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MEN'S EXPERIENCES OF PARENTING SUCCESSFULLY WITH A SERIOUS
MENTAL ILLNESS (SMI)

By

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Bachelor of Social Sciences (Psychology) 2014
Bachelor of Social Sciences with First Class Honours (Psychology) 2016

A THESIS

Submitted in partial fulfilment of the requirements for the degree of

Masters of Social Sciences

School of Psychology

Faculty of Arts & Social Sciences

WAIKATO UNIVERSITY
Hamilton, New Zealand

2018

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ABSTRACT

Many of the men in Aotearoa/New Zealand with Serious Mental Illness (SMI) are fathers, who like others maintain intimate, loving relationships and live healthy and fulfilling lives. This research seeks to understand what enables this group of fathers to sustain their relationships and parenting responsibilities, through times of illness and stress. The study interviewed twelve New Zealand European men aged between 34-68 who were coping well with their illnesses and parenting responsibilities.

Findings revealed that fathering was perceived as a positive element of individual identity that contributed to overall well-being, motivating these men to overcome their adversities. Communication was considered key in the maintenance of relationships. Fathers shared the responsibilities of providing and child-rearing with their co-parents and routinely participated in the household chores, demonstrating the practices of a truly 'involved father'. Recovery was viewed along a continuum, and self-managed care was considered pivotal in the maintenance of well-being. Support consisted predominately of small kin networks, of which partners and or parents/in-law were the principal supporters. General Practitioners provided the primary point of mental health contact. For those who engaged with specialist mental health services, the needs of their children and or families were not incorporated into their care.

In conclusion, these men and their families are focused on living good, meaningful, and engaged lives irrespective of, or perhaps because of SMI. At the centre of their success appears to be an interrelated process of shared responsibilities, effective communication, and organised routines with a significant degree of reciprocity evident across their relationships. In conjunction with this, individually these fathers demonstrate an absolute sense of personal responsibility for the maintenance of their overall well-being.

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ACKNOWLEDGEMENTS

It is my pleasure to thank those who supported me through the many arduous hours that went into the completion of this Thesis; it was a steep learning curve.

My heartfelt thanks go out to the participants of this study, who shared with me their thoughts, feelings, and experiences that made this thesis possible.

I would like to thank my supervisor's Dr Carrie Barber whose patience, support, and guidance has helped me to develop a greater understanding of the methodology involved in conducting this type of research. I hope that this body of work does justice to the level of expertise and academic knowledge you have shared with me throughout this process. Also, I would like to acknowledge my secondary supervisor Dr Armon J Tamatea for being there, just in case. It is always reassuring knowing someone has your back.

Lastly, a special thank you must go to my partner Hayley for the inspiration she provides me with every day, it keeps me going.

CHAPTER 1: INTRODUCTION

The fathers within this study demonstrate that you can live a good, meaningful life with a Serious Mental Illness(SMI).¹ What constitutes living well with an SMI varies from person to person and can only be judged by those experiencing it (Mead & Copeland, 2000). What becomes evident in hearing these stories is that you can not define these men by their illnesses or the impact it periodically has on their families. Having an SMI is a part of who they are and how they function as a family unit; as such, it forms a very normal part of their everyday existence. By sharing their stories these men, illustrate that SMI affects all kinds of people, who like others can establish and maintain intimate, loving relationships, and live healthy and fulfilling lives. These fathers are good men and great parents who have warm relationships and do all the everyday, and extraordinary things that the rest of us do.

Parenting is one of the most complex and challenging roles we take on as adults, with family providing perhaps the most important context for child development (Kerig, Ludlow, & Wenar, 2012). In combination with biological and environmental factors, parent-child-family relations shape the neurological, physiological, and psychological mechanisms through which children experience and interact with the world around them (Price-Robertson, 2015). For most children, family represents the centre of their universe, with the way parents interact with their children influencing the adults they grow up to be.

¹ SMI is referred to as a condition that affects people over the age of 18 who have or have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the DSM-5 criterion, resulting in serious functional impairment which substantially interferes with one or more major life activities e.g. relationships, self-care, employment, or recreation (Development Services group, 2016).

However, when the symptoms of SMI are active, they have the potential to impact on an individual's ability to parent, affecting family members (in particular their children) in differing ways. Parents with mental illness and their families are some of the most vulnerable in our communities (Maybery, Reupert, Patrick, Goodyear, & Crase, 2005). In comparison to those without mental illnesses, these families are more likely to experience social isolation, financial hardship, and interpersonal difficulties, while simultaneously coping with the direct impact of the active mental health symptoms, such as emotional blunting or delusional behaviour (Maybery et al., 2005).

According to Marston, Maybery, and Reupert (2014) parents with SMI report greater stress, decreased confidence, and reduced enjoyment in child-rearing activities. With their co-parents, spouses, or partners also subject to increased feelings of worry, anxiety, frustration, and for many, guilt. Sometimes, because of a parent's mental illness instead of nurturing, responsive, sensitive parenting the Children of Parents with Mental Illness (COPMI) are confronted with inconsistency and neglect (Reupert & Maybery, 2007). For some, this results in the development of insecure attachments and the in/externalising of emotional problems, potentially leading to psychological dysfunction. Compared to their peers, COPMI are two to three times more likely to develop mental health problems (Marston et al., 2014).

However not all COPMI develop mental health problems despite their exposure to considerable risks, as a number of crucial protective factors act to positively influence mental health outcomes. Some of these protective factors act to shield children from risk, such as the child having an easy as opposed to a difficult temperament (Nordahl, Zambrana, & Forgatch,

2016). More commonly protective factors act to reduce exposure to risk. For example, a child with good social-emotional skills is more easily able to make friends. As a consequence, they are less likely to experience peer rejection and social isolation (risk factors). This is of particular interest to this study because according to Cabrera, Fitzgerald, Bradley, and Roggman (2007) involved fathers influence the social-emotional development of their children independently to mothers.

This study seeks to understand the perspectives of twelve men with SMI, who were coping well with their illness and fatherhood, in regards to what helped them to be the best fathers, co-parents, and partners they could be. In doing so, it hopes to illustrate family, individual, and systemic factors that may underlie the maintenance and success of their interpersonal relationships. Families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the each other (Brown, 1999). Consequently, to understand what enables some fathers with SMI to sustain their relationships and parenting responsibilities through times of illness and stress, one has to explore the functionality of the family, as a unit.

Being a father contributes to many aspects of men's lives; children enhance a sense of identity, belonging, and achievement, and continuously provide most fathers with the inspiration to be the best people they can be. However, for some men, SMI affects their capacity to manage their responsibilities as parents and gets in the way of maintaining functional relationships with children. Thus, it is the unique ability of some fathers with SMI to adapt in the face of this challenge, which this research seeks to explore.

CHAPTER 2: LITERATURE REVIEW

WHY DOES FATHERING MATTER?

Pudney (2006) describes fathering as the actions of a man who provides his child with a sense of identity and place, one who nurtures guides and protects his children while providing the emotional and material support necessary for healthy development. Pruett (2000) defines this as *involved fathering*, describing it as the secret ingredient to relationship health across the father-child-co-parent continuum. An involved father feels responsible for and behaves responsibly toward his child. This encompasses being emotionally engaged and physically accessible, playing an active role in the childcare and rearing decisions, and where applicable, contributing material support to sustain the family's needs.

According to Cabrera et al. (2007), fathers matter because they have an influence on children's social and emotional development, independently of mothers. Children who are socially competent display behaviours that reflect positive self-identity, interpersonal skills, self-regulation, and planning and decision-making skillsets. Children who are emotionally skilled can express, understand, and recognise emotions as well as learn the causes and consequences of them. These authors suggest that because social and emotional development begins during infancy in the context of reciprocal social relationships, the quality of a child's early experiences with their caregivers, including fathers, is critical for the development of future relationships. Thus, the degree and type of father engagement has significant effects on outcomes for children across the lifespan (Cabrera et al., 2007).

In a summary of the research Allen and Daly (2007) present an overview of the key trends of father involvement literature. Their review offers a multitude of studies in support of the findings that father involvement has enormous implications for the social, emotional, physical and cognitive development of their children, their co-parenting relationships and on the adult development of the men themselves (Allen and Daly, 2007).

Of particular interest amongst the findings of this review is that infants of highly involved fathers are more cognitively competent (Pedersen, Anderson, & Cain, 1980), are better problem solvers as toddlers (Easterbrooks & Goldberg, 1984), and have higher IQ's by three years of age (Yogman, Kindlon, & Earls, 1995). Their school-age children tend to be better academic achievers (Nord & West, 2001) possess better verbal and reading skills, and score better across academic measures than the children of uninvolved fathers (McBride, Schoppe-Sullivan, & Ho, 2005). Therefore, the children of engaged fathers are significantly more likely to attain educational achievement, career success, occupational competency, and general psychological well-being comparative to the children of non-engaged fathers (Allen & Daly, 2007).

Historically a strong focus on the mother's role in attachment relationships contributed to an initial lack of awareness about the importance of the father-child relationship (Bretherton, 2010). However, over time research has evolved to depict a more accurate representation of the role and function of parent-child relationships, illustrating that infants and children develop a variety of attachments with adults (and children) with whom they regularly interact, including

their fathers (Bretherton, 2010; Easterbrooks & Goldberg, 1990). Thus, it makes sense that infants whose fathers are involved in their care are more likely to be securely attached to them.

High father involvement is also associated with feelings of parental acceptance, which is a factor in the development of self-concept and esteem (Allen & Daly, 2007). The children of involved fathers demonstrate lower levels of childhood depression, less emotional stress, and lower levels of negative emotionalities, such as fear and guilt. The children of these men also present with fewer conduct-related problems and possess a greater sense of self-competence, higher levels of self-reported happiness, and also have less anxiety related symptoms than do the children of uninvolved fathers (Allen & Daly, 2007). Furthermore, the children of involved fathers are more likely to demonstrate a higher tolerance for stress and frustration (Mischel, Shoda, & Peake, 1988) and are better able to manage their emotions and impulses in an appropriate manner (Flouri & Buchanan, 2003).

There are also considerable benefits of father involvement for the fathers themselves. Men who are involved in the care of their children feel more intrinsically important to their child and are more self-confident, active, and consequently satisfied as parents (De Luccie, 1996; Owen, Chase-Lansdale, & Lamb, 1982; Russell, 1982). Spending time caring for their children provides the opportunity for fathers to nurture their relationships and to display affection, helping them to see their interactions with their children positively, to better understand them, and to be more accepting of them. In turn, this leads to enjoying much closer, more productive father-child relationships (Allen & Daly, 2007).

Research has found no biologically based difference between the sexes in sensitivity to infants (Lamb, Pleck, Charnov, & Levine, 1987), or capacity to provide intimate care (Parke, 2000). There are however numerous ways in which fathers parent differently to mothers. For instance, the vocabulary a fathers use tends to be more demanding than that of mothers as they typically ask more what, where, when and who questions of their toddlers. In doing so, they encourage them to use a broader range of vocabulary and produce longer phrases (Tamis-LeMonda, 2013). The verbal exchanges between fathers and their infants, and mothers and their infants, have been found to independently and uniquely predict higher social competence and lower levels of aggression (Feldman, Bamberger, & Kanat-Maymon, 2013). Typically, fathers display a preference for activation and stimulation in their interactions with their children; they tend to be more unpredictable, facilitating increased frustration tolerance and they focus predominately on real-world consequences as opposed to relational factors, in their application of discipline (Pruett, 2010).

