants consented to take part with nine engaging in the interview process. All participants lived with their partners or wives, ages ranged from 23 years to 57 years old, three participants were first time fathers and six participants had multiple children. Five fathers were employed, four fathers were either unemployed, full time parents or retired.

Ethical approval was obtained from Bangor University Ethics committee (Appendix 1 & 2) and the study was subject to NHS Research and Development review (Appendix 4).

**Data Collection**

Semi-structured interviews were utilised to explore participants detailed accounts of their experiences, supported by probing questions (Pietkiewicz & Smith, 2014). An interview schedule was prepared in advance (appendix 7). Following guidelines by Smith et al (2009), a range of interview questions were developed by the research team based on research literature and discussion with a local community nurse. The schedule was arranged to move from

descriptive and concrete questions into more reflective and sensitive questions, covering the experience of becoming and being a father. However, the participants lead was followed, and the schedule was used flexibly as recommended by Smith et al (2009). To ensure credibility and aid analysis, field notes of observations and reactions were recorded (Elliot & Timulak, 2005).

Participants attended a single interview at an agreed convenient time and location (three in a local health clinic, five in a local third sector children's centre and one at home). The interviews were conducted by the lead researcher in February 2018 and ranged between 23 minutes and 70 minutes in duration. Information about the study, interview process and confidentiality and anonymity were given, and written consent was obtained (appendix 5 & 6). Participants were given the opportunity to ask questions before and after the recorded interview and informed of their right to withdraw at any time. After the interview, participants were thanked for their participation, given the opportunity to discuss the effect of the interview and made aware of sources of further support if necessary. All participants received a £20 voucher for their involvement.

**Data Analysis**

Data was analysed in accordance with the Smith et al (2009) guidance. Interviews were audio recorded and transcribed verbatim. Relevant linguistic information such as pauses, stutters and laughs, along with non-verbal information such as gesture and positioning were recorded to enhance analysis. Interviews were listened to and transcripts were read and re-read to enable the researchers to immerse themselves in the data (Pietewscitz & Smith, 2014). Exploratory notes about the content, context, initial interpretative comments and reflective comments were made on the transcript. Emergent themes were then recorded and listed. This enabled connections and differences between the emerging themes to be explored, similar

themes were then grouped. Referring back to the transcribed text ensured the themes stayed close to the data and captured what the participants had said.

After repeating this process for each transcript, a list of superordinate themes and subthemes was collated. Supporting the themes with verbatim quotes from the participants ensured that the themes captured the participant's experience. Although the first author undertook the analysis, to ensure credibility the lead researcher and another researcher (EM) independently analysed two transcripts and triangulated themes, which showed high agreement. In addition, regular consultation between the researchers was undertaken at each point of the analysis. To maintain a reflexive stance, a reflective diary was used by the lead researcher throughout the process, in addition they attended further training in IPA. Throughout the analysis an audit trail was maintained of the analytic process to ensure the interpretative analysis was kept close to statements made by participants during their interviews (Biggerstaff & Thompson, 2008).

**Results**

Four superordinate themes emerged from the data (Table 1). In this section, each theme is explored narratively, supported by participants own verbatim quotes[1]. Recurrence of themes for each participant is presented in Table 2 (Appendix 8).

[1]To conform with NWCPP guidelines, participant quotes are included within tabular format in the text body, numbered from 3-30.

**Table 1:** Superordinate and subordinate themes

| Superordinate Themes | Subordinate Themes |
|---|---|
| Adjusting to the new role | Expectations to reality |
| | The adjusting self |
| | Getting through the pregnancy |
| | Bonding |
| Making sense of new position within the family | The adjusting couple relationship |
| | Role in parenting vs role as a provider |
| Co-creating childhood and future | Guider |
| | Joining together |
| Sources of influence and support | Repetition and reparation from own childhood |
| | Challenging societal constructions of fatherhood |
| | Sources of support for fathers and their families |
| | Meeting fathers needs |

## Adjusting to the new role

### Expectations to reality

Father's reflected on different journeys to fatherhood. For some, the timing fitted within their life plan, as Callum illustrates "I love being a dad. It couldn't have happened at a better time to be honest with you". Though, for two fathers, although they planned to have children, for various reasons went through IVF described by Luke as a "very hard road", highlighting an emotionally challenging process. For others, fatherhood was less planned and encountered as a shock, as Peter discusses "I was white. I was like, "Ok 'cause I didn't know how to react".

Most fathers recalled their expectations of what fatherhood would be like. For many this was based on their past experiences with children, through family and friends or work. As Luke illustrates, he observed the various parenting practices utilised by his friends whilst recognising that his own baby's needs may be different. He seemed to be expecting unknown and unpredictable elements to fatherhood.

> “I never felt like becoming a Dad was something I could prepare for, and not that I avoided it or didn't look into it at all or see other Dad's in my life for friends that are Dad's and seeing how they do things…it was more of, a well, let’s see what happens [laughs].” [Luke]

Table 3

Some fathers envisaged fatherhood as hard work, Scott put this down to a “bit of common sense like…just knew it was going to be a hassle”. Whilst for many they described a process of truly realising the demands of parenthood through experience when the baby arrived “I didn't think it would be as hard as it is” (Martin). In some fathers the arrival of their baby raised anxiety, as Curtis exemplifies.

> “Getting things wrong. Not being able to do the right things if you get me. Just worried that I might end up doing something that might put her in harm or something, because giving her meds or something. Might end up giving her too much or something like that. I suppose they are the worrying factors a bit. Once you get used to doing, you know, giving her the Calpol or something like that, everything is sort of simple then it is.” [Curtis]

Table 4

Curtis felt a strong duty to protect his daughter, whilst also feeling anxious about unintentionally harming her. He describes a process of developing mastery “once you get used to doing…everything is sort of simple then”, which seemed to reduce or remove this previous threat to his role as protector. Fathers of multiple children seemed to use previous experience, and possibly already established mastery, to view anxieties around having a small baby as more transient, as Daniel describes.

> “At the beginning, it’s a lot harder and then when they settle down and they sleep, it gets easier as it goes on. Until they get to a teenager. [Laughs]” [Daniel]

Table 5

**The adjusting self**

Having a child caused a significant change in identity for most fathers. Some participants described this as entirely positive with their role as father becoming a prominent identity. Within this, some fathers experienced a sense of loss for parts of their self. Curtis described a process of shock and adjustment, with an overarching sense of acceptance and inevitability about his new role. Despite the clear sense of commitment to fatherhood that he and many other fathers felt, this role was incongruent with other aspects of his life before: his use of the words "you've got to change the way you used to be and everything" suggests a major shift in his personal identity in terms of his autonomy and own self. However, he reflects on this as a positive change.

> **"**Obviously it's life changing init. It's just shock at first, then you have to deal with it really, you've got no choice have you.... You mean, you've got to change the way you used to be and everything. It's not just you anymore, it's. We've got the the little one as well, so you've got to change. The way you used to do things and the way you used to, you know you can't go out as much as you used to anymore. [Both laugh]. But, no it's changed it for the better anyway." [Curtis]

Table 6

For Scott, this process was different, he had become primary caregiver for his children and described a sense of loss of his self and own autonomy caused by the prominence of his father identity. This causes him to feel anger, and a sense of being trapped: "I have to suck it up, sit in the corner", due to the incongruence of his social and autonomous self and the strength of commitment he has to meet his family needs.

> "I've lost my independence because when I had a job, I could have just said - I'll pay my dues, see you later deal with it. But no, I have to suck it up. Sit in the corner and deal with it." [Scott]

Table 7

Martin widened his focus from his self to include his baby, stating "I didn't realise how selfish I was before the baby…and I didn't even realise that, since then, you know, I, I go with the baby, Its changed that. Completely". Within this reprioritisation there seems to be a maturation process occurring for some fathers. Callum describes the significance of the change in his self, "it made me grow up". Peter explains this as shifting from immaturity, "young", "foolish", "going out age" to investing in his prominent role as provider for his family.

> "I was 21, so still a young, foolish, still going-out age. So was [Partner]. We went through our ups and downs like every couple does but you do the responsible thing, I settled down into work, took a more prominent role, I wasn't messing about where you take the odd weekend off or throw a sicky, it was real. Once [Son] was born, it was real. That was it. I had responsibilities." [Peter]

Table 8

**Getting through the pregnancy**

Interestingly, not many fathers focused on the pregnancy period. Those who did had experienced complications during conception, pregnancy or labour.

Fathers who discussed pregnancy often focused on their partner's emotional difficulties rather than their own. As Luke exemplifies, by emphasising the difficult process for his partner, this allowed him to share that it was emotionally difficult for him too. However, rather than sharing his emotional needs, he discussed his use of coping strategies. This avoidance of fathers sharing their own emotional experiences directly could imply a defense to protect themselves emotionally, or as adherence to a stereotyped masculine value such as stoicism.

> "We had a long journey to get [Son]…I mean it was a very hard road for my wife, so I mean we both shared that but it was by harder for her than for me but it was a difficult thing and I think err when we found out we were finally pregnant um, it was still a while of oh we know this can happen, this can happen, this can happen…If there's a problem I want to fix it [laugh]. So if I can't fix it then, so,

> so, its' that was err, the most difficult part… so I mostly cope in unhealthy ways, um, comfort eating or getting lost in work, something like that." [Luke]

Table 9

**Bonding**

Most fathers discussed an instant overwhelming emotional connection with their baby: "It was instant. From the minute he was there, I balled my eyes out" (Peter). Some fathers were shocked at how early they bonded with their child and reflected on a reciprocal interaction occurring between themselves and their babies, with this often bringing them a sense of joy. As Martin illustrates, he expected early parenting would be "quite boring". Instead, through experience, he reflected with enthusiasm on a shared reciprocal positive connection with his baby, showing sensitivity and attunement as he enjoyed noticing his infant's developing personality.

> "Just the love…you get off her, you know what I mean just, erm, yeah especially when you come home from work and she's beaming to see you yeah, yeah... I didn't think it would be as, I can't I can't get these guys who do not want to be with their kids. I can't I can't understand them… [I thought it would be] quite boring, you know (says laughing), you know I didn't think she would be as quick as she is, and she's quite funny." [Martin]

Table 10

This reciprocal interaction appeared to be soothing process for the fathers and many discussed the activation of positive emotions and the positive impact this had on their own wellbeing.

> "Just seeing them smile, you know, brings a smile to my face. When I have down days, [Eldest child] will do something that will make me laugh and then I won't be down again. She is comic (both laugh) she is, she's great." [Callum]

Table 11

Callum describes a process of his daughter communicating her positive emotions through smiling, creating a positive emotion in him which changes his trajectory when feeling low.

Daniel uses the phrases “feel better” and “feel-good factor” to describe this experience, which suggests that the positive attachment and shared connection offers a source of joy and resilience.

**Making sense of new position in the family**

**The adjusting couple relationship**

Most fathers expressed a general sense of growing closer together with their partner, “it’s made it stronger” (Anthony) and “in a lot of ways we've, we've grown closer” (Luke), however this oscillated at times with weaker and more difficult moments within their couple relationships.

> “Sometimes it's a bit stressful init. We do snap at each other as well, when we are both overtired and that, but I suppose we expected it really, you know getting overtired and suppose getting down each other’s throats and you know. But it's expected, do you know what I mean, when we are both sitting there shattered and then, she's not settling and then, it's one of them but apart from that everything’s been great.” [Curtis]

Table 12

Curtis illustrates the impact of stress and tiredness on the couple relationship, his use of “it’s expected” and “it’s one of them” highlights his and many other fathers description of a process that is a normal, accepted part of parenthood as a couple. For some fathers though, the impact of having a child caused a longer adjustment process in the couple relationship, which developed their understanding of their partner’s needs. Martin describes a process of moving from struggling to relate to his wife’s needs and focusing on his baby to developing a sense of compassion and understanding for his wife. He made sense of his struggle to emotionally support her wife as being “old-fashioned”, potentially relating this to an aspect of masculinity.

> “I don’t get embarrassed, I don’t get jealous either, so it didn’t really come to me that she would... I was a little bit, little bit selfish and a little bit you know, I only

> thought about me [laughs]…More support regarding making her feel wanted and making her feel loved, that kind of thing maybe I'm. You know. Maybe I'm a little bit old fashioned and think of me and the baby really." [Martin]

Table 13

**Role in parenting vs role as a provider**

Many fathers emphasised the importance of taking an equal role in caregiving to their partner. There was a common emphasis on the importance of being available for their baby and developing a strong attachment relationship, as illustrated within Anthony's quote below. His use of the phrase "virtually the same person in different bodies" emphases the position of equality he places his caregiving role.