WHAT'S KNOWN ABOUT MEN'S EXPERIENCES OF FATHERING WITH A MENTAL SERIOUS MENTAL ILLNESS

There is no specific epidemiological data within Aotearoa/New Zealand, which focuses on fathers with SMI. However, specialist Mental Health and Addiction Services typically deal with men at this level of severity. The Ministry of Health (2015) reports the total number of people accessing these specialist services for 2014 as 162,222 (3.5 percent of the population) approximately 50% of these are males (Mental Health Foundation, 2014). Men with mental illness are more likely to be fathers than those without a psychiatric disorder; estimates place the

numbers of men with mental illness who are fathers, to be as high as 75% (Reupert & Maybery, 2009). Historically much of the research on parental mental illness centres upon mothers, especially when exploring cognitive, emotional and social development over the early years of life. Perhaps, this is because in many societies women are more involved than men in the caregiving role, thus are more engaged in the process of children's early development and socialisation (Cassano, Adrian, Veits, & Zeman, 2006). In most societies, the parenting roles of mothers and fathers differ. Likewise, men have a different distribution of psychiatric disorders from those of women (e.g., men have lower rates of depression). Furthermore, a disorder labelled identically for either gender (e.g. bipolar disorder) may affect men and women differently because of their gender. This suggests that paternal psychiatric disorders could potentially differ significantly from maternal disorders in their effect on children (Connell & Goodman, 2002).

Research into fathering with mental illness predominantly explores the vulnerability and risk a father's illness imposes upon his children, with paternal depression representing the most comprehensively studied disorder in this regard. Reviews suggest that paternal depression negatively affects the development of children and is associated with both behavioural and emotional problems in infancy, childhood, and adolescence (Sweeney & MacBeth, 2016; Wilson & Durbin, 2010). A review of other paternal psychiatric disorders such as bipolar, schizophrenia, anxiety and substance abuse, suggests that most pathologies affecting fathers are associated with an increased risk of behavioural and emotional difficulties in their children, in a similar magnitude to those of mothers (Ramchandani & Psychogiou, 2009).

Explicit research into fathers experiences of SMI is exceptionally scarce; an extensive literature search revealed only three studies that exclusively focus on this topic (Price-Robertson, 2015). In a New Zealand context to the best of my knowledge, it is non-existent. Of the three studies in the Price-Robertson (2015) review, the Galasinski (2013) study conducted in Poland, was comprised of 35 semi-structured interviews of fathers with either schizophrenic or affective disorders. These men ranged in age from 30 to 70. In contrast to the current study, the majority of these fathers were not living with or involved in the day-to-day lives of their children, and most were not in a stable relationship with the mothers of their children.

Galasinski's study underscores conflicting social expectations of what it means to be a father in a westernised context (e.g. an enterprising, tough, and influential man, who affords a nurturing role model, while providing for the family). And a social discourse that positions fathers with mental illness as anti-role models (Galasinski, 2013). Presumably, because the illness by nature affects ones "manliness". The dominant experience by the fathers in this study was an almost universal sense of inadequacy that cumulated into a sense of failure to meet socially prescribed and personally held expectations of fatherhood. Although most of the participants within this study spoke about their emotional attachment to, and love and devotion for their children, they also reported that this closeness, if not supported by other behaviours, was inadequate. Galasinski (2013) summarised this belief as "a good father is one who loves, but a really good father is ones who does, who changes this love into doing" (p. 44).

Another significant finding of this research was the apparent lack of communication about mental illness between the men in this study and their families. These men either did not

communicate the fact that they were ill, or did so in the simplest possible terms, with many of these men hiding their illnesses from their children and for some, from their wives and extended families (Galasinski, 2013). This study painted a predominately-negative picture of what it was like to be a father with a Serious Mental Illness (SMI).

Similarly, none of the 11 fathers who participated in the Reupert and Maybery (2009) qualitative study lived fulltime their children (although five had regular contact). These men ranged in age from 20 to 50 and were subject to serve depressive, bipolar, and schizophrenic disorders. Many of these participants also expressed being familiar with the conflict between social and self-expectations to remain strong and provide for one's family, while experiencing the symptoms of Serious Mental Illness (Reupert & Maybery, 2009). For most, this was reflected in a reluctance to talk to their partners, families, or friends about their illnesses reinforcing their sense of isolation, similar to those in Galasinski's study. However, a sense of inadequacy was not as widespread amongst those interviewed, as all the men reported positive fathering connections with their children.

This demonstrates that for the fathers within Reupert and Maybery's (2016) study having children helped sustain, and in fact bolstered their sense of mental health and general wellbeing. These men described fatherhood as central to the image they had of themselves, even though some did not have regular contact with their children. Many of the fathers within Reupert & Maybery's (2009) study disclosed that it was at times difficult to maintain relationships with their children, with a number of these men strongly believing that their mental illnesses played a

negative role in custody, and child access disputes with their former partners. Many reflected anger and frustration relative to this experience (Reupert & Maybery, 2009).

While all of the fathers within Reupert and Maybery's (2009) study recognised that they needed support to maintain their health and wellbeing, most were dissatisfied with the assistance they received. Many of these men believed that when/if they did seek help from services (e.g. with a parenting concern or a custody issue), professionals tended to pathologise their problems by assuming that the issues encountered stemmed from their illnesses. Although all of the experiences reported within Reupert and Maybery's (2009) study reflected a degree of hardship many of the narratives indicated that for these men having children provided a sense of purpose, meaning, focus, and direction helping them to better manage their symptoms within the context of their lives. For the men in Reupert and Maybery's (2009) study, fatherhood was an important part of self-image. For some, the stigma associated with mental illness as well as the fear of losing access to their children underlay a reluctance to seek help.

Likewise, Evenson, Rhodes, Feigenbaum, and Anetsolly's (2008) United Kingdom (UK) study of 10 fathers with psychosis ranging in age from 34-67 (the majority within intact families), reported that for their participant's fatherhood conveyed a sense of achievement accomplishment and pride. Although at times parenting was portrayed as both challenging and painful for these men, fatherhood was considered an important part of their identity, that by becoming a parent they transitioned to the status of "father" or that of "family man" (Evenson et al., 2008). The central concern for these fathers was the way in which psychosis at times of unwellness could undermine their parenting role, which for some manifest in fears of alienation,

isolation, and emotional disengagement, affecting the father-child relationship. Moreover, a few of these men reported that antipsychotic medication acted “as an emotional straitjacket” contributing to their experience of emotional disengagement from their children (Evenson et al., 2008).

Another factor that presented considerable disruption to family life for these men was the impact of hospitalisation during periods of acute psychosis. Some of these fathers disclosed that hospitalisation undermined their ability to fulfil their parenting role (Evenson et al., 2008). A few of them expressed reluctance for their children to visit them in hospital. The rationale for this was described as a means of protecting the father-child relationship through preventing children from seeing them in a “place like that” (Evenson et al., 2008). Despite the apparent difficulties inherent in parenting with a psychotic disorder, the participants believed that fatherhood had a positive impact on their lives generating a feeling of achieving something significant, something that could provide enough impetus to make positive changes in their lives (Evenson et al., 2008). The results of this study indicate that although psychosis may at times, directly and indirectly, undermine father-child relationships, fatherhood also brought with it both purpose and meaning, giving additional direction to the lives of those affected.

THE IMPACTS OF PATERNAL MENTAL ILLNESS ON CHILDREN

A review of literature relative to paternal mental illness and child development reveals that paternal depression is the most comprehensively studied disorder (Reeb, Conger, & Wu, 2010; Sweeney & MacBeth, 2016; Wilson & Durbin, 2010). Findings across these studies

indicate that paternal depression is associated with both internalising and externalising childhood problems, as well as conferring an increased risk of developing various psychiatric disorders throughout childhood, adolescence, and on into young adulthood.

Sweeney and MacBeth (2016) reviewed research evidence from prospective studies for an association between paternal depression and child and adolescent emotional and behavioural outcomes. Their findings suggest that paternal depression does, independently from mothers, negatively impact on child development (Sweeny and MacBeth, 2016). These authors posit that the impact of a father's depression on his offspring is most apparent in the antenatal, postnatal, and adolescent stages of development. The degree of this association is dependent on a number of contextual factors for which they postulated a mediational model of risk. In short: paternal depression contributes to negative expressiveness, hostility, and a reduced degree of father-child involvement. When marital conflict is added into the equation, the likelihood of childhood pathology increases significantly (Sweeney & MacBeth, 2016).

The timing of paternal depression appears to play critical a role in childhood outcomes. Reflective of this, the majority of the studies reviewed by Sweeney and MacBeth (2016) associated paternal antenatal depression with emotional and behavioural problems in children aged between 2 months and 7.5 years. In this review, paternal depression in the postnatal period was associated with internalising and externalising problems from early to late childhood. Moreover, Sweeney and MacBeth's (2016) review also indicated that paternal depression is associated with increased risk of negative adolescent functioning, again resulting in internalising and externalising symptoms in children and young adults aged from 11 to 21 years of age.

These results are echoed in Reeb et al.'s (2010) study. Which reports that paternal depressive symptoms are a strong indicator of depression in adolescents (particularly daughters) after controlling for previous adolescent symptoms, maternal depression and family demographics (Reeb et al., 2010). Their findings indicate that adolescent gender and perception of a father's hostility moderate this association. Indicating, that females subject to high paternal hostility are particularly vulnerable to the effects of depression. These authors report that maternal and paternal depressive symptoms appeared to have an additive rather than an interactive effect on adolescent functioning (Reeb et al., 2010).

There has been less research focusing on paternal mental psychiatric illnesses other than depression. Anxiety disorders are frequently comorbid with other mental disorders and are common across the general population. Prevalence rates in Aotearoa/New Zealand are reported at 24.9% (Wells et al., 2006). Studies posit that the children of parents with an anxiety disorder are at a two-fold risk of developing anxiety disorders themselves (Ramchandani & Psychogiou, 2009). In some situations, a fathers' anxiety has a greater effect than that of a mothers. Because typically children look to fathers more for protection in the face of possible threat, in order to assess whether the situation is dangerous and should be avoided (S. Bögels & Phares, 2008; Kiliç, Özgüven, & Sayil, 2003).

Moreover, a study measuring the mental health outcomes of children following an earthquake demonstrates this phenomenon. The presence of a father's post-traumatic stress disorder as opposed to mothers was found to be the most significant indicator in the development

of the childhood anxiety disorders (Kiliç et al., 2003). It has also been suggested that fathers have a greater influence on the development of social anxiety in their children because of their role in the socialisation process (Ramchandani & Psychogiou, 2009).

An area where the impacts of paternal disorders have been explored more than that of mothers is that of substance abuse, particularly alcohol (Ramchandani & Psychogiou, 2009). Longitudinal studies demonstrate that paternal alcohol misuse is related to conduct disorder and substance misuse and dependence in children, with higher rates indicated for boys. Paternal alcohol misuse is also associated with an increased risk of depression and mood disorders in adolescents, along with academic underachievement, low self-esteem, and relationship difficulties (Ramchandani & Psychogiou, 2009). Similar to other research, studies exploring alcohol misuse suggest that paternal disorders appear to be associated with the development of behavioural problems and maternal disorders associated with the development of emotional problems in offspring. Research also indicates that the children of fathers, who use drugs, had more emotional and behavioural problems and higher rates of other psychiatric disorders than those from families that did not abuse substances (Ramchandani & Psychogiou, 2009).