> "I think we've got a good bond. Really good bond. 'Cause we do things together. It's not just, "Go and ask your mum." We always do things together, all of us, which I find really enjoyable… 'Cause we both cook, we both sort the kids out, we both do housework. [Laughs] It's virtually the same person in different bodies" [Anthony]

Table 14

Other fathers, whilst also placing importance on caregiving, placed greater emphasis on their role as provider. Martin described himself as a "breadwinner and…assistant" to his wife and took over care when his wife was struggling. Whereas Peter placed his sole focus into providing financial security for his family.

> "I do look at her a bit more and think, "You're a bit more – the last hope, in a way. You're my last (.) chance at being something more than just Dad goes to work… So, I'm either getting up and gone before they get up, or I'm coming home when they're just going to bed. And it's horrible. But all they see is Dad's working, Dad's working. Yeah. It's not nice. It's horrible. Like, [Partner] says to me, "I might as well be a single mum." Yeah. For 60 hours a week, yeah, you are…you're not having to worry about absolutely anything other than what they're doing all day." [Peter]

Table 15

He exemplifies that for some men they saw their role as scaffolding the maternal – child relationship and felt a great responsibility for meeting his family's financial needs. Repeatedly using the word "it's horrible" suggests that this is self-sacrificing, he has a strong sense of regret and loss for not building a stronger emotional connection with his children. This and a sense of mortality - "my age" [Daniel] or "my health" [Anthony] - often led to fathers experiencing conflict in their roles as father or rebalancing their life to be more available and involved in nurturing tasks. For some couples, this strengthened the family unit, for others this caused some conflict, as Daniel described "trying to do too much" and "taking the mother role away from Mum."

Many fathers discussed the challenge of trying to find a balance between meeting their roles as providers and nurturers. Anthony reflects on how once he struck that balance this enabled him to feel more fulfilled in life "makes me a bit happier".

> "That was the plan, to try and find a job that helped me work with [Partner] at home, with the children, then go to work as well. It's been a long time to find one. It's good. I find that a good balance...Makes me a bit happier. Nothing worse than you're having children and then you think you're just in work all the time. So it's nice, I can actually spend time with them and work, which is quite important to me". [Anthony]

Table 16

**Co-creating a childhood and future**

**Guider**

Many fathers envisaged their role as providing guidance for their children. For some this was focussed around practical problem solving and supporting their children to learn from their experiences, rather than a more nurturing or emotionally supportive role, as Peter describes.

> “Knowing that I’m there is enough. So, they can come to me for anything. They can ask me for help, they can ask me for guidance, they can ask me to teach them something. that’s fine, but whenever they fall over or they’re hungry or they’re hurt, they’ve got a question, they don’t come to dad. They go to mum. Mum. Mum’s the word... it’s that right and wrong path. It’s knowing that you’ve got to give them the knowledge to learn their own ways of what’s right, what’s wrong…. So, for me, they have to make a mistake to make the correction. I love watching that, but I’m always there for any downfalls or any mistakes.” [Peter]

Table 17

Other fathers discussed the value of “expressing love” (Greg) whilst taking a guiding role, as Daniel illustrates. His use of conversational style when expressing an interaction with his child shows a sense of how he seeks to understand and acknowledge his child’s internal experiences and soothe these with the sharing of emotion and physical affection “it’s like a natural drug in your body”.

> “If you’re feeling down, “Come here, mate!” Gives you a hug. I don’t know if there’s a natural drug in your body, but you feel better. If you’re feeling down, someone comes up to you,” And how are you doing? Aw, give us a hug.” Makes you feel better. If the little one’s feeling down, crying, sit them down, “What’s wrong?” Just encourage them, then, “Come on, you speak. Tell me what’s wrong.” That’s most important.” [Daniel]

Table 18

The majority of fathers discussed their aspirations for their children’s future as achieving greater things then they did, often acknowledging the detrimental impact of community norms. To achieve this, fathers often discussed instilling values in their children - “you can be serious and down in the dumps about everything, but the reality is you need to have a laugh” [Scott], “dust yourself back get back up and say ok I've failed, you're going to fail before you succeed in life aren’t you so.” (Callum). Martin felt that he would struggle to guide his daughter effectively himself due to his own lack of academic achievements and instead planned to encourage her to find role models in her educators.

> “Show her what the area can be, yeah know…she doesn’t have to follow mine and [Wife]’s path. And she doesn’t have to follow everybody else’s path around her. You know and just be you know just be poor and that, she can do whatever she wants. But she’s got to kind of not follow their lead. Make her own path like… going to be hard because, because, you know, you know, academically, you know, I didn’t do well. But I suppose if, if I just show her to, to, follow her teachers lead and to, when she goes to college to follow the lecturers lead and all that then she will be. Then she’ll be ok” [Martin]

Table 19

Some fathers saw discipline as central to supporting their child’s development, as Curtis exemplifies: “Obviously, I wouldn't want to be too strict with her, but you've got to try and find that balance between obviously between being too strict and strict so. I wouldn't want to go over the top with her and (.). To be honest keep her on the straight and narrow really”. This suggests he sees a value in discipline but is yet to balance this in his fathering role. Whereas, Luke sums up his perceived model of fathering as “Being there when life sucks, being there when life is good, not just, um, wellbeing encouraging voice into his life and a disciplinary voice into his life. Um, yeah, helping him discover who he is.”. His use of different voices suggests he is seeking a balance between encouragement and discipline to shape his son’s trajectory, however acknowledging a sense of being available for him through positive and difficult parts of life.

**Joining together**

Many fathers emphasised sharing a common interest or joining together in activities. As Luke illustrates, his phrase “experience things with him” suggests a coming together and closeness in sharing activities, he envisioned that he could impart his own skills and interests to support this.

> “I think just to experience things with him, experiencing what. It's like to pet animals or see animals at a zoo or um, you know, figure out what sports he might be

> interested… if he is interested in art, that will be a bit difficult to me but I'm quite open to it, I like to do things with my hands so hopefully teaching him how to use tools and stuff one day." [Luke]

Table 20

Luke described a curiosity about his son's interests, whereas other fathers sought to shape their child's interests, as Curtis discusses "she is not going to be the normal typical girl. [Both laugh] sort of a little bit of a Tomboy as well, so that will be my fault that one!". He sees their coming together as developing and sharing in some typically masculine behaviours. Peter saw similarities between himself and his son "he's gonna be my doppelganger, if you like. He's gonna know how to do something, he's gonna wanna know why it does it".

Almost all fathers spoke about the importance of having "fun" or "laughter" as a family value through which they connected with their children. Greg saw having fun as his central quality as father, the significance is shown through his repetitive use of the word "fun" and his description from his and his children's view, comparing it with values which other people may emphasise.

> "Fun. Fun. If there was just one word, fun. Fun. Because (.) Mums and Dads, even though they have the same rules and same duties, they do different things in different ways...For me, fun. If they could say, describe your Dad, "Fun." That's how I'd say, fun. Other people may say caring, loving. For me, fun." [Greg]

Table 21

**Sources of influence and support**

**Repetition and reparation from own childhood**

All fathers spoke about how their parents met their own needs as a child and about how they have adjusted their parenting to meet these needs for their own children.

> "I hardly saw my dad when he was in work all the time. I found that really hard…My dad was quite good, though. When he was growing up, he had to go into care…He was adamant that that wouldn't happen to us. So when the four of us were

there, he'd just work and work and work. He'd always have good holidays, we'd always have food on the table, and Christmas was always good. That was his aim. I think he was quite good at that. On the other hand, never seeing him…Thought to myself, is there a way I can kind of work and be at home a lot as well?..Trying to find a way of just balancing it right. So I think, at the moment, it's quite good. The kids will say, "Oh, are you gonna work tonight, dad?" and then say, "Yeah, I'm off at the weekend." [Anthony]

Table 22

Like Anthony, many fathers described a sense of loss within their childhood relationship with their own father. He rationalised his father's lack of availability as out of his father's control and integral to his family's basic needs being met, articulating an appreciation of the experiences his father created for the family in which they could spend time together, describing his fathers 'good' intentions. Anthony highlights an intergenerational reparational process, with his own father working hard to protect ruptures in his relationships with his own children following his experience of being taken into care and Anthony fighting for a balance between two competing roles of availability and provider.

Fathers who experienced abuse or neglect within their own parenting relationships appeared to strive towards repair and prevent repetition within their relationships with their own children. They often used their own parents behaviour as a guide of how not to parent their own children.

"I didn't have a great father, growing up…that has shown me a lot of what not to do. It has played a huge role on um, how I interact with my [infant], there's a lot of opposite of what my dad did. Because my mum, I only had this conversation with my mum after [infant] was born. "What kind of stuff did Dad do for us as babies?" She said "he didn't do much"…So, yeah it (breathes in loudly), the negative side of that has probably made me a better Dad. But that has been tough … Sometimes it comes up, yeah…Dad he never played with us as kids, he wouldn't get on the floor with us and play with us and but err, so I could be like well, [infant]'s happy playing

> on the floor, I could just sit on my phone and not interact with him, or choose to interact with him. Um, so what, I enjoy playing with my [infant], so I mean to do that, to show him, showing my [infant].” [Luke]

Table 23

Luke describes the lack of availability and the use of punishment from his father, his pauses and deep breaths highlight the negative feelings that these reflections stir up for him and how these memories are triggered through his experiences with his own son. Since his son was born his father’s role in his own childhood has been at the forefront of his mind, finding himself asking his mother about his father’s involvement in parenting tasks and being acutely aware of occasions in his relationship with his own child which replicate his own childhood. He describes the ‘negative side’ of his relationship with his own father as making him a ‘better Dad’, using this as a guide to meet the needs of his child that were not met for him during his own childhood, highlighting reparation in the intergenerational cycle. This process was similar for Peter: after being neglected during his own childhood, he was now focused on working hard to meet his family’s basic needs and described the relief of his children not going through the same experience.

> “Do I look at my childhood and think about the way I was brought up? Yeah, of course you do. But not for the worst. It’s for the better. So I look at things that happen to me that I went through and I think to myself, but he’s not going through that so he’s not experiencing it”. [Peter]

Table 24

For Callum, the trauma of his childhood abuse at the hands of his father had resurfaced through becoming a parent. He was determined not to repeat his father’s abuse and separated his father off as ‘evil’ in his mind, somebody he could never be like.

> “How my dad did it yeah. A hell of a lot different. I'm firm but I am fair. Whereas just my dad … he was an evil swine…I suppose that sometimes I feel like I’m like paying for those mistakes in a way. Because of how he was with me. My past came and bit me back on the backside even after I’d put it away for, for so long…I do think

about it, which makes sense, it's always going to be there in the back of my mind. It's always going to be there, it's going to be a part of me for the rest of my life. But now I just think yeah you didn't have great dad but I'm probably doing not great but better than what you did… my dad was evil. I'm firm but fair but I'm not evil. I don't want them to say oh my dad was an evil sod." [Callum]

Table 25

For some fathers, they described adopting positive aspects of their own experiences of being parented in their father role. These often centred around parenting behaviours which fathers believed supported them positively in life. Within these experiences, some fathers described refining the negative aspects such as discipline using physical punishment, as Martin explains.

"really good parents yeah. [smiling]. Yeah and me Dad's not here now but my mum is even better grandmother. Yeah, yeah, it seems like she wants to be. It's all she ever wanted to be you know. She's enjoying it more…they teached, they showed me how I can be. Yeah, yeah. Yeah, yeah, yeah. Just showing her right from wrong, being there, you know, helping her with the schooling and all that like. …I'm sure when my Dad took me somewhere I didn't realise sometimes he didn't want to go. But you know, you've gotta, you've gotta give haven't you. My mum and Dad were quite disciplined as well. They disciplined us, in like a rough way, you know. But it was a si-, But I suppose it was a sign of the times. you know what i mean. We don't do that know, you know what I mean. And me and [Wife] won't do that…Maybe me mum and Dad were just taught you just hit your kids. Yeah you know what I mean. I don't judge them for it. You know. But that is the only part that I won't carry on. I won't do that." [Martin]

Table 26

Martin describes his positive experiences of being parented, emphasised by his smiling and happy tone. He places strong emphasis on his parents showing him "how I can be" and a strong desire to take forward elements of his parents' behaviour into his role as a father, whilst repairing and refining the transmission of discipline within his own parenting.

### Challenging societal constructions of fatherhood

Although not consistent across all fathers, three men reflected on societal views of fatherhood, describing situations in which they encountered and challenged stereotypical views of male and female parental roles. This was a particularly strong theme for Scott as the primary caregiver for his children: he reflected on the disparities between perceived male and female parental roles through his frustration about men often being praised for parenting tasks that are expected from women.

> "When it comes to children, it's all female dominated…Like everywhere you go, it's like, you're doing a great job and like, well what do you mean by that? Well you're doing a great job with the girls. I'm glad that they are saying that but at the end of the day, when you've got children, that's sort of the responsibility that you've got to take on… But if it was a woman doing it, it would just be expected to do a good job. Like nothing would be said to a woman." [Scott]

Table 27

### Sources of support for fathers and their families

Many fathers discussed feeling supported within their current family and community settings, describing a range of current social connections in which they can access support. For some fathers, as illustrated by Curtis, extended family support and knowledge buffered their parenting role, and reduced worry.