In a recent meta-analysis about the risk of mental illness in the offspring of parents with schizophrenic, bipolar, and major depressive disorders. Rasic, Hajek, Alda, & Uher (2014) demonstrate that the children of these parents are at increased risk of developing psychiatric disorders, particularly the same disorder as their parents. They report that the children of parents with schizophrenic or bipolar disorder have around a 1-in-3 risk of developing a mood or psychotic disorder alongside a 1-in-2 risk of developing any mental disorder. Because little of

this body of research focused specifically on fathers, it is not clear whether a father's bipolar or schizophrenic disorder poses a risk independently of a mother's (Price-Robertson, 2015; Ramchandani & Psychogiou, 2009). Fathers have reflected the worry associated with passing on a disorder to one's child in previous research. For example, the participants in Evenson et al.'s (2008) study exploring the lived experience of fathers with psychosis spoke about fears that their children would develop their illness.

Furthermore, the children of parents with SMI face an increased risk of death from unnatural causes. In exploring implications for clinicians working with fathers subject to mental illness. Fletcher et al. (2012) report that younger children (0-4) of fathers with an SMI have a ten-fold increased risk of death by homicide, and that the adolescent children of these fathers are more than twice as likely to commit suicide. These authors further report that psychiatric illness among fathers can have a devastating impact on children's well-being and that even milder forms of mental illness can have serious developmental effects on children.

THE IMPACT OF MENTAL ILLNESS ON FATHER'S PARENTING BEHAVIOUR

In a review of the key issues of fatherhood and mental illness, Price-Robertson (2015) reiterates that parenting behaviour is one of the key mechanisms through which parental mental illness translates into problematic outcomes for children. This is of particular relevance because, parenting behaviour and parent-child relations play a significant role in most theoretical models

of child development (e.g. attachment, object relations, family systems). And because parenting is one of the most readily modifiable risk factors accessible for intervention, (Fletcher et al., 2012; Price-Robertson, 2015).

In a meta-analytic review, (Wilson & Durbin, 2010) examine the effects of paternal depression on a fathers behaviour, identifying that depressive disorders are common during the child-rearing years of men, as well as for women. Their review compares the impacts of maternal versus paternal depression on parenting behaviours such as, decreased positive emotions, responsiveness, warmth, sensitivity, and increased negative emotions such as hostility, intrusiveness, and disengagement. They postulate that a likely mechanism in the familial transmission of depressive pathology from parent to child is the quality of positive parenting the child receives. These findings suggest that the effects of depression on positive parenting behaviours are pointedly larger for fathers than for mothers. Thus, paternal depression (independently from maternal) can significantly interfere with the formation and maintenance of adaptive paternal relationships (Wilson & Durbin, 2010).

Elgar, Mills, McGrath, Waschbusch, and Brownridge (2007) in a study exploring the mediating role of depressive symptoms on parental behaviour. Propose that the presence of parental depressive symptoms interferes with good parenting practices, impacting on a parent's ability to be nurturing, maintain firm and consistent boundaries, and to avoid negatively reinforcing their children's behaviour. These behaviours, in turn, contribute to child maladjustment (Elgar et al., 2007). It is thought that the risk conferred by either paternal or maternal depressive symptoms is comparable. However, some research suggests that mother-

child interactions have more impact on the development of self-esteem and emotional wellbeing, while father-child interactions have more impact on social competencies (Elgar et al., 2007).

Price-Robertson's (2015) review reported on a few studies that have investigated the impact of other psychiatric disorders on fathers parenting behaviours. The studies within his review suggest that a variety of psychological disorders are associated with parenting difficulties. For example, a study of father's with attention deficit hyperactivity disorder (ADHD) found that the participants demonstrated a lax parenting style with more frequent arguing during parent-child interactions than fathers who did not display ADHD symptomology (Harvey, Danforth, McKee, Ulaszek, & Friedman, 2003). Similarly, a father's anxiety has been correlated with reduced warmth in father-child relationships (Bögels, van Oosten, Muris, & Smulders, 2001) and controlling parenting behaviour (van der Bruggen, Bögels, & van Zeilst, 2010). Some studies indicate that different disorders evoke distinctive parenting deficits. For instance, Johnson, Cohen, Kasen, and Brook (2004), found that while antisocial personality disorder was associated with poor supervision of children, anxiety disorders were not.

Furthermore as stated in Price-Robertson's (2015) review, mental illness can influence parenting behaviour as well as parent-child relations, by contributing to discord or violence within the family unit. Some studies indicate that psychiatric illnesses are associated with marital hostility and or conflict (Beardslee, Gladstone, & O'Connor, 2011; Cummings, Keller, & Davies, 2005). This, in turn, may contribute to the problematic parenting behaviours that impact upon parent-child relations.

MENTAL ILLNESS OR MENTAL HEALTH: A SHIFT IN FOCUS

According to Slade (2010) over recent years, people subject to mental health problems have given voice to what life is like for them, and what helps them to move beyond the role of patient. The recovery movement has emerged out of these people's accounts of what it looks and feels like to struggle with mental health issues. This understanding of recovery has evolved from the shared experiences of those subject to mental illnesses. As a result, it emphasises a centrality of hope, identity, meaning, and personal responsibility (Slade, 2010). Jacob (2015) describes the concept of recovery as individuals with mental illness being in control of their life, rather than waiting for the return of often-elusive premorbid levels of function (Jacob, 2015).

This “wait to get better” approach is reflective of a deficit interpretation of mental health recovery, which is entrenched within a highly medicalised paternalistic culture. Consequently, it frames recovery from mental illness into categories of relapse, reoccurrence, and the remission of symptom profiles, overtime. In doing so, it views recovery from a mental illness as reflective of recovery from a physical disease (Jacob, 2015). Albee and Joffe (2004) argue that accepting the claim that “mental illness is an illness like any other” (p. 423), diminishes the likelihood of effective treatment and prevention. By distracting attention away from important social causes of a wide range of mental disorders.

According to Jacob's (2015) editorial, the Recovery Model of Mental Illness argues that recovery from mental illness is possible, but that the process is a journey and not a destination. As such, it does not imply a return to asymptomatic levels of premorbid functioning. Instead, it

illustrates that recovery is a process of stops and starts, and twists and turns. That echoes one's life journey; it is not a linear progression. Consequently, the process of recovery calls for optimism and commitment from people with mental illness, their families, and from all of the mental health professionals involved in their care (Jacob, 2015). The recovery process also requires that "the mental health system, primary care, public health, and social services embrace new and innovative ways of working" (p. 118).

Moreover, Jacob (2015) posits that the recovery model challenges people to look beyond the diagnostic symptoms of distress. It supports the view that people with mental illnesses need to move forward, set new goals, and get on with doing the things that give meaning to their lives. If one takes this on board, then the process of recovery shifts its focus from; that of being entrenched in the practice of getting rid of problems, to a position that recognises, fosters, and celebrates people's abilities, interests, and dreams (Jacob, 2015).

In their article *What Recovery Means to Us* Mead and Copeland (2000) provide a consumer perspective rooted in experience which has helped to shift, shape, and guide personal and professional knowledge of recovery. It is through the shared experiences of these authors and countless others who have prevailed through tremendous adversity that peer-led self-management programs, such as the Wellness Recovery Action Planning™ (WRAP) have emerged (Davidson, 2005; Mead & Copeland, 2000).

RESILIENCE, FAMILY & MENTAL ILLNESS

Power et al (2016) describe resilience as the capacity to overcome adversity despite the challenges or trauma it may present. For individuals, resilience is commonly associated with specific factors, like personality traits or access to resources or supports. For example, having a sense of optimism and a well-paid job would likely enhance the resilience of a father with a bipolar disorder. Family resilience, on the other hand, is more complex; in so much as it refers to the relationships between the individuals within the family, and the interpersonal bonds that connect them. Consequently, it reflects a situational or relational view of resilience and is concerned with the particular qualities and strengths of family relationships (Power et al., 2016).

Walsh's (2003) article draws together findings from individual resilience studies and research on effective family functioning to define key the processes underlying family resilience. Walsh (2003) suggests that a families' resilience is facilitated by shared beliefs systems that **make meaning out of adversity**. Families who demonstrate a resilient approach perceive adversity as a shared challenge, and often see the crisis as meaningful. In this way, they can contextualise their experience of distress (Walsh, 2003). These families also demonstrate hope, optimism, and confidence in overcoming the odds, show initiative, and accept what cannot be changed. In conjunction with this, these families often share a belief in a larger purpose, something that transcends the family, faith for example (Walsh, 2003).

Moreover, according to Walsh (2003), resilient families also demonstrate positive **organisational patterns** and can adapt to fit new challenges. These families exhibit an

interpersonal connection that is reflected in their mutual support of each other and their respect for the boundaries of individual family members. Walsh (2003) reports that resilient families use consistent and **clear communication** in their interactions with each other. They further foster resilience by sharing a range of honest emotional expressions, alongside exhibiting mutual empathy and taking responsibility for their feelings, and behaviour (Walsh, 2003). When it comes to problem-solving resilient families, demonstrate resourcefulness, share the decision-making process, and take a proactive future orientated position, to build on their successes and learn from failures (Walsh, 2003).

Power et al (2016) reminds us, that while Walsh's constructs of family resilience applies to families affected with parental mental illness, an understanding of contexts specific to parental mental illness is needed to better conceptualise it. For example, **making meaning out of adversity** may relate to being able to help a parent with mental illness normalise their times of un-wellness, in open and transparent ways. Doing so may allow other's (family members and support people) who are witnesses to any bizarre or unusual actions due to the symptoms of mental illness, be less scared and or apprehensive about interacting with the affected parent (Power et al, 2016). **Organisational patterns** may be simply about maintaining daily routines, like sitting together for family meals. And, good **clear communication** may be about generating an open, honest, and collaborative plan for dealing with the symptoms of the parents illness, when or if they become problematic.

FLOURISHING IN LIFE

Seligman (2010) suggests we should be just as concerned with making our lives fulfilling, as we are with reducing levels of suffering. Stating that mainstream psychology has traditionally been focused on developing and delivering interventions that relieve misery and distress. Although these objectives are necessary, desirable, and commendable, decreasing negative emotion does not necessarily equate to increasing positive emotion (Seligman, 2010). This is because building better relationships, more meaning, more engagement, and more positive emotion in life is entirely different from the building the skills required to overcome anxiety, depression, or anger (Seligman, 2010). So, positive psychology aims to develop interventions that improve well-being or as Seligman defines it, to flourish.

According to Seligman (2012), flourishing can be defined in terms of five pillars or domains, known the PERMA theory. **P**-positive emotion involves grasping a sense of optimism, gaining pleasure from satisfying one's needs, and increasing one's experience of enjoyment, either intellectually or creatively. **E**-engagement involves being thoroughly absorbed in activities to the point where one gets lost in the task, creating a sense of 'flow'. **R**-relationships refer's to genuine, authentic connection to other people. **M**-meaning equates to having a sense that one's life is purposeful beyond the pursuit of pleasure, this could be related to a sense of spirituality or collective social consciousness. And **A**-accomplishment parallels having direction, being motivated to achieve, contributing to a sense of satisfaction, pride, and fulfilment. Seligman proposed that one's perception of the extent to which individuals experiences the PERMA pillars determines their sense of flourishing (Seligman, 2012).

In developing a multidimensional measure of flourishing Butler and Kern (2016) iterate that there is considerable evidence to support that positive constructs, like well-being, optimism, building better relationships, having meaning one's life, and striving to achieve goals, are associated with positive life outcomes. Like, better mental health, lower rates of divorce, greater educational and occupational attainment, stronger friendships, and better physical health (Davidson, 2005; Diener & Chan, 2011; Huppert, 2009; Lyubomirsky, King, & Diener, 2005).

However, because there was no validated instrument to measure the five PERMA domains, as separate but correlated constructs, Butler and Kern (2016) developed the PERMA-Profiler. A 23 item measure that maximises brevity while maintaining psychometric integrity. This measure demonstrates acceptable reliability, temporal stability, and evidence for convergent and divergent validity, at both a content and analytical level (Butler & Kern, 2016).

A particular benefit of this measure is that it assesses well-being across multiple domains, making it an ideal tool for identifying positive interventions that enable people to flourish. For example, if a person scores unusually low in the realm of **M**-meaning, then interventions might target identifying core values and strengths, to direct purposeful value-driven goals.

NOTHING HAPPENS IN ISOLATION

When considering the relationship between a father's mental health and the influence, this has on his ability to sustain his relationships and maintain his parenting responsibilities. It is

helpful to conceptualise the family as a system. According to Brown (1999), Bowen's Family Systems Theory suggests that a family is an emotional unit that uses systems thinking to describe complex interactions. By nature, families are intensely connected. Individuals within the unit are strongly affected by other members' feelings thoughts and behaviours, this connectedness and reactivity make the family interdependent. Thus, a change in one person's function is usually followed by a reciprocal change in others (Brown, 1999). The systemic interplay between members of a family becomes apparent when we begin to explore various elements. Like how communication, cohabitation, parenting, shared responsibilities, the degree of social support, and access to resources. May individually, and or collectively impact on the function of families, subject to mental illness.

Amato's (2014) research draws from a large longitudinal dataset to addresses how the transition to cohabitation and marriage affects men's and women' reports of depression and thoughts of suicide. According to Amato (2014), research has routinely demonstrated that married people have better health on average than single people do. Outcomes include less depression, more happiness, more life satisfaction, and a greater sense of overall well-being (Amato, 2014).

Findings from Amato's (2014) study suggest that the transition to marriage is associated with a decline in depressive symptoms and suicidal ideation, which is reflective of previous studies. Moreover, the degree of the decline (-.15) was the same for both genders. Similar reductions in these measures were found in the transition to non-marital cohabitation, indicating that the positive effects on men and women's mental health were associated with living with a

partner, rather than marriage per se (Amato, 2014). These findings support the notion that it is the social support provided by cohabiting, rather than the institutional nature of marriage that is beneficial for emotional well being.

Furthermore, it appears that the benefits of cohabitation or marriage persist (perhaps) indefinitely for men. However on average for women, these benefits decline after the first year. Thus, it would appear that the long-term benefits of cohabitation or marriage are at least in part dependent on gender (Amato, 2014). These authors reiterate that the temporary advantage for women may be a reflection of gender inequality, or that women are more attuned to relationship quality than are men (Amato, 2014). These results are concerning for the women whose mental health declines as a result of dissatisfaction with marriage or cohabitation, because of the potential implications for the quality of parenting and children's well-being. Research consistently indicates depression for both mothers and fathers is associated with problematic parenting, and a lack of affection, coercion, and enhanced risk of psychosocial problems among children (Amato, 2014).

Fincham (2004) presents an overview of the significant findings in literature exploring communication in marriage; he posits that the most frequent and damaging problems confronting couples are those related to poor communication. Research regarding communication behaviour suggests that when faced with conflict distressed couples' demonstrate more complaining and criticism of each other, interrupt each other, present fewer self-disclosures and positive suggestions. Moreover, distressed couples are less likely to pinpoint the problem, and more likely to display negative solutions and verbalise the problem in critical ways (Fincham, 2004).

Reciprocal negative behaviour appears to be the nemesis of communication between distressed couples; the most significant challenge is to find an adaptive way of exiting the cycle. Other patterns of communication such as the demand-withdrawal are also common and are associated with low marital satisfaction (Fincham, 2004).

Fincham (2004) further reports that research exploring support giving and affectional expression demonstrates that supportive spousal behaviour is a strong predictor of marital satisfaction. In addition, high levels of positivity in the problem-solving act to moderate the harmful effects of interpersonal conflict, providing an adaptive means of exiting the cycle. Furthermore, a person's perceived empathy (e.g. responsiveness to other), self-disclosure, and relational competence are highly correlated with marital satisfaction, which in turn signifies effective couple communication styles (Meeks, Hendrick, & Hendrick, 1998).

Exploration of a person's background and their characteristics offers an alternate perspective into the context of interpersonal communications. For example, studies reveal that individuals with a history of depression during adolescence are more likely to marry earlier and experience higher rates of marital conflict (Fincham, 2004). Demonstrating that a history of psychopathology and the level of ones' current symptomology are important antecedents in understanding the process of communication between couples. Other broader environmental issues also need to be taken into consideration when considering communication in marriage. Such as the couples specific family contexts, life events, and stressful circumstances, alongside their social, economic, political, and cultural contexts (Fincham, 2004).

Morrill, Hines, Mahmood, and Cordova (2010) reiterate that co-parenting is one of the most important processes to have emerged out of research exploring marriages and parenting. It can be defined as a unique component of the spousal relationships, where parents either work together or struggle against each other when raising their child/ren (Morrill et al., 2010). A reliable finding in the co-parenting research is the positive association between marital health, and co-parenting quality, as characterised by effective communication, collaboration, and family warmth (Morrill et al., 2010). In an interactional fashion, co-parenting is also thought to influence a couple's relationship through the affirmative actions of spouses supporting each other, which in turn is strongly associated with marital satisfaction (Morrill et al., 2010).

Moreover, co-parenting is also thought to enable parents to coordinate their parenting roles and resources in ways that benefit the children. In contrast, parents with a weak co-parenting coalition are more susceptible to antagonism and competition, which can lead to conflicting expectations for their children (Morrill et al., 2010). In addition to this, it is postulated to be more difficult for men than women, to maintain personal boundaries between marital and parent-child subsystems at times of relationship stress. Suggesting that fathers are more susceptible to their emotional reactivity spilling over into the parent-child context. However, perhaps because of gendered expectations, a women's mothering role is not usually viewed as optional. Therefore, there is a greater expectation to continue their responsibilities as parents regardless of the functioning of their marital relationship (Morrill et al., 2010).

Feldman (2000) reiterates that the degree of equality evident in shared parenting responsibilities enhances a couple's satisfaction with each other, their union, and consequently

the health and wellbeing of the family as a unit. In her study, Feldman examines couples views on sharing the household and childcare responsibilities, and how these relate to marital satisfaction. Her results illustrate that the extent to which couples are satisfied with their marital relationship is related to the various determinants of father-child involvement, for example, the degree of involvement in and responsibility for household work and childcare (Feldman, 2000).

Moreover, findings indicate that the degree of a fathers involvement in routine household activities and the day-to-day care of his children appears to have an intensifying effect on a fathers sensitivity during child father interactions, benefiting the longterm father-child relationship (Feldman, 2000). In conjunction with this, father involvement in household activities and childcare has also been shown to predict positive change in maternal sensitivity (Feldman, 2004). Cumulatively these results illustrate that the amount and range of a father's engagement in household and childcare responsibilities are directly related to levels of paternal and maternal engagement with, and sensitivity to their children, and the degree of their marital satisfaction (Feldman, 2004).

Social support networks are an essential component of the recovery process. According to Portugal et al. (2016), In conjunction with better adaption to stressful situations, the feeling of being cared for and loved is significantly related to lower levels of anxiety, depression, and the manifestation of somatic of symptoms. These authors investigated the relationship between a persons social support network, their mental health, and quality of life. Findings indicated that for those in emotional distress the degree of someone's social integration or isolation (as

classified by their score on the social support network index) either minimised or maximised the adverse effects on quality of life (Portugal et al., 2016).

In a study investigating the relationships between depression and the frequency and quality of social connections. Werner-Seidler, Afzali, Chapman, Sunderland, and Slade (2017) report that it is the qualitative nature of one's social network rather than the frequency of contact that is related to depression. Their findings indicate that having three or more family members (or friends) to confide in was associated with lower levels of depression (Werner-Seidler et al., 2017). While not having access to this level of emotional support increased the likelihood of having a depressive episode.

In a study looking to understand the relationship between family support and the reciprocal processes within the family. Pernice-Duca (2010) explains that interconnectedness with family members, self-care, and personal empowerment are external factors related to the recovery journey, that reflect a balance between autonomous and relational dimensions. However, finding a way of giving back alongside receiving support, is at least as critical as receiving support in of itself, because reciprocity of support increases self-esteem and self-efficacy, forming an essential part of the recovery process (Pernice-Duca, 2010).

Findings from this study indicate that the greater the support and reciprocity within a family support network the more significant the recovery, even after controlling for level of psychiatric illness (Pernice-Duca, 2010).

Another factor contributing to social connectedness, self-esteem, and the recovery journey of a father with SMI is that of employment. Work is a critical factor in social inclusion, and it has significant positive effects on peoples mental health and well being. By providing income security, social status, and a sense of identity (OECD, 2012). Having a job is associated with considerable benefits compared to unemployment, but the quality of work is also important. Poor working conditions, reduced use of employee skills, low pay, and insecure employment can act to threaten mental health, as can work pressures and maintaining one's performance in a competitive job market (OECD, 2012).

Furthermore, in discussing the realities of unemployment, OECD (2012) reports that there are numerous studies that have established higher incidences of mental health problems and lower levels of well-being, amongst the unemployed. On average the people who are unemployed, have almost twice the prevalence of mental health problems. Evidence from transition studies shows, that mental health deteriorates when people move from employment to unemployment, and that when peoples employment status is reinstated their mental health often improves (OECD, 2012).

According to Christiansen and Palkovitz (2001), economic support is a meaningful way that fathers contribute to the development of their children. The perception of providing material support to sustain child needs is an essential element of good enough parenting (Reder, McClure, Jolley, & Ebrary, 2000) and is common amongst fathering literature (Pruett, 2000). For most fathers, providing for the needs of the family is key to self, and in line with social concepts of what constitutes being a good enough father. Christiansen and Palkovitz (2001) suggest that

providing as a form of paternal involvement is inadequately conceptualised. They state that the provider role should not only be definable in terms of financial capital, but also in terms of human capital, through the ethics, skills, and knowledge a father models and shares with his children. And in terms of social capital, as in the nurturing of relationships and networks that benefit their children. Through enabling them to experience events and engage in shared activities. Which of course takes us back to financial capital, illustrating the multidimensionality of the provider role as a form of parental involvement.