> "I've got her family around me and I've got my family near so. We all live by each other so…They've been through it all, her dad, her Step-Mum has all been through it, so you know what I mean? It's handy to have them there, so you can just put her in the pram and go around there if you think there is something wrong… or if we want a couple of hours to ourselves." [Curtis]

Table 28

Where support from extended family or friends was not so readily available, involvement from Health Visitors was particularly valued by some fathers. For Greg, he initially describes

his Health Visitor as being part of their family, emphasising the intimate nature of this supportive relationship.

> "They are brilliant. They're honestly brilliant. There's a – he's been in our family – not family, but he's been involved with our family for 11-plus years, because of [Daughter] and the children we've got now. Oh, he's done so much for [Wife]" [Greg]

Table 29

Other fathers valued connections with other community services such as the church, work colleagues and friends.

**Meeting fathers needs**

Fathers were initially quite defensive about the need to access support or build connections with other fathers within the community. As Curtis illustrates, many fathers framed connecting with other fathers as 'needing help', rather than extending their social support network.

> "I dunno really because I see myself as not needed help if you get me, so I know there is help needed for Dad's it's there but it is hard to say without actually needing it yourself." [Curtis]

Table 30

Potentially accessing support could be seen as a form of weakness, particularly as fathers often said they "do not care" how people perceived them in their community and often described keeping their emotions to themselves. Anthony described men as having to "act hard, masculine or rough" and "it has always been like that down here" reflecting hiding emotional needs as a self-protective function within their community culture. Others describe their focus on their families-needs and lack of focus on their self, as explored earlier.

However, despite this initial resistance, fathers often went on to discuss what could be helpful. Many focusing on developing real life relationships and connections within their community rather than "artificial" relationships with services.

## Discussion

This is the first study to explore the experience of fathers of infants living in a socially deprived area of the UK. The four superordinate themes offer an insight into the complex processes that fatherhood entails in terms of the adjustment to the new role, finding a position within the family unit, the roles taken as a father and the sources of influences on the father from family and society.

Previous studies (Kowlesser, Fox & Wittkowski, 2015a) have used transition theory (Draper, 2003) to understand the process of transition to fatherhood, which suggests that men move through stages of separation, transition and incorporation. Within the current study, fatherhood brought a sense of maturity and growth, for some father's this led to a separation and sense of loss of elements of their previous autonomous and social self. However, all men described their fatherhood identity as taking prominence in their self-concept, which is a common theme in previous research (Chin et al, 2011; Benzies & Magill-Evans, 2014). The transition phase focuses on the fathers experiences of the pregnancy, however unlike previous studies (Kowlessar, Fox & Wittkowski, 2015a,b) men did not discuss their experiences during pregnancy unless there were difficulties present. The reasons for this are unclear: whether this period no longer had any significant relevance to their current self at the time of the interview, or whether they were avoidant of talking about their emotions within this period. In line with this finding, Scism and Cobb (2017) in their review found fathers described the birth as the beginning of fatherhood. Mirroring the incorporation stage and consistent with previous

findings (Bradley et al 2004; Kowlessar et al, 2015a), once the baby had arrived fathers became more certain and confident in their father role.

The prospect and experience of fatherhood saw men beginning to share themselves more intimately with their partner and baby and focus on longer term commitments. This suggests that fatherhood is a key point for a man's identity to mature, bringing some resolution to their search for sense of self and identity (Erikson, 1980). Similar to previous studies (Delicate, Ayers & McMullen, 2018; Kowlessar et al, 2015a; Chin et al, 2011) fathers reported a general sense of coming together with their partner, however many reported some conflict occurring, which was often viewed as a normal process of having a baby or as a process which helped them to understand their partner's needs.

For some fathers in the current study, their new role as father assumed taking a provider role to offer financial security and safety to their partner and child, whereas others focused on balancing this role with taking part in and supporting their partner with caring and nurturing tasks. Taking a provider role is a shaped 'culturally ideal' fatherhood role driven by hegemonic masculinity (Connell & Messerschmidt, 2005), which seemed to have prominence in fathers' description of their own fathers' involvement within working-class culture. Therefore, it may feel normative within this culture to focus efforts on taking a provider role within the new family during this position of identity change (Noone & Stephens, 2008). However, the predominance of the provider role is shifting within society with nurturing becoming a more prominent and valued role for fathers (Draper, 2003; Gatrell, Burnett, Cooper & Sparrow, 2015). Fathers within the current study reflected this cultural shift by clearly valuing being available and nurturing their children, either changing their work life balance to achieve this or experiencing loss and regret where this was not possible.

Typical masculine values such as stoicism have been suggested to be protective for men, particularly during childbirth (Dolan & Coe, 2011). This stoical position was present in fathers within the current study, who were often defensive about their need for support and tended to focus less on their needs and emotional experiences and place their partner and/or children's needs at the forefront. Previous studies have found that fathers tended to focus on mother's support needs rather than their own (Bradley et al, 2004; Darwin et al 2017). Maybe for the men in this study, showing emotion could be assumed to be a sign of weakness as defined by the norms of masculinity within their community. This particular value is likely to create a lack of emotional sharing and help seeking, which could be a mechanism in which depression develops and is maintained in men within the perinatal period (Seidler, Dawes, Rice, Oliffe & Dhillon, 2016).

Fathers' reports of enjoying getting to know their baby through positive reciprocal interactions, and developing a consistent, reliable bonds mirrors previous research that showed that high positive arousal in father-infant dyads was associated with father attachment security (Feldman, 2003). Pertinent to the current study was the explicit link between these interactions and the reported positive impact this had on their mood, an insight which offers opportunities to better understand the psychological mechanisms underpinning mood and coping within the perinatal period.

A prominent finding is the process of intergenerational reparation that fathers describe: that of being aware of their own unmet needs or difficult experiences from childhood and efforts to ensure that this is repaired within their children's' experience. This finding echoes previous studies (Chin et al, 2011). The current study also provided insight into this process for fathers who experienced severe neglect or abuse. Whether intentional or not, many fathers appeared to have some awareness of their own and their parents 'Ghosts in the Nursery',

changing not re-enacting their own early experiences of helplessness and fear (Frailberg, Adelson & Shapiro, 1975). In addition, many fathers, including those with history of abuse or neglect discussed positive childhood experiences through feeling loved and accepted by at least one parent or local figure, continuing these processes in their own father role. These 'Angels in the Nursery' provide early care-receiving experiences characterised by intense shared affect providing a core sense of security and self-worth which can be drawn upon in parenthood, with a protective effect against the cycle of maltreatment (Leiberman, Padron, Van Horn & Harris, 2005). However, this study does not explore this process over time, it could be more apparent at later stages of childhood.

**Limitations and recommendations for future research**.

A homogenous sample was sought for inclusion within the study as recommended for an IPA study (Smith et al, 2009). However, the relatively self-selecting nature of the sample presents potential bias, where fathers who chose to be interviewed may be likely to be more involved and naturally more reflective about their experiences of fatherhood. The current study included fathers of different ages, employment status' and numbers of children, but did not include representation from single fathers, those who did not live with their children or had no contact with their children. The findings therefore cannot be assumed to generalise to these other sub groups of fathers. Furthermore, the nature of this analysis does not allow for differentiation between universal elements around experiences of fatherhood from those that may be influenced by the socially deprived community from which this sample was recruited.

The sample size was small but in line with recommendations for a doctoral thesis (Smith et al, 2009). This enabled an idiographic, in-depth exploration of how fathers made sense of their personal worlds (Pietkiewicz & Smith, 2014), but further limits generalisability of the findings. However, overlapping findings with limited previous research (i.e. Kowlesser

et al, 2015a; Chin et al, 2011), suggests that these findings may have some applicability more widely.

Reflecting on the double hermeneutic processes of using IPA, the lead researcher was able to use their experience as a father, male and clinician to develop understanding of the participants lived world whilst reflexively bracketing these experiences as far as possible to prevent researcher bias (Ahern, 1999), supervision supported this process. Being a male and probing men's emotional experiences could have challenged the norms of masculinity (as explored above) and supported participants to share their own personal processes to a greater extent. In addition, to ensure that the analysis reflected fathers' experiences and to minimise researcher bias, the research team compared the themes and the interview schedule, agreeing that they did not mirror one another.

This study provides a starting point for more rigorous longitudinal methodology, which can explore transition to fatherhood over time, supporting fathers to reflect on their experiences at key time points such as conception, pregnancy, birth and throughout childhood. In addition, further qualitative studies that explore fatherhood in different groups of fathers in terms of their culture, involvement with their children or living situation are indicated. Particularly, interventions to support fathers require development and evaluation, as recommended below.

**Implications for clinical practice**

The findings of this study have a range of clinical implications for fathers and their families. There is often focus on developing father support groups and although men are challenging hyper-masculine stereotypes, these groups can be associated with men being effeminate, eccentric or failures placing them at a lower-status to other men (Dolan, 2014). This study observed that fathers can associate father-based support interventions with having a need for help, a weakness, and may find this threatening to their sense of self. Fathers

perceived their role as joining together with their children through shared activities, this could be mobilised as a basis for providing a social intervention for fathers.

Depression often has a systemic presence and can be detrimental to bonding and child development (Ramichandri et al, 2011). Many fathers discussed the positive effect of a reciprocal interaction with their infant on their mental health. Potentially, this could provide a mechanism through which encouraging and supporting father-infant attunement and interaction could prevent or alleviate depression and support infant development, this warrants further research. In addition, health professionals should be aware of the potential for men to avoid emotional sharing, this may reduce help seeking behaviour and maintain mental health difficulties such as depression.

There is a wider public health focus on the intergenerational effects of adverse childhood experiences (ACEs) across the lifespan (Hughes, Ford, Davis, Homolova & Bellis, 2018), however many fathers discuss the repetition of positive childhood experiences and reparation of their own childhood traumas within their model of parenting. Providing a space for fathers to reflect on their own experiences of being parented and adjustment to fatherhood could be useful. Midwifes and Health Visitors are well placed to undertake this role as a form of early intervention for father, mother and infant mental health and wellbeing.

Although work was often a prominent aspect of their identity, many fathers reflected on the adverse impact of work on their relationships with their children. This highlights the importance of an adequate period of paternity leave and both shared flexible working and parental leave. Father's described a drive to nurture their children, in addition they can provide a buffer within the family unit if their partner has perinatal mental health difficulties, which in turn could support childhood development (Bockneck et al, 2014; Chang et al, 2007). This

suggests potential cost-benefits by reducing the impact of perinatal and infant mental health difficulties.

## Conclusion

This study offers an insight into some of the psychological processes that underpin the transition to fatherhood for men living in deprived communities. To understand and meet fathers' needs requires appreciation of the adjustment process, intergenerational patterns, the changing role of fatherhood and prevailing values of masculinity. More research is needed to further understand the psychological processes of fatherhood and develop support tailored to fathers' needs.

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# Chapter 3:

# Contributions to Theory and Practice

## Introduction

This thesis explored the influence of community on adjustment and resilience in childhood and fatherhood. A structured narrative review identified protective factors present within the social and community environments of children and adolescents with adverse childhood experiences (ACEs). Whereas the empirical paper explored the psychological adjustment to fatherhood for men living in a deprived community.

This final paper will consider the contributions of this literature review and empirical study in two ways: 1) theory and research implications, 2) clinical implications.

## Implications for Theory and Research – Empirical Paper

The empirical study provided an initial investigation into men's experiences of becoming fathers living in a deprived community. To the authors knowledge this was the first study to explore fatherhood within this demographic in the UK. Many findings were similar to previous qualitative studies exploring fatherhood, such as adjusting to the role, growth and conflict in the couple relationship, balancing the provider and nurturer roles and intergenerational reflections (Bradley, Boath & Mackenzie, 2004; Chin, Hall & Daiches, 2011, Kowlessar, Fox & Wittowski, 2015a). However, some new key insights were observed relevant to this group of fathers and are discussed in this section.