In summary, this brief review of the literature demonstrates that there is a significant body of research (Allen & Daly, 2007; Cabrera et al., 2007; Feldman et al., 2013; Pruett, 2000) supporting the notion that fathering matters. Not only because of the considerable cognitive, behavioural, emotional and social benefits afforded to children of growing up with an involved father. But also, because of the multidirectional advantageous conferred across the co-parental continuum, and, because of the substantial benefits of father involvement for fathers themselves.

Research exploring the impact of fathering with a mental illness indicates that the children of fathers with mental illness are more likely than other children to experience behavioural problems. And, face an increased risk of developing psychological disorders across their lifespans (Elgar et al., 2007; Fletcher et al., 2012; Price-Robertson, 2015; Wilson & Durbin, 2010). Most of the research exploring fathering and mental illness has focused on the vulnerability and risk a father's illness imposes on his children.

Over recent years a few studies have explored the parenting experiences of the fathers themselves (none within the context of Aotearoa/New Zealand). The findings from these studies indicate that fathering is an integral part of identity, contributing to a sense of pride and purpose for men. However the majority of fathers interviewed across these studies did not live with their children, and most struggled to maintain their parent-child-co-parent interrelationships. Evident amongst the experiences of the men participating in these studies, were varying degrees of conflict between social and self-expectations of what it meant to be a father, and their realities of living with the symptoms of their SMI (Evenson et al., 2008; Galasinski, 2013; Reupert & Maybery, 2009).

The recovery movement calls for optimism from people with mental illness, their families, and the health professionals involved in their care. It calls for a shift in perspective from a focus on the reduction of symptoms, to empowering people to develop the capacity to live well with their mental illnesses.

In support of this future-orientated emphasis on optimism, meaning, and personal responsibility for fathers with SMI. This study looks to explore the lives of men who were able to sustain their parent-child-co-parent relationships and maintain their parenting responsibilities in spite of, or perhaps because of their SMI. In doing so, it hopes to illustrate family, individual, and systemic factors that may underlie the maintenance and successes evident in the familial relationships of these men.

CHAPTER 3: METHOD

This research was qualitative in nature which may be defined as a method of discovering how others feel and think about their worlds, by enabling them to describe their experiences in their own words (Rubin & Rubin, 2012). The project involved exploring the lived experiences of 12 fathers impacted by mental illness, who have, and continue to manage their interpersonal relationships while actively parenting/co-parenting their child/ren through times of illness and stress.

RECRUITMENT

The original means of recruitment for this study was multifaceted. The recruitment of participants for this study specifically focused on fathers living with mental illnesses who were actively parenting, whether they were cohabitating with their children or not. Interest in talking to fathers who manage to sustain their parent/co-parenting relationships and manage their parenting responsibilities was conveyed in the recruitment material. Contact was initially made with a number of peer lead mental health support services within the Waikato region, such as Centre 401 and Progress to Health. Alongside men's support services within both the Waikato and Auckland regions such as the Father and Child trust, and Male Support Services to request permission to promote this study. In conjunction with, this two major regional Māori health providers, Hauora Waikato, and Te Kohao Health were also contacted.

These initial contacts were made via email and followed up with a phone call in an attempt to secure a meeting with members and or managers about the research. In conjunction with this, a flyer about the study (appendix: 1) was submitted to these organisations for posting on their noticeboards, websites, and or Facebook pages. Furthermore, to cast the net as far as possible a media release (appendix: 2) was generated for the University of Waikato's Faculty of Arts and Social Sciences (FASS) Marketing and Communications Coordinator, which was then distributed to various media outlets. Out of the above methods, only the media release and the subsequent publicity were fruitful in securing participants.

In response to this media release, two regional newsagents ran the story in their publications (appendix: 3), these articles were also simultaneously run on both the Stuff and Scoop news websites (appendix: 4). The net result from this publicity about the research was an expression of interest to participate in the study by twenty-two men. All of these participants were responded to, in order to establish whether they meet the criterion for participation in the study by answering yes to the following questions.

- 1: Are you a father?
- 2: Are you actively involved in the parenting/co-parenting of your child/ren?
- 3: Do you have a Serious Mental Illness (e.g. Bipolar, Schizophrenia, or Mood affective disorder (s)?)
- 4: Would you consider that you currently have this illness under control?

Twenty of these respondents met all four of the inclusion criterion. Of these twenty, one potential participant lived too far out of the Waikato region to be included in the study. Another

seven after having received the participant information sheet and interview schedule dropped out of the study leaving twelve participants.

Participants Age range	34 – 68
Participants Ethnicity	New Zealand European 12
Participants average number of children	3
Participants living with co/parent	10
Participants Diagnoses	Bipolar disorders (6) Depressive disorders (4) Anxiety Disorders (1) Schizophrenia spectrum and other psychotic disorders(1)

Figure1: Participant demographics

THE INTERVIEW PROCESS

In order to capture the unique stories of these men, an individual semi-structured interview was conducted. Each interview was 80-120 minutes long and consisted of the researcher asking the participants specific questions, *e.g. “so, thinking back can you tell me your story of becoming a dad?”* And following up the participant's answers with prompts to expand the conversation, *e.g. did you experience any of the signs or symptoms of your illness during this time?* These questions were pre-specified on an interview schedule. However, the researcher varied the wording, order, and or delivery of the questions in response to each participant’s context.

Prior to the interview each of these men was sent (via email) an information sheet (appendix:5) that; (a) conveyed a formal invitation to participate and informed them of the researchers intention to audio record the interview; (b) outlined the nature and the aims of the

interview; (c) Informed the participants of the researchers intention to use a cultural advisor for the anonymous analysis of their transcripts (where appropriate); (d) informed the participants of their rights; (e) discussed issues of confidentiality; and (f) informed participants about the use of the results following the completion of the dissertation and their access to them. In addition to the information sheet, each participant was sent a copy of the interview schedule (appendix: 6). Along with a research consent form (appendix: 7).

At the beginning of every Interview, each participant was asked if they had read and understood the information sheet, interview schedule, and consent documents. At this point, the limitations of the confidentiality agreement were further discussed. Moreover, to ensure that the identities of the participants were protected, participant numbers (e.g. P1) were allocated to each participant as identifiers. Further to this, any specific context, (e.g. place of work or town lived in) relative to a participant that could potentially identify them has been omitted from the text.

CONTENT ANALYSIS

The analysis of these interviews reflects Rubin and Rubin (2012) model of data analysis in responsive interviewing. The researcher was the sole transcriber and encoder. A Microsoft Word (2010) processor was used to enter the typescript, which enabled the use of speech-line numbers for text identification. Express Scribe Software was used to interface with the recorded dialogue.

TRANSCRIPTION

The first step in this process was to transcribe each of the twelve interviews into an accurate rendition of the questions and answers. These interviews were not transcribed verbatim as certain phrases and filler words (e.g. Um's and Ah's) were omitted. Rubin and Rubin (2012) suggest that the degree of precision of a transcript is subject to variability depending on the type of analysis the researcher plans. Alongside the omission of inessential filler words, these transcripts were also subject to the correction of some grammatical errors and the summarising of some sentences (e.g., where the narratives went off topic). Halcomb and Davidson (2006) explore the functionality of strictly verbatim transcripts and advocate the use of a reflexive, iterative process of transcript production. The transcription procedure for this study looked to conserve time resources and minimise interpretive complexity, by keeping dialogue fluent and to the point. To ensure that the result was an accurate interpretation of the interview content, a copy of the transcript was forwarded to each of the participants for their feedback and final approval.

During the transcription process, tentative ideas arising from the interviews were noted and kept in a separate reflections document. In conjunction with this, any notable quotations echoing the research question were highlighted within each participant's typescript document. These reflective practices assisted the researcher to identify and systematically explore concepts and themes for coding.

CODING

Following the completion of the transcribing process the primary researcher read through each of the interviews to explore concepts, themes, and exemplars broadly representative of the research question “*What is it that allows some men with SMI to sustain parent/co-parent relationships, and to manage their parenting responsibilities through times of illness and stress*”?

Initially, six concepts were identified. Each of these was coded via the allocation of colour and transferred into single a word document, which acted as a framework to guide the analysis. Each of these initial themes was then reviewed with the master's supervisor. At which point it was decided that these initial themes were overly complex and needed to reflect the participant's experiences more closely. In response to this, it was suggested that the researcher use the participant's language to develop a model for illustrating the concepts. Following this process of re-conceptualisation, the re-worked themes were again reviewed by the primary supervisor, and it was agreed that ideas reflected by the model appeared, to be an accurate reflection of the participant's experiences. Thus, the next step in the process was for the researcher to re-read and re-code each of the transcripts to illustrate the new themes.

SORT AND COMPARE

Following the completion of the re-coding process excerpts from the transcripts representing these themes were again coded via the allocation of colour, and copied and pasted (this time) into

individual data files representative of each theme. Following which the content of each file was summarised, at which point the researcher was able to compare the excerpts to identify similarities and differences across the lived experiences of these fathers. In doing so, the researcher was able to integrate the differing lived experiences and perspectives of these twelve men into a cohesive representation of what enables some men with SMI to sustain their interrelationships and manage their parenting responsibilities through times of illness and stress.

CHAPTER 4: FINDINGS

The content analysis of these twelve interviews identified five interrelated themes as contributing to the ability of these fathers to sustain their relationships, and manage their parenting responsibilities through times of illness and stress. Defined in the model as successful fathering with a Serious Mental Illness (SMI).

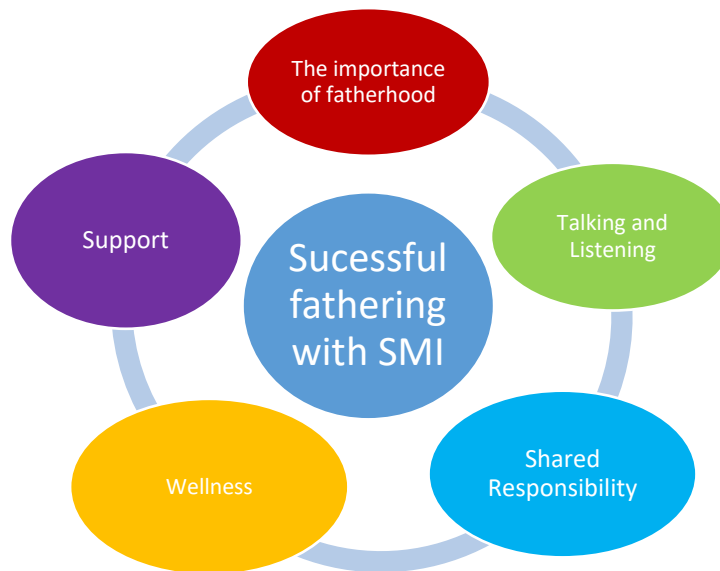


Figure 2: *Model of Interconnected Themes*

THE IMPORTANCE OF FATHERHOOD

For the participants of this study being a father was reported as an overwhelmingly positive element of individual identity. The role of fatherhood provided a focus and meaning to the lives of these men that significantly contributed to their psychological well-being.

Most of the men participating in this research described being at a point in their lives where they were ready for fatherhood, of having made a conscious choice to become parents. In general, this was described by these men as being in a position where they were able to provide, as having good supports (including role models) in place, and as being ready and willing to put the needs of family first.