First, many fathers reported an intergenerational cycle of reparation and repetition within their own model of parenting. Within this, fathers discussed repetition of their own positive experiences of being parented, whilst adjusting their parenting to meet their own unmet childhood needs in their children. This has significant importance in the prevention of child maltreatment, particularly as studies have identified child maltreatment in one generation is positively associated to child maltreatment in the next (Schofield, Lee & Merrick, 2013). The

psychoanalytic ‘Ghosts’ (Frailberg, Adelson & Shapiro, 1975) and ‘Angels’ (Leiberman, Padron, Van Horn & Harris, 2005) ‘in the nursery’ were discussed in the empirical paper to give further insight into this reparative process. These refer to often unconscious processes which are replayed throughout the subsequent parenting of each generation, relevant to negative and positive relational experiences with caregivers respectively. A central premise of this concept is that the conscious remembering of generational ACEs prevents repetition. Many of the fathers in the current study clearly discussed parts of their own experiences of being parented that they were consciously choosing to repair, some gave examples of this intergenerational repair process for their own parents. It is important to consider that fathers may be unaware of some of these unconscious repetitions within their own parenting and as such the methodological reliance on men reporting their own experiences through interviews would have been unlikely to capture these processes. Observational approaches to measurement or interviews with partners or couples may provide further insight. Indeed, it may not be until later childhood when these ‘Ghosts’ are activated and played out within the father-infant dyad. This requires further investigation through longitudinal approaches, as discussed below.

Second, most fathers described a significant shift in their self-concept from egocentricity to a relational focus encompassing their partner and children; this was a rapid process for many fathers and involved a reprioritisation of the self. Research has rarely explored this process at a theoretical level, the current study and one recent study (Kowlessar et al, 2015a) found a similarity between father reports and Draper’s (2003) Transition Theory. This theory conceptualises the transition to fatherhood as stages of separation, transition and incorporation. Both studies found similarities in the separation stage with fathers reporting disconnection from their social and autonomous selves. Within the transition phase, Kowlessar et al (2015a) observed that pregnancy was central to this process, whereas the current study

found fathers tended to focus on envisaging their role with the baby and their partner and rarely referred to the pregnancy. The incorporation stage was similar between both studies with fathers describing a relational focus on their new baby, engaging in shared interactions and settling into their chosen roles as a father.

Furthermore, the current study provides a fit with McCall and Simmons (1978) identity theory, this has previously been utilised to conceptualise the change in fathers' sense of self during their transition to fatherhood (Habib, 2012). The theory suggests that a person's self has multiple identities organised in a hierarchy of prominence based on their ideal self. The prominence of an identity is dependent on support from others, commitment to the identity and extrinsic and intrinsic rewards from the identity. Although fathers often reported a sense of loss of their previous social and autonomous self, this did not appear to cause any conflict or mental health difficulties as their commitment to their father roles took prominence. However, fathers who could not meet their prominent fatherhood role, for example if providing prevented them from taking a nurturing role; they often described feelings of loss and sadness. Accordingly, it could be hypothesised that fathers who experience fatherhood as a significant loss of their prominent identity, or if they lack support from others or rewarding experiences, may subsequently be at risk of a role conflict and mental health difficulties such as depression or disengagement from their fatherhood role may occur. This is consistent with previous research which found that adjustment to fatherhood is related to congruence with pre-existing life and life stage (Bradley et al, 2004) and warrants further research in fathers who are absent or report perinatal mental health difficulties.

Third, many fathers discussed rewarding reciprocal interactions with their infant characterised by positive arousal and enduring positive emotion. This positively arousing co-regulation has been found in a study of 100 videotaped father-child interactions (Feldman,

2003). This seemingly presents a potential mechanism for resilience, encouraging a stable bond and improving paternal mood. Supporting this interaction between fathers and their infants may have a range of protective effects for fathers and their infants, these clinical implications are explored in the next section.

The sample size was small (n=9) and participants were recruited from one community. Although, this limits the generalisability of the results, the use of Interpretative Phenomenological Analysis (IPA) enabled an in-depth analysis of the psychological processes occurring within the transition to becoming a father in a deprived context. Fathers were cross sectionally asked to reflect on their experiences of fatherhood, this may have presented a bias in which fathers did not report on certain events due to a loss of saliency over time i.e. pregnancy and birth. Longitudinal designs would be a positive direction for further research, with interviews at varying time intervals such as conception, pregnancy, birth and throughout childhood. This would provide a more accurate representation of the psychological processes fathers experience across time and support generalisability and applicability of the current findings.

***Reflection on the qualitative research process***

At times I was highly aware of the conflict between my role as researcher and professional role as a Trainee Clinical Psychologist (TCP). At the initial planning stage and during data analysis I was working within an Early Years CAMHS service within the same location that the research study took place. Within this work, I experienced working with children from 0-7 years and their parents living within the same community. There was a large overlap between these two roles, particularly around parental mental health and child development and emotional wellbeing. It was difficult from the perspective of usually being in a 'helping' role, not to formulate difficulties or offer support. At these times, I was acutely

aware to bracket these elements of my clinical role. However, my experiences as a TCP did bring some advantages. In particular, the confidence that I had gained to contain and tolerate distress, adopt a curious approach and explore peoples lived experience with sensitivity using a person-centred approach, allowed me to explore a deeper understanding of participants lived experiences. Keeping conscious awareness of these processes ensured that I asked questions and probes in line with my research objectives rather than being therapeutically supportive. Working closely with services within the recruitment area aided finding participants to take part in the study. In addition, I was able to use skills from my clinical role to provide a containing ending to the interview and signpost to support if necessary. This occurred for one participant who reported some difficulties with his partner's mental health.

During the interviews and analysis, I felt able to relate to many of the experiences being described by the fathers and I was able to reflexively use my similar experience to support my understanding of their experiences. When thinking through my own experiences as a father, I noticed that it is often easy to connect with and describe values rather than reporting on the reality of experience. For example, I would describe myself as a father who values spending time playing with my children. However, as I write this thesis the current reality is that I am not as available as I would like to be. It is painful to describe that I have not really been able to fulfil this role as I would have liked to over the past few months, whereas it is much easier to reflect on the value that I hold and often more socially desirable. Taking a reflexive approach, led me to wonder whether some of the fathers were more likely to discuss values rather than the reality of more difficult experiences and often led me to probe and question further to gain deeper insight to the reality of fathers' lives. This is a description of the double hermeneutic, a two-stage interpretation in which a participant is trying to make sense of their world and the researcher is trying to make sense of the participant making sense of their own world (Smith,

Larkin and Flowers, 2009). Supervision supported the processes of self-awareness, bracketing and reflexivity within the double hermeneutic stance.

What was clear from the interviews but not captured within the research data was that many fathers reported that they did not usually have the space to discuss their own experiences and found this useful. Unfortunately, I often did not have the time to discuss this with participants. I wondered at the time what was useful about this experience, it seemed having an opportunity to have their emotional needs attended to and chance to process some of their experiences within a relational interaction was in some way helpful. I felt a sense from many fathers that discussing their inner emotional self was not a familiar experience, it is not clear how far they were able to articulate their experiences. In addition, I was sitting with them as a father, clinician and researcher, considering the finding that fathers often perceived the need for support as a weakness which is threatening to their sense of self, this may have prevented some of the fathers from discussing experiences which they found difficult or were shameful. I found myself at these times questioning and deepening their responses in an attempt to create an interaction where it was safe to reveal their emotional being. This reflection does not diminish the validity of the data but rather questions whether some elements of the fathers more difficult experiences may be hidden.

**Implications for Theory and Research – Systematic Review**

The literature review focused on exploring predictors of resilience in children and adolescents outside of the family home. The review identified six protective factors: peer relationships, school environment, relationships with other adults, activity involvement, religion and neighbourhood characteristics. Within the six protective factors identified within the review, there seemed to be two strong themes:

1. Developing safe and supportive relationships with peers, teachers, other adults.

2. Forming a connection and being motivated to engage in activities such as school and extra-curricular activities.

Attachment theory can provide a framework which offers theoretical understanding of the impact of relationships. Safe and secure attachment relationships with a primary care-giver in childhood, characterised by sensitive attunement, synchrony and the reparation of ruptures in parent-infant interactions are well-established to support a child to develop an internal 'working model' which allows a person to regulate their emotions and manage future relationships (Bowlby, 1969). Children who experience ACEs within the home environment are less likely to have experienced these secure relational experiences (Van der Kolk, 2015). Rather the lack of caregiver modulation of their arousal or the constant presence of threat may cause children to over-regulate and inhibit emotion (avoidant attachment), under-regulate with great displays of uncontrolled emotion (ambivalent attachment) or oscillate between both styles (disorganised attachment) (Baer & Martinez, 2006). These behaviours are help-seeking strategies, moulded through the child's experience with their caregiver or perpetrator of abuse (Cook et al, 2017). These children may expect others to be unresponsive, unavailable or unwilling to meet their needs, or even to be abusive and endangering. In addition, living within an environment with toxic stress can cause children to function within a survival mode and react to perceived threats within their environments (Cook et al, 2017). Secure attachment in the caregiving relationship can buffer stressors and provide resilience for children exposure to traumatic experiences (Blaustein & Kinniburg, 2007).

Li and Julian (2012) emphasise relationships as the active ingredients of recovery from childhood trauma and recommend that relational connections which are positive, natural and

appropriate for the child should be the target of efforts to make change. Bronfenbrennor (1979) specifies four criteria to the ideal dyadic interaction, including attachment, reciprocity, progressive complexity and balance of power. It is within these nurturing relationships that children can learn to understand and regulate their emotions, develop skills and learn how to function effectively in future relationships (Van der Kolk, 2015). As the literature review demonstrates, when children report feeling understood, heard, trusted and cared for by others around them they are more likely to be resilient. This is consistent with models of trauma informed care which seek to repair and develop adaptive working models of attachment (Cook et al, 2017).

The literature review demonstrated that having a positive connection to school, motivation to work and engagement in sports and activity has an association to resilience in some children with ACEs. Positive psychology offers some further theoretical insight into these findings. Fredrickson's (2004) Broaden and Build theory reports on a range of experimental studies that find positive emotions such as joy, interest and curiosity broaden a person's momentary thought-action repertoire, for example feeling joy can trigger an urge to explore (Garland et al, 2010). By broadening this thought-action repertoire, positive emotions enable greater access to social bonds and novel creative actions, which allow a person to build personal resources. This is opposite to the state of withdrawal and avoidance associated with shame which often occurs in the context of childhood trauma (Bath, 2015). Potentially, engaging in activities and having positive and motivational connections to school can provide a sense of enjoyment, interest, curiosity and contentment, which can be shared at a relational level providing opportunities to learn personal skills and experience positive healing relationships which can support resilience. This is further explored in the next section.

However, the review had some limitations. It did not explore the links between community and societal factors and individual and relational factors, this should be the focus of future research. In addition, studies did not often differentiate between single (type I) and multiple/chronic (type II) trauma. Exposure to type II is likely to have greater negative developmental outcomes over the life course (Van der Kolk, 2015). Further, for younger children it is suggested that the attachment system should be the focus of intervention, whereas due to their developmental stage, adolescents are more able to make use of social interventions (Cook et al, 2017). Further research is required to explore the impact of community-based interventions across the developmental range of childhood and adolescence.

**Clinical Implications**

Both papers highlight the importance of conducting clinical psychological research in community settings. The studies did not seek to pathologise or search for clinical problems within the samples they explored, rather they sought to understand the natural psychological processes occuring within the participants usual contexts. The aim of this thesis is to understand the processes of how individuals adjust and develop resilience within their natural environment which can be capitalised within supportive interventions.

This section aims to suggest ways clinical psychology can support fatherhood in deprived communities and to enhance resilience in children after ACEs within community settings. This draws heavily on the wide-ranging competencies of clinical psychologists to integrate psychological and societal understandings of family functioning (Galbraith, Balbernie & White, 2012). Clinical psychologists are well placed to offer leadership, supervision, consultation and training to develop psychologically informed communities and health and social services (BPS, 2010).

**1. Screening for Adverse Childhood Experiences**

Screening for ACEs in childhood and parenthood is often suggested to inform support and referral to services (Hughes et al, 2017). This has received some criticism due to the assumption imposed that everybody with ACEs has the potential for adverse outcomes or adverse outcomes are related to ACEs, which diminishes the notion of resilience (Finkelhor, 2017). In addition, Metzler, Merrick, Klevens, Ports and Ford (2017) argue that the focus on ACEs creates a narrative of sole responsibility on parents, they suggest that rather there should be a strengths-based focus on supporting safe, stable and nurturing relationships and environments.

The resilience research shows that a sizeable group of individuals do not experience adverse outcomes after ACEs (Walsh, Dawson & Mattingly, 2010) and the empirical study demonstrated that not all fathers disclosing ACEs report ongoing difficulties, albeit limited by a small sample size. Both the literature review and empirical paper identified that many individuals go through their own natural processes of healing. This thesis has shown that we can learn from these individuals and scaffold the natural resilience processes. It may therefore be more effective to screen for mediating processes, such as mental health difficulties e.g. depression, PTSD and anxiety, early attachment relationship variables such as sensitivity and attunement, couple functioning (Finkelhor, 2017). This would identify a greater number of the 'at risk' individuals who would benefit from support and intervention rather than simply all individuals with ACEs.