I guess I wanted children; I always knew I would be a good dad, but I was always putting it off. Because I didn't think I had the right structure yet, to bring a child into this world. That was important to me, I want my children to have the best provided for them, and I wasn't going to do that half-arsed [Participant 06].

Well, I think I was prepared; It had been a plan for a long time. I guess we got to a point where we were settled down. We have both seen the best and worst of each other. So, I don't know; maybe I was just ready to be a parent [Participant 01].

Not all of the pregnancies represented by this group of fathers were planned. However, the fathers of these “surprise babies” were no less enthusiastic when they learnt that fatherhood was in their immediate futures.

So it was all a little bit accidental, as many are. My wife and I weren't planning or expecting to have children, but um yeah. It was quite exciting, I mean there

was no sense of doom, or fear or “O heck what have we done”. So I/we thought it was great [Participant 04]

After six months of courtship, as it were, we decided to take things a little more seriously during which time she fell pregnant with our first son, which started us down the path of taking other steps for us to secure the family’s future [Participant 03].

All of these fathers demonstrated positive, wide-ranging, and active participation in the lives of their children as providers, nurturers, and teachers. These high levels of involvement were evident in the way that these fathers described how they routinely engaged with their children.

I guess being a good dad is um, providing. And that’s material things like clothes, food, and shelter. But also providing mental support, like providing confidence, getting them interested in things and having a sort of a full whole active life [Participant 06].

I’ve always held them, always played with them, always given them hugs and kisses, and things like that [Participant 03].

Yep, reading all of the time, making up stories, storytelling, laughter, lots of those sorts of things. In terms of play, I would often be silly, dress up, act out

characters, and play music with my guitar, those were great times [Participant 05].

It's as simple as just being there, being there for your kids, being there for your partner, and being there for yourself [Participant 01].

I feel I'm a valuable part of their life, and that I have something to add. For me, it's pretty important to give time and create moments and memories [Participant 12].

For the participants of this study being a father was described as an overwhelmingly positive experience. They talked about how fathering and co-parenting provided a focus and meaning for their lives. Being a father became a fundamental component of their identity. For these fathers, their children help sustain, and in fact bolster their sense of wellbeing conveying a sense of achievement, accomplishment, and pride.

I think the biggest thing in keeping me well has been, being, a husband, and a father. This has been the central role of my life. I've said to a lot of people that it's been my kids and my wife that have kept me (most of the time) well. Because I've had this role to fulfil, I've had a job, I've had a focus in life [Participant 02].

Just watching their development and things like that, it's cool, it makes getting through the days and months a lot easier sometimes. To see these little

landmarks every so often is like you know, it's like getting a little further, bit by bit, and that's cool. They help me, they don't know that they help, but they do. Um, I feel proud I guess, is the first word to describe it. Proud of both my boys, their good little lads, you know I love getting home to them [Participant 06].

For some, being a father enabled them to internalise a more selfless perspective into their worldview. For others, the reciprocal act of caring in of itself enhanced their ability to manage mood better.

There is something fundamental about having children; I find it hard to articulate exactly what. My dad always recons the kids mature the parents. So I guess caring for your kids you become in a way fairly selfless. You know the world is not just about me anymore [Participant 10].

So, even on days when I feel terrible, and depressed and horrible, if my boys come up to me and want a cuddle, I still give it to them. And that's beautiful, I love it, love that sort of thing. That can and does change my moods quite, quickly as well [Participant 07].

Many of the fathers within this group voiced how overcoming the everyday problems and obstacles inherent in the experience of mental illness, fatherhood, and co-parenting contributed to their family's ability to thrive. Despite, or perhaps as a result of exposure to adversity.

Ok so we went through all this shit, and it was a hard time. But looking back I think it gives you a lot of strength. To know that when that shit happens in the future, you have the knowledge and experience to know that you have dealt with it in the past. So it's not going to be new, it's going to be a shock, It will be hard, but hopefully, you have built up some resources, and you will get through it [Participant 04].

In a way, I'm kind of glad (it's not a good thing to have) but mental illness, having gone through that and experienced it gives you just such a strength I think. And, also for the children to see that and to see actually you know "dad had some bad times" but he is onto it now, and he's been good for a long time, he's recovered [Participant 06].

Some of the men in this study revealed a belief that as a man and as a parent it was at times necessary and for some desirable, to present as emotionally tough.

I'd try and let them see that "dads always happy". So, I think I protected them quite a lot because I've been able to hide it from my kids [Participant 02].

At times, I feel that if I try to express it to my wife, then I'm not a bloke. It's like, what's wrong with me, I shouldn't be whining to my wife about how I'm feeling [Participant 07].

So, I tried to adopt (well up until just before my wife and I separated) the stoic attitude, more than anything else. In general, I don't think that it's been perceived as acceptable for men to talk about anything which casts them in a way which can be seen as weak [Participant 03].

Perhaps in response to this notion of toughness, some of these men used a strategy described as “putting on the mask”, as a means of getting through some of the more challenging aspects of co-parenting with mental health problems.

Because I know I haven't got anyone to fall back on so I just kind of, I'm really good at putting on a mask and just dealing with it. Um, and smiling, and gritting through my teeth, and saying everything is ok and it's not, it's really, not [Participant 06].

I become a different person, um I don't want to be with people, I don't like to talk to people, I don't like to see people. And the thing is, I've always been able to hide it from the kids. Because I'll say and do things, like “dads going to his room to read his book”. But see when I was through there in my room, I was dying for someone to come in and see me, praying for it. But as soon as they come and see me, I'd put on a mask and send them away. No, go away dad 's fine, he's reading, and I'm dead tired [Participant 02].

TALKING AND LISTENING

Good communication within the context of interpersonal relationships requires an ability and willingness to talk honestly and openly about one's own emotions, attitudes, perspectives, and experiences while taking into consideration those of others. Most of the fathers in this study revealed an ability to both talk with and listen to their significant others, enabling these families to respond in mutually beneficial ways, during times of illness and stress. These fathers made explicit reference as to how effective communication between themselves their partners, children, extended family, or other supports such as friends, impacted positively on their ability to maintain their wellbeing. Thus, the act of talking appeared to help moderate the impact of the symptoms.

For example, I'll say "look I'm feeling really wound up about going and getting out of the door to go and do ... today", and all that sort of stuff. And she will say why? And then she will talk it through with me, helps me to rationalise everything [Participant 01].

I tend to, you know, if I'm having a day where I'm really struggling I'll actually say to the kids "guys, look, I just need to talk to you about this, can we actually go home, cause I'm actually really struggling, and I think I need to go home and have a rest [Participant 03].

So it's sort of being aware of what stresses you and trying to catch it before you get overwhelmed by it. And for me talking it out with my wife reduces the stress [Participant 10].

Just being honest and open, you know there is a real vulnerability that comes with that. Nevertheless, just saying to people that I am dealing with... and it affects my ability to do ... is nothing to be ashamed of. Honesty is important, and that goes right across the board wife, kids, work, and your support network [Participant 12].

For those fathers who were not cohabiting with their co-parent, the act of good communication became imperative in maintaining balance and stability relative to their parenting responsibilities.

Although good communications was probably not the hallmark of our relationship, over time we have kind of learnt how to communicate things to each other. So most Wednesdays we get together. That's kind of with a view to keeping in touch with what's happening with each other, but it's predominately like for logistics with the kids, just coordination. And I guess communication in general [Participant 03].

Some of these fathers spoke about the importance of receiving honest feedback to help monitor their behaviour. Overall, these men appeared to value the perspectives of those closest to them, often relying on the eyes and ears of others, including those of professionals, to help keep them on track.

I've always been very, very wary of those early signs, and being able to say to L--- "look, you know I've just noticed over the last couple of days I'm only getting 6 hours sleep, and I'm feeling really good, let's just keep an eye on that" , um yeah, that's really helpful [Participant 04].

I remember, with the whole meltdown thing "the event", and talking with mum about it and saying "Yeah, I'll be alright mum" and her saying "No you are not alright", stop telling yourself you are fine, you are not fine". And that was a real eye-opener, to the fact that I wasn't Ok, I was unwell [Participant 01].

When I begin to feel unwell, now that they are older they can see it in me. Now they know, cause they will say things like "dad, have you taken your tablets".

[Participant 02]

One thing I would always make sure of when visiting adult mental health, was to have my wife there. Um, simply as a check, just to make sure that I'm not there telling a very convincing story about how well I am. So, I need that check and

balance somebody else to say actually; you know there is something else going on [Participant 04].

A couple of the fathers spoke about how talking with others about their illness led them to the realisation that experiencing mental ill health is, actually a relatively common experience.

I went along to a group, and it was quite sobering to sit down in a room with about 20 odd other men (cause it was a men-only group) and just looking at the different ethnicities body shapes, lifestyles, jobs, there was even a radio personality. People who I would think have a great life, so it was sobering to talk with them, and think “It’s kind of normal” to have issues like mine [Participant 07].

When I actually say I’ve got depression and that, it’s amazing how many people put their hands up and say I’ve got that too, or this, or whatever it may be [Participant 06].

When you are in a community group, and you start to talk about your experience of mental illness, it’s amazing just how many people come forward and say thank you I also suffer from... It starts a genuine conversation that often, leads to relieving people’s distress through the act of sharing [Participant 12].

Another aspect of talking and listening to each other as co-parents that appeared to contribute to the healthy function of these fathers and their families was that of a consistent approach to child rearing.

My wife and I would talk about what's happening with the kids. Especially if we hit something where one said one thing and the other said another. Then we would realise that something was wrong we are not connecting here. So we were fairly consistent [Participant 10].

My wife and I talked a lot about how we managed our kids, we talked about what worked, you have to be consistent, and so you have to talk. As parents, you have to agree [Participant 8].

Well, we never sat down in advance and said "Ok these are going to be the rules" we just kind of let things play out as they did. Then we kind of, after we get them to bed, we kind of said to each other "ok we need to stop doing this", or we need to tell him no for this and so on and so forth [Participant 06].

SHARED RESPONSIBILITY

Shared responsibility in the context of co-parenting may be defined as a collaboration between partners. Within this study, this is reflected by the participant's overarching belief in equality and consequent respect for the experiences, opinions, and values of their co-parents.

One of many similarities across these interviews was the extent to which these men shared the responsibilities of child-rearing and participated in household chores. The types and degree of shared responsibility varied. Some of these fathers took on the role of primary caregiver while others shared the earning, child rearing, and household labouring roles. Perhaps one of the most striking facets of these relationships was the degree of gendered equality disclosed in the role divisions amongst these households.

So one of us will walk the dog, and one of us will get the baby up, and gives the first bottle, and gets things ready for the day, the next day we will alternate. We share a lot we made a conscious decision to do so [Participant 01].

We both worked, we both looked after the kids and shared the jobs. And it's never bothered me I've always been involved with the kids. I took great pleasure in it. I loved being a career, from day one [Participant 02].

When I get home, we usually take turns cooking dinner, getting bedtime organised, getting bottles ready, changing nappies, getting them both in bed (we tag team on that), it all works pretty well. And that includes house-work you know, vacuuming, washing etc. [Participant 06].

When one person is tired, the other can step in, when one parent gets a little bit short with the kid's the other can you know, sort things out. And, there is more

discussion around; you know this issue that has arisen right now [Participant 04].