**2. Supporting fathers**

Despite research exploring paternal mental health such as depression remaining in its infancy, a range of risk factors have been identified, although the direction of causality is not

always clear. These include a previous history of depression and/or anxiety, presence of depression in partner, being in an unsupportive relationship, unemployment, incongruity between the expectations and reality of fatherhood, lack of social support, feelings of separation and exclusion from bonding (Edward, Castle, Mills, Davis & Casey et al, 2015; Goodman, 2004).

Fathers often reported after the interview that they did not usually have opportunity to discuss their experiences and found this useful. Considering the risk and resilience processes within the transition to fatherhood identified within the current literature and the empirical study, access to a therapeutic conversation within a safe space may be an effective intervention and warrants evaluation. Therapeutic conversations can support fathers to reflect on intergenerational processes, adjustment to fatherhood, changing couple relationship and their model of parenting. This could be delivered by health professionals within the perinatal period such as midwifes and health visitors. As discussed earlier, supporting fathers to become consciously aware of their difficulties and reflect on their current fathering role may have a protective effect on supporting adjustment and preventing intergenerational transmissions of abuse. Within a reflective conversation, solution focused approaches (Sommers-Flanagan, Polanchek, Zeleke, Hood & Shaw, 2015) may be useful to support fathers who struggle to articulate their emotional experiences to take a practical focus to their difficulties. Clinical psychologists working within perinatal services could offer training, consultation and supervision to support this process. This approach could form early intervention to prevent and/or signpost fathers prior to mental health difficulties becoming severe or child protection issues occurring.

Fathers reported positive reciprocal interactions within the father/infant dyad having a positive effect on paternal mood. This positive mood inducing process warrants further

investigation as to whether it can support intervention for paternal mental health difficulties such as depression. In addition, supporting a positive father/infant attachment can be protective for children across childhood (Opondo, Redshaw, Savage-Mcglynn & Quigley, 2016). One potential intervention is Video Interaction Guidance (VIG; Kennedy, Landor & Todd, 2011), this approach utilises strengths-based video feedback of parent/child interactions to promote attunement and intersubjectivity, with a developing evidence base in parent/infant dyads (Fukkink, 2008). In addition, preliminary evidence has demonstrated improved interaction in mothers with postnatal depression (Vik & Braten, 2009). Intervention-based randomised controlled trials would be a starting point to utilise interventions which support positive attunement, synchrony and reciprocity within the father/infant dyad. Whilst evidence for paternal mental health interventions is building, health professionals in contact with fathers should be mindful and enquiring about mental health difficulties in fathers. When difficulties are suspected, fathers should be signposted, with their agreement, to appropriate mental health services. However, these services are often separate to child and family services and there remains a gap in which the systemic relevance of fathers' mental health to the stability of the family unit is often not addressed. This could be addressed by perinatal services expanding their provision to a family model including fathers, particularly with the evidence demonstrating interactional links between paternal, maternal and infant mental health and wellbeing (Royal College of Midwives, 2011).

Fathers often describe feeling excluded from aspects of maternity care and education (Chin et al, 2011; Kowlessar, Fox & Wittowski, 2015b). Fatherhood support groups could provide information and skills appropriate to different periods, i.e. pregnancy, babyhood, early childhood and teenage years, or a source of social connection with other fathers. Nash (2018) interviewed Australian men who had experienced antenatal preparation classes, finding that men reported groups as useful but did not feel comfortable sharing their feelings in a group

setting; this is in contrast to Barclay and Lupton (1999). Previous studies have identified men valued male facilitators who were fathers and did not mind whether facilitators were health professionals or not (Friedewald et al, 2005; Lee & Schmeid, 2001; Nash, 2018). Fathers in the empirical study were often avoidant sharing their emotional experiences and often equated father support interventions with a need for help; they may see this as a weakness and a threat to their self. However, fathers perceived their role as joining together with their child through shared activities, this could be mobilised within social interventions. Groups should therefore not mirror a female centric approach, rather they should be based on activities with promote fathers to join together and develop supportive connections. They could be coproduced and led by willing fathers within communities, this may have some effect on breaking down barriers which currently prevent fathers from accessing support groups.

In addition, fathers within the empirical study described a drive to undertake a nurturing role with their infant, many reflected on the negative impact of work on this role. Studies show the buffering role that fathers can have on the family unit, particularly if their partner has perinatal mental health difficulties (Bockneck, Brophy-Herb, Fitzgerald, Schiffman & Vogel, 2014; Chang, Halpern & Kaufman, 2007). Therefore, fathers should be supported and encouraged to use flexible working and parental leave, this should improve family outcomes and reduce demand on services, providing cost benefits for society. For this reason longer periods of paternity leave should be explored by government.

**3. Community interventions for children with ACEs**

The systematic review offers a starting point for public health, educational and local community services to commission interventions which provide support at the community and societal levels of the ecological model (Bronfenbrenner, 1979). The research around religion and neighbourhood is within its infancy and there are several methodological flaws which

require resolving, it is therefore not possible to make any firm suggestions for intervention within these factors. In addition, religion has different meaning for different individuals and groups within society, it is not ethically acceptable to make recommendations based on religious practices. Importantly, however, there are four main findings which are associated with positive outcomes and are practically possible to intervene, these include peer relationships, school environment, relationships with other adults and activity involvement. Although further research is required to more robustly explore these factors, the evidence base can be developed through designing and robustly evaluating interventions based on these factors.

First, emotionally supportive peer relationships and networks with pro-social peers should be encouraged. These could be scaffolded through providing access to activities for peers to meet, as discussed below, and supporting children to develop social relationship skills. There are a range of evidence-based interventions that can be provided in schools and communities, such as the range of FRIENDS programmes which provide group based cognitive behavioural therapy, from ages 4 until adulthood, to promote social skills and emotional resilience (Ruttledge et al, 2016).

Second, schools are a significant source of resilience within the lives of children and adolescents, offering an escape from potentially traumatic home lives and opportunities to develop personal resources. Training educators and school-based staff about the psychology of trauma, relationship building, and behaviour management would be beneficial to enhance the school environment (Wiest-Stevenson & Lee, 2016). Particularly ensuring teachers have time to develop relationships with pupils that are characterised by care, encouragement and fairness and support children to develop a positive connection to school by harnessing their motivation in some form.

Third, a similar training approach could be undertaken to support adults in the child's current environments, such as teachers, coaches, activity leaders or social workers, to develop safe and reparative relationships with children and adolescents. Mentoring has associated positive outcomes for maltreated children (Taussig & Culhane, 2010), this could be provided by youth workers or befrienders.

Fourth, sports and activities offer a space for children to access connections with peers, adults and provide a source of stability and enjoyment. Rather than focusing on measuring activities which children are currently engaged in, it would be appropriate to develop sports and activities within schools and local environments which can be robustly evaluated, ideally through controlled trials. Bergholz, Stafford and D'Andrea (2016) offers a range of practical trauma-sensitive approaches that coaches can utilise when designing, running and managing sports activities, they suggest co-production and a focus on strengths and emotional and relational skills development.

Within these factors it is clear that forming and maintaining relationships with others is central to resilience building. To ensure efficacy, community-based interventions would benefit from incorporating trauma informed models. One such model is the 'three pillars of trauma-informed care' (Bath, 2015), which emphasises three categories to inform intervention: safety, connections and managing emotions or coping.

1. **Safety** – refers to consistency, reliability, predictability, availability, honesty and transparency in relationships which create safe and stable environments. In addition, ensuring that children have developmentally relevant power and control in their lives.
2. **Connections** – engaging in normal activities and settings not only provide opportunities for making relationships but also prevent children avoiding relationships due to shame (Cook et al, 2017). Many children may present with

suspicious, avoidant or hostile behaviours towards adults as they associate these relationships with threat and negative emotion. Therefore, positive relationships with adults offer opportunities for children to learn to distinguish emotions which are harmful and those that are not.

3. **Emotion and impulse management/coping** - Schore (2002) describes difficulties with self-regulation of emotions as the prominent characteristic of childhood trauma. As such, adults should be supported through training to understand that challenging behaviours reflect children's inner pain and to be aware of the controlling and punitive responses these can elicit from adults. Bath (2015) suggests that adults should provide active listening whilst attuning to nonverbal cues, asking questions and reflecting back feelings to support children with ACEs to learn emotional literacy, whilst offering co-regulation by modelling containing regulating emotional responses to help the child return to emotional equilibrium.

Along with the factors identified within the literature review, incorporating trauma informed models will enrich children's environments to provide optimal opportunity to heal from trauma and develop resilience, which will support their later life outcomes (Ben-David & Johnson-Reid, 2017). In addition, as discussed earlier, positive psychology has much to offer in the recovery from trauma. Fredrickson's (2004) Broaden and Build Theory suggests that the school environment, activities and relationships should provide positive emotional experiences which enhance individuals thought-action repertoire and in turn develops children's personal resources. However, there is minimal evidence to support the use of this theory in clinical practice. Much further research is required, this could occur through the development and robust evaluation of activity and school-based programmes, utilising principles of this theory.

## Conclusion

Overall, the literature review and empirical study provide a timely and significant contribution to supporting fathers in deprived areas and children with experiences of ACEs through community interventions. When developing the ideas for this thesis, I was keen to make the empirical study and literature review as practical as possible to ensure that they could make a positive impact on the lives of fathers and children. The papers were developed through engagement with local stakeholders and my aim is for both papers to enhance support and intervention within local services. With this in mind I have been in contact with stakeholders throughout the process and have made plans for the findings to be disseminated into local services. I am passionate about supporting people within their community contexts and mobilising the natural resources occurring within people and communities. I look forward to continuing this passion throughout my career in clinical psychology.

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# Appendices

I. Bangor University School of Psychology Ethics Approval

II. Bangor University School of Psychology Ethics Amendment Approval

III. Confirmation NHS REC Review not Required

IV. NHS R&D Approval Letter

V. Participant Information Form – English & Welsh Versions

VI. Participant Consent Form – English & Welsh Versions

VII. Interview Schedule

VIII. Representation of Themes across Participants

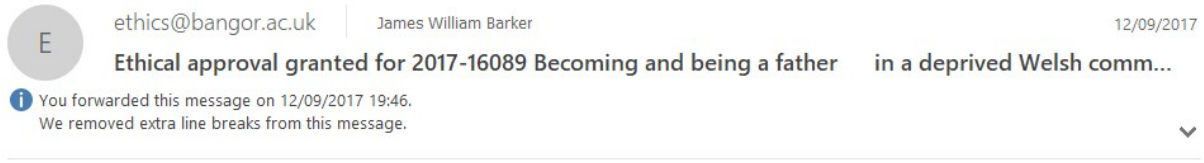
IX. Annotated Section of Transcript

X. Word Count Statement

# Appendix I

## Bangor University School of Psychology Ethics Committee Approval

Email confirmation of Bangor University Ethical Approval




Dear James,

2017-16089 Becoming and being a father in a deprived Welsh community

Your research proposal number 2017-16089 has been reviewed by the Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

# Appendix II

## Bangor University School of Psychology Ethics Amendment Approval

## Details of Amendment

| | | |
|---|---|---|
| **Application number:** | 2017-16089-A14230 | Download as PDF |
| **Project Title:** | Becoming and being a father in a deprived Welsh community | Download attachments.zip |
| **Amendment requested by:** | Barker, James | |
| **Principal Investigator:** | Barker, James | |
| **Study Start Date:** | 01 Sep 2017 | |
| **Study End Date:** | 28 Sep 2018 | |
| **Other Researchers:** | Jackson, Mike - Agreed<br>MEAR, Elizabeth - Agreed<br>Burnside, Elizabeth - Agreed | Resend password for username mear3596 |
| **Nature of Amendment:** | Change recruitment criteria from 'fathers of infants between 6-12 months' to 'fathers of infants between 3-18 months'. | |
| **Department** | Psychology | |

**LAST MODIFIED: 07 Feb 2018 01:29p.m. by psp6bc**

Review

Information sheets duly amended

**Approval Status:**Approve

## Email confirmation of Bangor University Ethical Approval of Amendment

ES

ethics@bangor.ac.uk | James William Barker 07/02/2018

**Ethical approval granted for 2017-16089-A14202 Amendment to to Becoming and being a fat...**

We removed extra line breaks from this message.

Dear James,

2017-16089-A14202 Amendment to to Becoming and being a father in a deprived Welsh community

Your research proposal number 2017-16089-A14202 has been reviewed by the Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

# Appendix III

## Confirmation NHS REC Review not Required

**From:** Mike Jackson
**Sent:** Tuesday, August 1, 2017 3:05:31 PM
**To:** James William Barker
**Subject:** FW: Ethics query

FYI – keep a copy of this for future reference

**From:** "Mike Jackson (BCUHB - Clinical Psychology)"
**Date:** Tuesday, 1 August 2017 15:01
**To:** Mike Jackson
**Subject:** FW: Ethics query

**From:** Rossela Roberts (BCUHB - Research & Development)
**Sent:** 01 August 2017 15:01
**To:** Mike Jackson (BCUHB - Clinical Psychology)
**Subject:** RE: Ethics query

Hi Mike,
Yes, Aaron is correct, this will not require REC review
Regards
Rossela

**From:** Mike Jackson (BCUHB - Clinical Psychology)
**Sent:** 01 August 2017 14:56
**To:** Aaron Pritchard (BCUHB - Research & Development)
**Cc:** Rossela Roberts (BCUHB - Research & Development)
**Subject:** RE: Ethics query

Thanks Aaron, thats very helpful.
Rossela – what do you think ?
Best
Mike

**From:** Aaron Pritchard (BCUHB - Research & Development)
**Sent:** 01 August 2017 14:32
**To:** Mike Jackson (BCUHB - Clinical Psychology)
**Cc:** Rossela Roberts (BCUHB - Research & Development)
**Subject:** RE: Ethics query

Hi Mike, interesting study and as James point out, addressing a field often neglected in traditional studies of family and child development.
You are right in that the participants are not being recruited in their 'capacity as patients of the NHS'. However, they are being recruited through health facilities and by NHS professionals from what I can tell. This may warrant that NHS ethics as well as NHS R&D approval is necessitated.
I'm copying in Rossela to check on this - as I am not 100% sure what the official line would be on this to be honest. My instinct would be that with thorough University Ethical review and R&D approval this study (interviewing fathers I their own right rather than as NHS patients) would be sufficient and appropriate.
Kind regards,
Aaron

**From:** Mike Jackson [mailto:mike.jackson@bangor.ac.uk]
**Sent:** 01 August 2017 14:17
**To:** Aaron Pritchard (BCUHB - Research & Development)
**Subject:** Ethics query

Hi Aaron
Could you give this a once over ? I don't think it should require Rec review, as the participants are not identified through their patient status. Am I missing something obvious, or is that correct ?
Thanks
Mike

**From:** "Aaron Pritchard (BCUHB - Research & Development)"
**Date:** Tuesday, 4 July 2017 10:18
**To:** Mike Jackson
**Subject:** UK wide change to IRAS forms

Hi Mike, see attached, changes being implemented to IRAS…
Thought it would be useful for you and the ClinPsych team to have this document.
Aaron

# Appendix IV

# NHS R&D Approval Letter

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

**Panel Arolygu Mewnol Y&D**
**R&D Internal Review Panel**

Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Clinical Academic Office
Bangor, Gwynedd
LL57 2PW

Chairman/Cadeirydd – Dr Nefyn Williams PhD, FRCGP
Email: Debra.slater@wales.nhs.uk
sion.lewis@wales.nhs.uk
Tel/Fax: 01248 384 877

Mr James Barker
North Wales Clinical Psychology Programme
Brigantia Building
Bangor University
Bangor
LL57 2DG psp6bc@bangor.ac.uk

07 November 2017

Dear Mr Barker,

**Re: Confirmation that R&D governance checks are complete / R&D approval granted**

| | |
|---|---|
| **Study Title** | Being and becoming a father in a deprived Welsh community |
| **IRAS reference** | 232607 |

Thank you for submitting your R&D application and supporting documents. The above research project was reviewed at BCUHB by the R&D Internal Review Panel (IRP) proportionate review (PR) process.

The Panel is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application. *A full list of documents included in the review is attached as an appendix.*

**The R&D Office, on behalf of the Internal Review Panel, is pleased to confirm that all governance checks are now complete and to grant approval to proceed at Betsi Cadwaladr University Health Board sites as described in the application.**

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (2009). An electronic link to this document is provided on the BCUHB R&D WebPages. Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If your study is adopted onto the NISCHR Clinical Research Portfolio (CRP), it will be a condition of this NHS research permission, that the Chief Investigator will be required to regularly upload recruitment data onto the portfolio database. To apply for adoption onto the NISCHR CRP, please go to: http://www.wales.nhs.uk/sites3/page.cfm?orgid=580&pid=31979.

Once adopted, NISCHR CRP studies may be eligible for additional support through the NISCHR Clinical Research Centre. Further information can be found at: http://www.wales.nhs.uk/sites3/page.cfm?orgid=580&pid=28571 and/or from your NHS R&D office colleagues.

To upload recruitment data, please follow this link: http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment.
Uploading recruitment data will enable NISCHR to monitor research activity within NHS organizations, leading to NHS R&D allocations which are activity driven. Uploading of recruitment data will be monitored by your colleagues in the R&D office. If you need any support in uploading this data, please contact debra.slater@wales.nhs.uk

If you would like further information on any other points covered by this letter please do not hesitate to contact me. On behalf of the Panel, I would like to take this opportunity to wish you every success with your research.

Yours sincerely,

Miss Debra Slater
Research Governance Officer

Copy to:

| | | |
|---|---|---|
| Sponsor: | Mr Hefin Francis<br>School of Psychology<br>Bangor University<br>Bangor<br>LL57 2DG | h.francis@bangor.ac.uk |
| Academic Supervisor: | Dr Elizabeth Mear<br>CAMHS, Child Health Building,<br>Wrexham Maelor Hospital,<br>Croesnewydd Road,<br>Wrexham<br>LL13 7ZA | elizabeth.mear@wales.nhs.uk |
| Academic Supervisor: | Dr Elizabeth Burnside<br>North Wales Clinical Psychology Programme<br>Brigantia Building,<br>Bangor University,<br>Bangor<br>LL57 2DG | e.burnside@bangor.ac.uk |
| Academic Supervisor: | Dr Mike Jackson<br>North Wales Clinical Psychology Programme<br>Brigantia Building,<br>Bangor University,<br>Bangor<br>LL57 2DG | mike.jackson@bangor.ac.uk |

# Appendix V

## Participant Information Form – English & Welsh Versions

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SCHOOL OF PSYCHOLOGY

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

**RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU**
**NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

PRIFYSGOL BANGOR UNIVERSITY

**Being and becoming a Dad in a disadvantaged Welsh community**

**Information about the study**
You are invited to take part in a research study examining the experiences of becoming and being a Dad.

**Why have I been asked to take part?**
You have been asked to take part because all father's with a child between 3-18 months who live at a permanent address in an area of North Wales which has been identified as deprived by the Welsh Multiple Deprivation Indictor (Welsh Government, 2017) are being invited to participate.

The Welsh Government describe deprivation is the lack of access to opportunities and resources which we might expect in our society, such as employment, health, access to services, housing and education.

**What does the study involve?**
The study will require you to sit with a researcher for about one hour to talk about your experiences of becoming a father and being a father. This interview will happen at a time and place which is convenient and private for you, such as a GP practice, health centre or even your home. You will be asked to fill out some forms which give you information about the study and for you to give your informed consent.

In return for your time and effort, you will be given a £20 One4All gift voucher which can be spent at many high street shops.

**Are there any benefits or risks?**
It is hoped that the study can help health professionals better understand the needs and experiences of fathers. The findings of the study will be made available for services to use to meet yours and your family's needs.

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The study will ask you to talk about your experiences of being parented yourself, your current relationships with your child's mother/partner, child and family, and how you find/see your community. This may raise some difficult experiences which may be upsetting, however the researcher will not push you to talk about difficult experiences if you do not want to.

**What will happen to my data?**
All data/information collected will be confidential, and you will not be identifiable in any report, thesis or publication, which arises from this study. The data from this study will be stored securely for a maximum of 5 years. If you choose to withdraw from the study and your data is identifiable to the research team, then you have the right to request that your data is not used.

If you lose capacity after you have given informed consent and undertaken your interview then your interview data will still be used, however you and your family have the right to request that your data is not used. If you lose capacity before the interview has taken place, then you will be withdrawn from the study.

**What if I don't want to take part?**
It is up to you to decide whether or not you would like to participate in this study. Deciding not to take part will not impact any other aspect of your involvement with health services. If you chose to take part you have the right to withdraw at any time.

**Who do I contact about the study?**
If you would like to talk at any point about this study, please contact:

James Barker, Trainee Clinical Psychologist
Telephone: 01248 388365
Email: psp6bc@bangor.ac.uk

**Who do I contact with any concerns about this study?**
If you have any concerns or complaints about this study, or the conduct of individuals conducting this study, then please contact either:

Hefin Francis, School Manager, School of Psychology, Bangor University, Bangor, Gwynedd LL57 2AS or e-mail h.francis@bangor.ac.uk.

Or Concerns Team, Betsi Cadwaladr University Health Board, Ysbyty Gwynedd, Bangor, Gwynedd, LL57 2PW or telephone 01248 384194.

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**NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

**Dod yn dad a bod yn dad mewn cymuned Gymreig ddifreintiedig**

**Gwybodaeth am yr astudiaeth**

Rydych yn cael eich gwahodd i gymryd rhan mewn astudiaeth ymchwil sy'n edrych ar brofiadau dod yn dad a bod yn dad.

**Pam y gofynnwyd imi gymryd rhan?**

Gofynnwyd i chi gymryd rhan oherwydd bod holl dadau gyda phlentyn rhwng 3 - 18 mis oed sy'n byw mewn cyfeiriad parhaol mewn ardal yng Ngogledd Cymru sydd wedi ei nodi fel un ddifreintiedig yn ôl Mynegai Amddifadedd Lluosog Cymru (Llywodraeth Cymru, 2017) yn cael eu gwahodd i gymryd rhan.

Mae Llywodraeth Cymru'n disgrifio amddifadedd fel diffyg mynediad at gyfleoedd ac adnoddau y gallem eu disgwyl yn ein cymdeithas, megis cyflogaeth, iechyd, mynediad at wasanaethau, tai ac addysg.

**Beth fydd yn digwydd yn yr astudiaeth?**

Bydd angen i chi eistedd gydag ymchwilydd am tua awr i siarad am eich profiadau o ddod yn dad a bod yn dad. Cynhelir y cyfweliad hwn ar adeg ac mewn lle sy'n gyfleus a phreifat i chi, megis meddygfa eich meddyg teulu, canolfan iechyd neu hyd yn oed eich cartref. Gofynnir i chi lenwi rhai ffurflenni sy'n rhoi gwybodaeth i chi am yr astudiaeth ac i chi roi eich caniatâd gwybodus.

I ddiolch am eich amser a'ch ymdrech byddwch yn cael cerdyn anrheg One4All gwerth £20 y gellir ei wario mewn llawer o siopau'r stryd fawr.

**A oes unrhyw fanteision neu risgiau?**

Gobeithir y gall yr astudiaeth helpu gweithwyr iechyd proffesiynol i ddeall yn well anghenion a phrofiadau tadau. Bydd darganfyddiadau'r astudiaeth yn cael eu rhoi i wasanaethau er mwyn iddynt eu defnyddio i ddarparu ar gyfer eich anghenion chi a'ch teulu.

Bydd yr astudiaeth yn gofyn i chi siarad am eich profiadau o gael eich magu eich hun, eich perthynas bresennol â mam eich plentyn/partner, y plentyn a'r teulu, a sut rydych chi'n gweld eich cymuned. Fe all hyn godi rhai profiadau anodd a all fod yn annymunol i chi; fodd bynnag, ni fydd yr ymchwilydd yn eich gwthio i siarad am brofiadau anodd os nad ydych eisiau.

**Beth fydd yn digwydd i'm data?**

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Bydd yr holl ddata/gwybodaeth a gesglir yn gyfrinachol ac ni fydd yn bosibl eich adnabod mewn unrhyw adroddiad, thesis na chyhoeddiad sy'n deillio o'r astudiaeth hon. Caiff y data o'r astudiaeth hon eu cadw'n ddiogel am 5 mlynedd ar y mwyaf. Os byddwch yn dewis tynnu'n ôl o'r astudiaeth ac os bydd y tîm ymchwil ar yr adeg honno yn gallu adnabod eich data, mae gennych hawl i ofyn iddynt beidio â defnyddio eich data.

Os collwch y gallu i weithredu ar ôl i chi roi caniatâd gwybodus a chael eich cyfweliad, yna bydd data eich cyfweliad yn dal i gael eu defnyddio. Fodd bynnag, bydd gennych chi a'ch teulu'r hawl i ofyn am i'ch data beidio â chael eu defnyddio. Os collwch allu i weithredu cyn i'r cyfweliad gael ei gynnal, yna byddwch yn cael eich tynnu o'r astudiaeth.

**Beth os nad wyf eisiau cymryd rhan?**

Chi sydd i benderfynu p'un a ydych eisiau cymryd rhan yn yr astudiaeth hon ai peidio. Os byddwch yn penderfynu peidio â chymryd rhan, ni fydd hynny'n cael effaith ar eich cysylltiad â gwasanaethau iechyd. Os penderfynwch gymryd rhan, mae gennych hawl i dynnu'n ôl ar unrhyw adeg.