WELLNESS

Almost all of the fathers interviewed for this study referred to the process of recovery along a continuum, reflecting that staying well was something that has to be maintained. These men demonstrate that you can maintain meaningful lives despite the persistent symptoms of mental illness. The majority of these fathers have learnt through time and experience that you have to care for yourself, that you must do whatever is required to be well because the consequences of not doing so were dire.

The feeling of knowing or understanding what drives your illness is the most empowering sensation or position that you can experience. [Participant 08]

Just trying to do this sort of health thing. At the moment, I'm going to try anything that I can do. So, I have got this treadmill, and I run on that every night, I hate it, and it's boring, but physical health is really important. Also, I'm eating better now, than I was. All this came up in my latest round of treatments. That you need to do this, because you will feel and be better for it, so, as I said I'm willing to try anything. Because I know the consequences are ultra-bad if I don't. [Participant 06]

It is just a health issue that I go through; I guess it's in remission now. Probably like cancer, you are not in the clear, it could come back at any time. Yeah, we got through the worst of it, it took quite a long time, and the treatment, some of it was pretty harsh. But it has to be done [Participant 04].

Over time all of these men have developed strategies for managing their symptoms. One of the key strategies reflected by a number of these fathers is to ensure that they take time to care for themselves.

You have to take time to enjoy the good things, so part of that is managing all of those little pieces and compartments in your life. Whether its work, family, play or even church, it's about keeping a balance [participant 12].

It's so easy to focus on everyone else, but you have to remember to focus on you, and that's a big learning curve for me over the last few months. So it's like don't be ashamed, or afraid to have time for yourself. If I spread myself thin, then I get frustrated, then I get depressed, because I haven't given myself time, or I haven't done anything I needed or even wanted to do [Participant 01].

I can push myself today, but tomorrow or the next day or the next day it's going to fall apart, and it's going to get messy if I'm not careful. So, It's that knowing that I have to care for myself! [Participant 10].

I try and take myself out of a situation if I think I'm escalating, or the situations escalating. I'll just say "look I just need to take myself away from this just now" cause I'll get really worked up and that starts a snowball effect. It's not me being a dick and trying to walk away from the problem. I just need to get away from the situation; it's best for everyone. [Participant 06].

Other strategies that the fathers within this study reported using related to mindfulness and gratitude practices, which have been shown to be helpful in dealing with the symptoms of mental illness.

I'm just trying to make it through the day". So, I just have to take the little win's as they come. Like congratulating yourself for the little things, you just have too. My wife does as well, she's always reminding me of those little achievements, that you did this or that [Participant 06].

Every walk you take can be like going on a holiday, a trip a vacation. So if you open your eyes to what's around you, then you notice that the world is a rich visual place no matter where you are, you just have to take it in [Participant 09].

Yeah going for a walk with your headphones on, it shuts everything else out, and I get lost in what I'm listening to [Participant 01].

I try and appreciate the good things that have happened a lot more, and not concentrate or dwell on the bad things. Someone in mental health services just told me, focus on the little things, you know individual raindrops, sort of things [Participant 06].

For most of these fathers regular and consistent use of psychotropic medication to manage the symptoms or their illnesses was pivotal in maintaining wellness.

Well, I live with it every day I have to fight it, every single day. It's like it's at my back all the time. If I miss my tablets for two or three days, I can turn into a monster. I need to take my medication, or I start to get unwell really quickly [Participant 02].

It's nice to get that right balance, for me I'm just such a big fan of medication, I mean lifestyle is crucial as well. But, I think there are just some things that need to be treated with medication, I mean you can't just CBT it all away [Participant 04].

Yeah, so I'm on a pretty good dose of medication that is working for me at the moment. Although it makes everything kind of beige and mediocre, sort of boring. I know that, well that the end justifies the means. I know the alternatives, and I know I can't afford to mess around now that I have got kids [Participant 06].

A number of these men spoke to the importance of ensuring they did the simple things, like ensuring that they get enough sleep, food, and exercise for their bodies and minds to operate efficiently.

So getting back to your original question of managing the depressive side of it. Every day I have the same basic things that I do, a routine that I stick to, always [Participant 09].

One of the things, when you get to wellness, is maintaining it. So, keeping a keen eye on the early warning signs. Primarily for me, these are not getting enough sleep, so my brain getting to active. Eating pretty well, balanced I guess, the occasional pie like this mornings. And exercise, I cycle every week, um, and I love it and probably can't get enough of it. It's all really important [Participant 04].

Alongside doing the day to day things required to function. A number of these fathers spoke about the need to purposefully do things that conveyed a sense of pleasure and enjoyment.

I have also laughed a lot more than what I used to. Um, so re-engaging myself with the things I love doing, like listening to music, writing, reading books, and watching movies [Participant 01].

I love reading because reading is something that I have discovered really helps with my depression. It's like I'm a horse with blinkers on and all my worries leave me. So, reading has been a great strength to me. I also listen to music, because again, that's all I'm thinking about, and I forget about the depression and all my worries [Participant 02].

But now I'm in recovery I've actually started to take enjoyment in the things that I used to get enjoyment out of life from. By rediscovering the things that I have enjoyed since I was 15 years old, that I still enjoy now. I realise that those are sort of deeper features of who I am, and they haven't got lost through the illness [Participant 04].

Another factor that perhaps contributes to the capacity of these men and their families to cope is that of access to resources. Most of the fathers within this group are educated men holding a range of degrees the majority of whom returned to study as adults. Therefore, most of the participants and or their partners are/were professionally employed.

During that time I decided to re-skill myself, so I went to AUT, part-time, it took me a few years, but I got a diploma in management and a diploma in business [Participant 01].

I left school at the age of 16, where I went off and did some boat building. Then, after a while, I realised I didn't like grinding fibreglass next to my face. So, I went off and studied a certificate in business [Participant 03].

At age 20 I got a special admission into University. I effectively did a double major that progressed on. So, Bachelor's, Honours, Masters and onto a PhD [Participant 04].

SUPPORT

Social support is posited as a key component in the maintenance of psychological well-being. The relationships that provide support, love, friendship and hope are identified as a major dimension in most concepts of health, wellbeing and recovery. A predominant finding across the men interviewed for this study was that all of these fathers appeared to be well supported within the context of their nuclear families (for most this support network included the Grandparents of their children). Predominately the central link in their support systems was that of their intimate partners.

I am very aware if it wasn't for the fact that I 'm married, and was able to be supported, to take a timeout. Then I would have been in really bad position, where would I have gone, what would I have done without my family's support [Participant 10].

There is just a whole lot of things that come in a bundle, and again I think really important for anyone with mental illness to have that kind of support. I think it is much easier when it is in the house, and it's a partner living with you
[Participant 04].

My ex-wife and I have a pretty open kind of way of doing things. So, she's currently studying, and I work. So, I try if she has a test, for example, or something that she has to attend after hours, then we will come to some arrangement. I'll look after the kids for a period of time to cover her. And alternatively, she will do the same for me [Participant 03].

There is absolutely no one else I can talk to other than my wife, cause the things that get to me I'm embarrassed about because as a man I perceive them as trivial. They're not, but I don't have anyone else I can talk to about emotional stuff, cause us guys just don't talk about it [Participant 10].

A number of the fathers talked about the positive influence of parental role models in their lives, and the consequences of having grown up in nurturing family contexts.

Well, I have been very, very lucky to have had that foundation from my own parents, a model of what a good relationship looks like. Not a perfect relationship, but one with tensions and arguments. Just having had that solid stability and getting through hard times together, you know that's pretty lucky.

And it's probably so key in terms of the possible outcomes of mental illness.

Either you have got the support, and you have got those role models, or you don't. It could be two completely different stories [Participant 04].

Ow yes, absolutely I grew up in a nurturing home environment I couldn't ask for any better. So it was really important to me that I provide a good structure for my kids. I come from pretty good stock, and I want my children to have the best provided for them, and for them to learn the kinds of values and things my dad taught [Participant 06].

Amongst this group of fathers, the degree of professional support varied. Predominately the health professional most often consulted in regards to maintaining mental health and wellness was Their General Practitioner (Gp). Most of these fathers had been involved with mental health services (usually community) over the course of their illnesses, and most had received some form of psychological counselling.

I have a great relationship with my Dr, when I'm really unwell I can go and see him, and he'll talk to me about it you know "you have had this before, and it will pass" and "we'll have a look at your medication" and blah blah, "you know you gotta keep taking it", and he has reassured me. [Participant 02]

And yeah I'm not crazy about mental health services. I told the 100% truth when I was there, and it's like um, "So you don't feel like killing yourself right now" Ok, so we will put you in this queue over here. [Participant 06]

I was lucky um, with the adult mental health services at some stage there was a lady there who was doing a PhD, so she had her masters in clinical psych and specialised in CBT, and we did a whole bunch of work, probably 12 sessions. And um, yeah it was really good. Its, very useful for being able to recognise the patterns of your thinking, and adjust your thoughts and behaviour, so it's good to have actually gone through CBT or what not. It's also good for the kids you know, being able to pick up on those things and make those changes. [Participant 04]

Some of these fathers reported professional health services as being supportive of their partners. However, this did not extend to their children or lead to any referrals for assistance as a family in coping with mental illness.

So, during those sessions their talking to L----- about how to help manage the situation and about strategies that she might use to cope, you know, asking how she is going and whatnot. But there was never any referrals on for L----- or the kids, for living with someone with mental illness or that kind of thing. [Participant 04]

CHAPTER 5: DISCUSSION

In Aotearoa/ New Zealand it could be estimated that on any given day there are more than 80,000 fathers living with the symptoms of Serious Mental Illness(SMI) (Ministry of Health, 2015). While a few recent international studies have explored the lived experiences of men fathering with a Serious Mental Illness(Price-Robertson, 2015). None to date has looked to explore what it is that enables some fathers with SMI to succeed as both parents and partners, where others often fail. Thus, the objective of this study was to investigate what underscores the ability of these twelve fathers, who all experience SMI, to sustain their relationships and manage their parenting responsibilities, through times of illness and stress.

The following discussion looks to explore the experiences of these fathers and compare and contrast these findings with relevant research. This discussion will work its way through the five central themes identified in the analysis of these interviews: (1) The importance of fatherhood, (2) Talking and listening, (3) Shared responsibility, (4) Wellness, and (5) Support, while endeavouring to unpack and understand what underlies the ongoing successes of these fathers.

THE IMPORTANCE OF FATHERHOOD

The transition to parenthood is a pivotal time in the life for an adult, irrespective of gender or mental health status. Research demonstrates that the addition of a child into one's life brings about more profound change than any other developmental stage in the life-cycle (Deave

& Johnson, 2008). Singley and Edwards (2015) suggest that the transition to fatherhood can be complicated and demanding, with a multitude of stressors. These include a lack of sleep, relentless infant needs, reduced income, time away from work, and continually changing relationship dynamics, all impacting on one's psychological ability to cope. A considerable body of research (Giallo et al., 2012; Paulson & Bazemore, 2010) illustrates the increased odds of experiencing paternal psychological distress (particularly depression) during the early parenting period. Thus, for the fathers in this study who already experienced fragile mental health before the arrival of their children, the drive to be ready or prepared for fatherhood appeared to be both adaptive and mutually beneficial.