**Â phwy y dylwn gysylltu ynglŷn â'r astudiaeth?**

Os hoffech siarad am yr astudiaeth hon ar unrhyw adeg, cysylltwch â:

James Barker - Seicolegydd Clinigol dan Hyfforddiant

Ffôn: 01248 388365

E-bost: psp6bc@bangor.ac.uk

**Â phwy ddylwn i gysylltu os oes gennyf unrhyw bryderon ynglŷn â'r astudiaeth hon?**

Os ydych yn dymuno gwneud cwyn am ffordd mae'r astudiaeth yn cael ei chynnal, gallwch gysylltu â'r heini a enwir isod am gyngor a gwybodaeth bellach:

Hefin Francis, Rheolwr Ysgol, Ysgol Seicoleg, Prifysgol Bangor, Bangor, Gwynedd LL57 2AS neu e-bost h.francis@bangor.ac.uk

Neu Tîm Pryderon, Bwrdd Iechyd Prifysgol Betsi Cadwaladr, Ysbyty Gwynedd, Bangor, Gwynedd, LL57 2PW neu rhif ffôn 01248 384194.

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# Appendix VI

## Participant Consent Form – English & Welsh Versions

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**RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU**
**NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

PRIFYSGOL BANGOR UNIVERSITY

(NB - Copy of consent form to be given to participant to retain in addition to signed copy kept by researcher).

**Title of Research: Becoming and Being a Dad in a disadvantaged Welsh community**

**Names and Positions of Investigators:**

James Barker – Trainee Clinical Psychologist

Supervised by:

Dr Liz Mear – Clinical Psychologist

Dr Elizabeth Burnside – Consultant Clinical Psychologist/Academic Director

Dr Mike Jackson – Consultant Clinical Psychologist/Research Director

**The nature of the research project**

This research project aims to explore fathers' experiences of being and becoming a father living in an area which the Welsh Government class' as 'deprived'.

**Procedures of the study**

The research study will be carried out in English. The researcher will endeavour to provide information in Welsh if this is requested by yourself.

You may have found out about the study from your health visitor or another healthcare professional. They would have sought your permission to pass your details on to the researcher. If you found out about the study from a poster, then you would have contacted the researcher. The researcher would have given you some information about the study and asked for your consent to take part. If you agreed, you will have been invited for an interview.

You will meet with a trainee clinical psychologist at a location and time agreed with you. The interview takes about an hour and will start by asking you for some basic details about

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yourself. The interview will then commence as a discussion about your experiences of being parented, becoming a father, being a father and your relationships with your child, child's mother/partner and family. The interview will finish with a debrief and an opportunity to discuss how you found the interview and if you feel that you need any further support.

Your interview will be recorded and transferred to a secure encrypted USB stick and an NHS computer system. This will then be written up or transcribed, during this process any names and identifiers such as workplaces, addresses will be changed to anonymise your information. Any contact details we hold for you will be stored on the secure USB stick and NHS computer system and will be deleted at the end of the study.

When the study has finished, our findings will be shared with you via an information sheet sent through the post, if you wish to receive this. The findings will also be written up as a scientific paper for publication in a journal and presented at a conference.

**Benefits and harms of procedures**

It is hoped that the study can help health professionals understand the needs and experiences of fathers to better support yours and your family's needs.

The study will ask you to talk about your experiences of being parented yourself, your current relationships with your child's mother/partner, child and family, and how you find/see your community. Although the researcher will aim to facilitate the interview in a sensitive manner, there is the potential that these topics raise some difficult experiences which may be upsetting. The researcher will not push you to talk about difficult experiences if you do not want to. If you do feel distressed, the researcher can signpost you to different services which may offer support. You also have the right to withdraw at any time, if you so wish.

If you mention any information which indicates that yourself or others i.e. children are at risk. The researcher is duty bound to report this to the relevant service such as social services.

**Questions or Queries**

If you wish to ask any questions about the study or would like any further information, please feel free to contact James Barker, Trainee Clinical Psychologist. Email: psp6bc@bangor.ac.uk or Telephone 01248 388365.

**Reimbursement**

Your **participation in this research study is voluntary** and you have a right to refuse to take part. If you do agree to take part you maintain a right to withdraw from the study without

explanation. Your withdrawal will not affect any other health services that you receive now or in the future.

To compensate for your time and effort, you will be given a £20 One4All gift card.

**Complaints**

In the case of any complaints concerning the conduct of research, these should be addressed to:

Hefin Francis, School of Psychology, Brigantia Building, Bangor University, Gwynedd, LL57 2AS.

And/or

Concerns Team, Betsi Cadwaladr University Health Board, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW.

**Consent**

| | Please initial |
|---|---|
| I have read this form and agree to participate in this study. | |
| I have been given a copy of this form, the information form and had a chance to read them both. I have had the opportunity to ask any questions that I may have. | |
| My participation in this research study is voluntary and I have a right to refuse to take part. If I do agree to take part I maintain a right to withdraw from the study without explanation. | |
| I understand that my data will be treated confidentially and any publication resulting from this work will report only data that does not identify me. | |
| I would like to receive an information sheet which outlines the findings of this study. | |

Signature: _____

Date: _____

Signature of Investigator: _____

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**NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME**

(NB - Copi o'r ffurflen gydsynio i'w rhoi i gyfranogwyr i'w chadw yn ogystal â chopi wedi'i lofnodi a gedwir gan yr ymchwilydd).

**Teitl yr ymchwil: Dod yn dad a bod yn dad mewn cymuned Gymreig ddifreintiedig**

**Enwau a swyddi'r ymchwilwyr:**

James Barker - Seicolegydd Clinigol dan Hyfforddiant

Dan oruchwyliaeth:

Dr Liz Mear - Seicolegydd Clinigol

Dr Elizabeth Burnside - Seicolegydd Clinigol Ymgynghorol/Cyfarwyddwr Academaidd

Dr Mike Jackson - Seicolegydd Clinigol Ymgynghorol/Cyfarwyddwr Ymchwil

**Natur y project ymchwil**

Nod y project ymchwil hwn yw edrych ar brofiadau tadau, sy'n byw mewn ardal a ystyrir yn 'ddifreintiedig' gan Lywodraeth Cymru, o ddod yn dad a bod yn dad.

**Trefn cynnal yr astudiaeth**

Caiff yr astudiaeth ymchwil ei chynnal yn Saesneg. Bydd yr ymchwilydd yn gwneud pob ymdrech i ddarparu gwybodaeth yn Gymraeg os byddwch yn gofyn am hynny.

Efallai y byddwch wedi clywed am yr astudiaeth gan eich ymwelydd iechyd neu weithiwr proffesiynol gofal iechyd arall. Byddant wedi gofyn am eich caniatâd i roi eich manylion i'r ymchwilydd. Os gwnaethoch ddod i wybod am yr astudiaeth drwy boster, yna chi fyddai wedi cysylltu â'r ymchwilydd. Byddai'r ymchwilydd wedi rhoi gwybodaeth i chi am yr astudiaeth a gofyn am eich cydsyniad i gymryd rhan. Os gwnaethoch gytuno, byddech wedi cael gwahoddiad i ddod am gyfweliad.

Byddwch yn cyfarfod â'r seicolegydd clinigol dan hyfforddiant mewn lle ac ar amser a gytunir â chi. Bydd y cyfweliad yn cymryd tuag awr a bydd yn dechrau trwy ofyn i chi am rai manylion sylfaenol amdanoch eich hun. Bydd y cyfweliad yn dechrau wedyn fel trafodaeth am eich profiadau o ddod yn dad, bod yn dad a'ch perthynas â'ch plentyn, mam y plentyn/partner a theulu. Daw'r cyfweliad i ben gyda dibriffio a chyfle i chi drafod beth oeddech yn ei feddwl o'r cyfweliad a ph'un a ydych yn teimlo bod arnoch angen unrhyw gefnogaeth bellach.

Caiff eich cyfweliad ei recordio a'i drosglwyddo i go bach USB wedi'i amgryptio ac i system gyfrifiadurol yr NHS. Yna caiff ei ysgrifennu neu ei drawsgrifio, ac yn ystod y broses hon bydd unrhyw enwau a

manylion megis mannau gwaith a chyfeiriadau yn cael eu newid fel na fydd modd eich adnabod o'r wybodaeth. Bydd unrhyw fanylion cyswllt sydd gennym amdanoch yn cael eu cadw ar y co bach USB a system gyfrifiadurol yr NHS a'u dileu ar ddiwedd yr astudiaeth.

Pan fydd yr astudiaeth wedi ei gorffen fe wnawn anfon ein darganfyddiadau atoch mewn taflen wybodaeth drwy'r post, os dymunwch ei derbyn. Caiff y canlyniadau eu hysgrifennu hefyd fel papur gwyddonol i'w cyhoeddi mewn cyfnodolyn a'u cyflwyno mewn cynhadledd.

**Manteision a pheryglon y dull gweithredu**

Gobeithir y gall yr astudiaeth helpu gweithwyr iechyd proffesiynol i ddeall yn well anghenion a phrofiadau tadau er mwyn rhoi gwell cefnogaeth i chi ac i'ch teulu.

Bydd yr astudiaeth yn gofyn i chi siarad am eich profiadau o gael eich magu eich hun, eich perthynas bresennol â mam eich plentyn/partner, y plentyn a'r teulu, a sut rydych chi'n gweld eich cymuned. Er y bydd yr ymchwilydd yn gwneud ei orau i gynnal y cyfweliad mewn ffordd sensitif, mae'n bosibl y gall y pynciau hyn godi rhai profiadau anodd a all fod yn annifyr neu annymunol i chi. Ni fydd yr ymchwilydd yn eich gwthio i siarad am brofiadau anodd os nad ydych eisiau. Os ydych yn teimlo'n drallodus, gall yr ymchwilydd eich cyfeirio at wahanol wasanaethau a all gynnig cymorth i chi. Hefyd mae gennych hawl i dynnu'n ôl unrhyw bryd, os dymunwch.

Os byddwch yn crybwyll unrhyw wybodaeth sy'n dangos eich bod chi neu eraill, h.y. plant, mewn perygl, yna bydd rhaid i'r ymchwilydd roi gwybod am hynny i'r gwasanaeth perthnasol, megis y gwasanaethau cymdeithasol.

**Cwestiynau neu ymholiadau**

Os oes gennych unrhyw gwestiynau ynghylch yr astudiaeth neu eisiau gwybodaeth bellach, mae croeso i chi gysylltu â James Barker, Seicolegydd Clinigol dan Hyfforddiant E-bost: psp6bc@bangor.ac.uk neu ffôn 01248 388365.

**Tâl**

Mae **cymryd rhan yn yr astudiaeth hon yn wirfoddol** ac mae gennych yr hawl i wrthod â chymryd rhan. Os cytunwch i gymryd rhan, mae hawl gennych i dynnu'n ôl unrhyw bryd heb roi rheswm am hynny. Ni fydd tynnu'n ôl yn cael unrhyw effaith ar unrhyw wasanaethau iechyd eraill rydych yn eu cael nawr neu yn y dyfodol.

I ddiolch am eich amser a'ch ymdrech byddwch yn cael cerdyn anrheg One4All gwerth £20.

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**Cwynion**

Os ydych yn dymuno gwneud cwyn am ffordd mae'r astudiaeth yn cael ei chynnal, gallwch gysylltu â'r heini a enwir isod am gyngor a gwybodaeth bellach:

Hefin Francis, Rheolwr Ysgol, Ysgol Seicoleg, Prifysgol Bangor, Bangor, Gwynedd LL57 2AS neu e-bost h.francis@bangor.ac.uk

Neu Tîm Pryderon, Bwrdd Iechyd Prifysgol Betsi Cadwaladr, Ysbyty Gwynedd, Bangor, Gwynedd, LL57 2PW neu rhif ffôn 01248 384194.

**Cydsyniad**

| | *Plîs rhowch eich llythrennau enw.* |
|---|---|
| *Rwyf yn cadarnhau fy mod i wedi darllen y daflen yma ac yn cytuno i gymryd rhan yn yr ymchwil.* | |
| *Rwyf wedi derbyn copi o'r ffurflen yma, y daflen wybodaeth ac wedi cael cyfle i ddarllen y ddwy daflen. Rwyf wedi cael y cyfle i ofyn unrhyw gwestiynau sydd gennyf.* | |
| *Rwy'n deall fy mod i'n cymryd rhan yn wirfoddol, ac mae gennyf hawl i beidio â chymryd rhan. Rwyf yn gwybod fy mod i'n rhydd i dynnu'n ôl o'r ymchwiliad ar unrhyw bryd, hyd at y pwynt cwblhau, heb roi rheswm a heb unrhyw ganlyniadau.* | |
| *Rwy'n deall y bydd unrhyw wybodaeth a gofnodir yn yr ymchwiliad yn aros yn gyfrinachol, ac ni fydd unrhyw wybodaeth sy'n fy enwi yn cael ei ddefnyddio os bydd yr ymchwil yn cael ei gyhoeddi.* | |
| *Fe hoffwn dderbyn daflen wybodaeth yn amlinellu unrhyw ganlyniadau o'r ymchwil.* | |

Llofnod: _____

Dyddiad: _____

Llofnod yr Ymchwilydd: _____

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# Appendix VII

## Interview Schedule

**Interview Schedule**

***1.*** **What is it like being a Dad?**

Prompts:

What do you enjoy?

What are the difficult bits?

What do you get from being a dad?

What does it feel like being a Dad?

What is a typical day like?

***2.*** **What about being a Dad is important to you?**

Prompts:

What kind of dad do you want to be?

Why are Dad's important?

How do you want to parent your child?

What does your child/children need from you as a Dad?

What role do you want to take in your family as a Dad?

What things would you like to do in the future with your kid?

What things about being a Dad do you look forward to in the future?

Are there any Dad-tasks that you are looking forward to?

Any times in your child's life that you are looking forward to?

How do you want to impact on your child's life/family's life?

How do you want your child to see you as a Dad?

When your child grows up, how would you like them to describe you as a Dad?

***3.*** **What did you expect becoming a Dad to be like?**

Prompts:

What do you think made you have those expectations?

Before your child/children was/were born, can you remember what were you thinking about when you looked ahead to becoming a Dad?

What did you look forward to?

Were you nervous about it at all? If so, what made you feel like that?

What were your hopes about being a Dad?

***4.*** **How did you find becoming a Dad?**

Prompt:

Has becoming a Dad changed you in any way? Or Does being a dad make you feel any different about yourself to before?

Has your life changed in any way?

What have been the easy parts? What have been the difficult parts?

Any moments that stick in your mind?

How has the baby fit in with your life?

Has your life changed at all?

How does it feel when you spend time with your baby? What do you enjoy? Is there anything you don't enjoy?

How did/do you find bonding with your child?

***5.*** **Can you tell me about how having a child has affected your relationship with your partner/child's mother?**

Prompts:

Can you describe your relationship with your baby's mother? Do you live together?

Have you noticed any changes in your relationship since becoming parents?

What roles do you take in family life/with your child?

What works well for you within your family at the moment?

Have you found your role/position in the family difficult in any way?

Any positive moments?

Any difficult moments?

***6.*** **Do you think that your own parents and experiences of being parented have influenced you as a Dad?**

Prompts:

Has being a Dad brought up anything from your childhood?

If yes, How do you feel when you think about your own childhood/experiences of being parented?

What were your parents like when you were young? Has this affected you as a Dad/your approach to being a Dad?

Has becoming a Dad made you think/feel differently about your own childhood?

Are there things that your own parents did or did not do that you hope to do/not do for your child/ren?

***7.*** **Can you tell me about how having a child has affected your relationship with family, like your parents, brothers and sisters etc?**

Prompts:

Have you noticed any changes in your relationship with your family? Own parents?

Has becoming a Dad made you think/feel differently about your family? Own parents?

Or Has being a Dad helped any of your other family relationships? Or has it made any other relationships within your family difficult?

***8.*** **How do you want other people to see you as a Dad?**

Prompts:

If I saw you with your child, how would I describe you as a Dad?

Do people see you differently now you are a Dad?

Do you hide any parts of being a Dad in front of others?

How would you like to be seen?

Are you a different Dad out in public to how you are indoors at home?

***9.*** **What would help you be the best dad that you could be?**

Prompts: Any changes at work? Home? In your community? Health services?

What support do Dads need?

Where would be the best place to access this?

What parts (if any) of being a Dad do you wish there was more help out there for? What would that help look like?

If you had a worry or problem around your family or your role as Dad, where would you go? Who would you tell? Whose advice would you most likely listen to?

What might get in the way of you getting the help you need?

What would worry you about admitting there was something worrying you/a problem?

# Appendix VIII

## Representation of Themes across Participants

**Table 2:** Recurrent Themes across Participants

| | | Anthony | Daniel | Martin | Scott | Curtis | Peter | Luke | Greg | Callum |
|---|---|---|---|---|---|---|---|---|---|---|
| **Adjusting to new role** | Expectations to reality | - | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Adjusting self | - | - | ✓ | ✓ | ✓ | ✓ | - | - | ✓ |
| | Getting through the pregnancy | ✓ | ✓ | ✓ | - | - | - | | - | - |
| | Bonding | ✓ | ✓ | ✓ | - | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Making sense of new position in family** | Adjusting couple relationship | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Shared parenting | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Balancing employment | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Co-creating childhood and future** | Guider | - | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - |
| | Joining together | - | ✓ | - | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Sources of influence and support** | Repetition and reparation from own childhood | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Challenging societal constructions | ✓ | - | ✓ | ✓ | - | - | - | - | - |
| | Sources of support | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Meeting fathers needs | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

# Appendix IX

## Annotated Section of Transcript

| Emergent themes | Original transcript | Exploratory comments<br>Descriptive comments – focus on describing the content of what the participant has said, the subject of the talk within the transcript (normal text)<br>*Linguistic comments* – focus on exploring specific use of language by the participant (*italic*)<br>Conceptual comments – focus on engaging at an interrogative and conceptual level (underlined) |
|---|---|---|
| Attachment<br><br>Questioning non-involved fathers<br><br>Family values<br><br>Strong commitment to fatherhood<br><br>Expectations different to reality<br><br>Teaching<br><br>Rewarding | **R: And how would you describe your bond with your daughter?**<br><br>M: Yeah um (.), tight.<br><br>**R: Tight?**<br><br>M: I didn't think it would be as, I can't I can't get these guys who do not want to be with their kids. I can't I can't understand them.<br><br>**R: Its made you kind of question that.**<br><br>M: Yeah, yeah, yeah, erm (can't understand) we're Catholics, we don't really believe in divorce and that. All my brothers and you know all my family and that have all stayed with the kids. You know so, it's never been, it's never been an issue. That divorce yeah.<br><br>**R: What did you expect being a Dad to be like before [Daughter] was born?**<br><br>M: Erm [Both laugh], yeah, yeah, quite boring, you know (says laughing). Yeah and just err (.). You know, just teaching her really, you know I didn't think she would be as quick as she is, and she's quite funny.<br><br>**R: Oh, is she?**<br><br>M: Yeah and you know um, yeah and its yeah know, I'm sure she doesn't know she is doing these things but. You know, you know, yeah. It's good. | *Tight* - Didn't think it would be as tight (bond)<br>Was he worried about bonding? Bonded greater than expected. Reality different to expectations?<br><br>Made him question absent fathers- *can't understand them* - Shows strength of bond and his role as father — making it hard to relate to absent fathers - why would others do that,<br><br>Family beliefs and values<br>Strong sense of family and roles with children driven by family and faith.<br><br>It will be *boring* – not an experience that he thought he would enjoy?<br>*Laughing – "yeah"* – embarrassing to share? Or emphasises the difference between his expectations compared to the positive reality?<br>Reality much better to expectations.<br>Expected his life changing to be boring?<br><br>Envisaged fatherhood as teaching child<br>Saw his role as a teacher – rather than nurturer? – helping her learn and develop<br><br>Discussed her qualities and strengths – suggests positive bond. – he enjoys her qualities. *Appeared proud when talking about these.* |

| | | |
|---|---|---|
| | **R: Yeah and what is a typical day like for you?** | |
| Work vs nurturing | M: Yeah, its normally, you know it's, it's getting up early for work, get, do my job, get home and once I've got home, my wife's normally knackered. [Laughs]. | Focus on work and then supporting wife when he gets home by taking over baby. |
| | **R: Is she?** | |
| Supporting wife | M: From having the baby all day. | Gives wife a break – sharing the care between them. |
| | **R: I bet.** | |
| Sharing roles | M: I take over the baby and let her do her own thing for a couple of hours. And normally by that time, you know it's time for the baby to go to bed, and you know. And we take turns, we're pleased to do that 'cause you know. Yeah | Shared role – take in turns<br>Pleased to do that – <u>why, he gets to spend time with baby or to give wife a break?</u><br>*'we're pleased'* sense of agreement together |
| | **R: Yeah and how do you share out the parenting roles? Between you and your wife?** | |
| Strong role in play | M: Yeah normally yeah, but she's back at work now, so it's hard to but it just used to be she was the mother, she was the hands on, she was. She was all that and then, I'd take over at playtime, kinda thing, you know, playing with her and staying with her and we'd take turns when putting her to bed as we did not want it to be that she only sleeps for her, 'cause then if she wanted to. To, to you know go out or to do anything then she'll sleep with me, she'll be doing that. And er and then yeah, we just get her to bed and then look after ourselves kind of thing [Both laugh]. Yeah that's it | Wife took on caregiving, hard now she's at work.<br><u>Been a change since wife went back to work – he is now more involved in childcare.</u> |
| | | His role at playtime<br><u>Saw his role as more involved in play then caregiving – wife's work caused a shift into nurturing?</u> |
| Baby's needs take priority | | Looks after selves second- <u>baby comes first</u><br><u>- focused on baby's needs – places their needs after this.</u> |
| | **R: So, what would you, what have been the best bits about having [Daughter]?** | |
| Reciprocal interactions | M: (.) What's she's learning and what's she's doing. Yeah you know now likes she's talking now, well she's starting to talk and er, well she comes out with you know things you've said yeah, yeah, yeah, what your teaching her and what you are seeing back. | Learning and doing more things – starting to talk.<br><u>- can interact more with baby, she is feeding back what he is teaching her – creating a shared interaction. Rewarding?</u><br><u>Developmental gains are reinforcing?</u> |

| | | |
|---|---|---|
| Responsibility<br><br>Looking forward to toddlerhood<br><br>Wife has responsibility<br><br>Supporting wife<br><br>Struggled to have baby<br><br>Protecting self from disappointment | **R: So, you kind of see her learning things from you and the changing every day?**<br><br>M: Yeah, yeah.<br><br>**R: Oh great and before you had [Daughter], what were you most looking forward to?**<br><br>M: (..)<br><br>**R: Or weren't you looking forward to things?**<br><br>M: Yeah, yeah, yeah, I was, we were just, I don't know, I suppose it's just, for me, it's when she's older, do you know what I mean, it's when she's a toddler, get even more of that fun back, but er, yeah I was just looking forward to, to (.), might sound mad, but a little bit more, you know, responsibility. A little bit more, you know, yeah, yeah. Yeah. That kind of thing.<br><br>**R: Who takes responsibility at the moment then for [Daughter]?**<br><br>M: More, more, more my wife. But erm but as I said, when, when, when I get home, I, I try and do, I try and. Give her the time as she's got her all day. Yeah, you know, ok. You know all night sometimes too yeah, yeah, yeah, yeah.<br><br>**R: And were you nervous at all about-?**<br><br>M: No, no.(.)<br><br>**R: Maybe?**<br><br>M: No, erm it was more because with be-because we had struggled to have, to have the baby. It was more erm, every scan, yeah it was another one where we just expected to lose her. Do you know what I mean. We didn't know whether it was a girl, we didn't know. No so we just expected, every time, it was like. Don't really hold on, because it was like, you know what I mean, yeah. Yeah, yeah. | *Pause* – was he not looking forward to fatherhood? Doesn't come to mind easily? Reflects state of mind during transition to fatherhood?<br><br>*'Yeah' repetition* – overcompensation?<br><br>Becomes more fun when toddler age – more interactive – he gains more responsibility<br>Less care needs, more interactive and engaging?<br><br>*Responsibility* – not enough responsibility currently? Maybe his role as a father becomes more prominent when child becomes more independent?<br><br>Wife has more responsibility now, but I give her time. – Wife has primary care duties, but he is trying to support wife and takes over care.<br><br>*No, No – pause* –– suggesting he went through an emotional struggle which took a while to recall – painful emotions?<br><br>Struggled to have baby – process of conception and pregnancy was a painful journey<br><br>*We just expected, every time* - Not holding on because could lose baby – not holding on to protect self. Long process with lots of disappointment and sadness? |

# Appendix X

## Word Count Statement

**Word Count Statement**

**Main content of thesis, excluding tables, figures, references and appendices:**

| | |
|---|---|
| Thesis title and abstract | 254 |
| Section1: Systematic Literature Review | 6409 |
| Section 2: Empirical Study | 7049 |
| Section 3: Contributions to theory and practice | 4875 |

Total of the main content of the thesis: 18,587

**Tables, figures, references and appendices:**

| | |
|---|---|
| Section 1: | |
| References | 2247 |
| Tables, Figures and Appendices | 3907 |
| Section 2: | |
| References | 1167 |
| Tables, Figures and Appendices | 4906 |
| Section 3: | |
| References | 1306 |
| Tables, Figures and Appendices | 0 |

Total of the tables, figure, references and appendices of the thesis: 13,533