Spiteri, Borg Xuereb, Carrick-Sen, Kaner, and Martin (2013) suggest that being better-prepared decreases parenting stress and optimises co-parent-parent-child interactions. This, in turn, contributes to more secure attachments improving the quality of life for both the parents and the children. Given that this study investigates how men with SMI successfully parent, perhaps it is not surprising that the majority of these men stated that they felt ready for fatherhood "*Well as much as I could be*" [Participant 04] and that they were prepared for the irreversible leap into the realm of parenting.

According to Eskandari, Simbar, Vedadhir, and Baghestani (2017) paternal adaption is defined as "the adjustment of men to the parental role, and its related responsibilities and challenges" (p. 54). This can be viewed as a stepwise process that men move through, beginning with their perceived readiness to parent. Like the fathers in the Eskandari et al. (2017) study, the men in this study ascribed readiness to gaining the knowledge and skills required to fulfil the

role. Predominately this was reported by these fathers as having planned for the birth of their child/ren. This equated to being physically ready in terms of the preparing the environment, being financially able to afford children, being emotionally stable in the context of their relationships and their respective illnesses, and by being as informed as is possible. This was achieved through being fully informed of and involved in the child birthing and rearing processes, alongside becoming conversant with the responsibilities and expectations of what's required to support their partners and growing families. This "how to" information was predominately accessed through antenatal classes, and or passed on from midwifery interactions. These fathers also reported reading self-help books, and or researching on the internet as a means of obtaining as much information as was possible.

The fathers in this study also expressed confidence in their ability to parent, which significantly contributed their feelings of readiness. Eskandari et al. (2017) define this as Parental Self-Efficacy (PSE). For most of the men in this study, this degree of PSE appears to have arisen at least in part, as a consequence of being exposed to "good fathering" role models. Social learning theory suggests that children model the parenting behaviour they have experienced. Therefore the type of family you grow up within influences the family roles you adopt as a parent (Hofferth & Goldscheider, 2010). For the most part, this held true for these participants as the majority of these men reported being raised by nurturing and involved fathers. However, for some of the men in this study, this was experienced in an alternate way, whereby, exposure to an emotionally distant authoritarian father resulted in a determination to become exactly the opposite type of parent "*I wanted to give my children what I never had*" [participant 2].

Others in this group of men recounted losing their fathers at a young age and subsequently stepping into the role of caregiver, nurturer, and provider as a means of helping their mothers. This, in turn, shaped their experiences of gendered roles growing up and influenced the way they enact their parenting roles and responsibilities. Demonstrating once again the impact that early social learning has on the way we act, react, and interact as parents, and partners.

The term “involved fathering” is a way of conceptualising what it means to be a good father. Pruett (2000) defines this as feeling and behaving responsibility toward one's child, being emotionally engaged physically accessible, providing material support, and being involved in child-rearing decisions. Evidence suggests that engaged fathering practices contribute to the cognitive, emotional, and social development of one's children. This in turn acts to mitigate adverse social and health outcomes (Allen & Daly, 2007; B. McBride & Darragh, 1995; Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008).

The fathers in this study demonstrated that every one of them genuinely exceeds any definition of involved fathering. This doing, or being a good father, is evidenced by a multitude of examples in the day-to-day interactions of these men and their families, these men are continually communicating this healthy, nurturing, empathic, compassion towards their children and families. Be it in the story being shared, a game being played, a nappy being changed, or in attending to the daily household labours of cooking and cleaning. These men are involved in

every way, in the lives of their children. This significantly contributes to the building of secure, resilient relationships that will extend intergenerationally.

The act of being an involved father in of itself often results in men feeling more self-confident and effective as parents. Consequently, they find parenting more satisfying which leads to even greater levels of involvement, perpetuating a self-propelling cycle (Allen & Daly, 2007). Accordingly, the role of involved father for these men has had a positive impact on their lives, and those of their children and families, playing a pivotal role in maintaining the psychological well-being of these men. Previous research (Evenson et al., 2008; Price-Robertson, 2015; Reupert & Maybery, 2009) exploring the lived experiences of fathers with mental illness also reflects this finding. The fathers in these studies reported positive fathering relationships with their children reflecting a sense of fulfilment, completion, and pride in their fathering roles.

TALKING AND LISTENING

Most of the fathers in this study attribute positive communication between themselves their co-parents, children, and their extended support networks as a key factor in maintaining their overall well-being. Imlay (2015) reports on his clinical experience that healthy relationships can have curative effects on individuals struggling with mental illness, whereby the healthy relationship serves as a buffer in warding off the symptoms of illness. When conceptualising and defining a healthy relationship Moore et al. (2004) locate mental health as either an antecedent and or a consequence in the relationship chain, implying that one's state of

mental health either helps or hinders ones interpersonal connectedness. They posit that communication (either positive or negative) is one of the key factors in mediating this relationship. Their review suggests that it is the quality and nature of the communication that moderates the happiness and well-being factors. In part, this appears to hold true for the families within this study.

Effective communication is a foundational skill in maintaining healthy, stable relationships (Hawkins, Blanchard, Baldwin, & Fawcett, 2008). Research exploring mental health and well-being suggests that the ability to communicate effectively is pivotal in living a good life with mental illness (Mead & Copeland, 2000). Communication for these men appears to be about staying in control of their lives, as they and their families ride out the ebbs and flows inherent in traversing mental health symptoms, which are constantly moving across a continuum from flourishing to struggling and back to flourishing again (Keys & Lopez, 2002). What appears to be front and centre for these men in sustaining their relationships is the talking with and listening to their families.

Consequently, this open and honest communication process ensures to the greatest degree possible, that the triggers and early warning signs of these men's illnesses can be collaboratively monitored, and responded to in prompt, inclusive, systematic, and transparent ways. Thereby minimising the disruption the symptoms of their illnesses, has on their lives. Black and Lobo (2008) state in their review of family resilience factors, that "harmonious communication is the essence of how families create a shared sense of meaning, develop coping strategies, and maintain agreement and balance" (p. 42).

Effective communication is a reciprocal process that requires not only the ability to communicate one's own emotions and needs; it encompasses the skill of being able to listen, to hear, and respond to the needs of others. These men and their families appear to be listening to each other with intent to understand their shared experiences. Brownell (2010) states that communication is listener defined, suggesting that listening is the central component of effective communication. At the core of the effective listening lies the ability to both validate and empathise with the experiences of another person. This is particularly important for those who are those exposed to the symptoms of mental illness. To validate someone's feelings is to accept, affirm, understand and then nurture them. To empathise is to be sensitive to and aware of them. Both of these behaviours are reflected in the actions of the fathers in this study and those of their significant others. The ability to validate and empathise with another also reflects a high level of Emotional Intelligence (EIQ). Malouff, Schutte, & Thorsteinsson (2014) demonstrate that heightened EIQ significantly correlates with higher levels of relationship satisfaction, resulting in greater relationship stability and higher levels of overall mental well-being.

Bloch, Haase, and Levenson (2014) report that when heterosexual couples encounter conflictual emotional events (e.g. disagreements or disappointments), they often respond to each other in harsh and contemptuous ways. Emotional regulation (defined in this context as downregulating) allows couples to escape these negative states. Each individuals downregulating behaviour serves to both reduce their heightened emotional arousal, as well as their partners (co-regulation) (Bloch et al., 2014). The findings of the Bloch et al. (2014) study indicate consistent with previous marital research that women appear to be more responsible for

and competent at regulating the affective balance. They found that a women's downregulation of negative emotion following a conflictual event was associated with higher subjective ratings of current and future marital satisfaction, for both genders. This did not hold true for men's downregulation. Therefore, it appears that when it comes to emotional regulation and marital satisfaction at least in the heterosexual realm, gender matters.

Extrapolating these results into the findings of this study, it is possible that the partners of these men confer a threefold downward-regulatory advantage to their relationships. (1) They are not subject to the extremes of emotional liability associated with SMI; therefore potentially possess a greater capacity to cope. (2) They may have been more socialised into greater monitoring of emotional reactivity to conflict, due to a gendered interpersonal orientation. And (3) Perhaps these women feel an added responsibility to be the emotional moderators, because of their partners' diminished capacity to cope. Consequently, it is probable that the majority of fathers in this study were assisted to manage their emotional reactivity during times of illness and stress, due to their partner's heightened ability to co-downwardregulate emotion reactivity in conflictual contexts.

All of the fathers of this study reported consistent and collaborative informal discussions with their co-parents around childrearing practices. To parent well entails a set of shaped and re-shaped intergenerational behaviours that require caregivers to be on the same page (Herbert, 2000). Undoubtedly, good clear communication is vital to positive parenting practices.

For parents subject to SMI, like the fathers in this study, periods of mental instability affects their capacity to communicate and at times parent effectively. Therefore, planning is required to counter the potential impact of any periods of unwellness (Phelan, Howe, Cashman, & Batchelor, 2013). In a review of parent training programmes for improving parental psychosocial health, Barlow, Smailagic, Huband, Roloff, and Bennett (2012) report that group-based parenting programmes lead to significant (albeit short-term) improvements in measures of parental depression, anxiety, anger, guilt, confidence, and stress, along with increasing satisfaction within the partner relationship. Reflective of these results the fathers and their co-parents within this study engaged in good parenting practices, that likely contributed to and arose from their clear, effective communicative practices. Perhaps this, in turn, has enhanced the overall psychological well-being of these men and their families enabling stronger, more cohesive family units, which are better able to cope with the stressors inherent in dealing with SMI. These results also hold true for the fathers within this group who were not residing with their co-parent.

Over the last few decades a substantial body of research has evolved that suggests there are considerable benefits for parents with mental illness to talk with their children about the symptoms of their illnesses (Beardslee, Wright, Gladstone, & Forbes, 2007; Compas et al., 2010; Fredman & Fuggle, 2000; Solantaus & Puras, 2010). However, the majority of the fathers within this study reported that they had not had any direct conversations with their children about their illnesses; some had intentionally hidden their illness from children. The prevailing belief amongst these fathers was that not talking about their illness would somehow protect their

children from confusion or worry. This is consistent with findings from other studies (Marston et al., 2014).

Fredman and Fuggle (2000) explain that talking with children about the symptoms of their parental mental illness enables them to create a context in which to make practical sense of their experiences. Doing so, allows them to externalise their parents' behaviours such as irritability or emotional detachment, as something separate from themselves. Marston et al. (2014) in evaluating a family-focused psycho-educational DVD about parental mental illness, reported that the intervention increased parental appreciation of the impact their mental illness has on other family members, particularly children. Consequently, this intervention significantly increased the likelihood that parents with mental illness would discuss their experiences and symptoms of mental illnesses with their families as a whole. Predominately because of the realisation, that holding these conversations normalised the symptoms of their illness in the context of their families, and acted to bolster their children's capacity to cope, instead of diminishing it (Marston et al., 2014).

SHARED RESPONSIBILITY

A common finding amongst the experiences reported by the participants of this study was the degree of equality stated in the role divisions amongst these families. Research relative to marriage and satisfaction with family life posits that what individuals expect out of their partners regarding housework and child care, depends on what is typical in that country. This reflects a relative deprivation perspective, suggesting that people engage in social comparison with similar

others and experience psychological distress if the comparisons indicate that they are relatively worse off (Kornrich & Eger, 2016).

According to Twamley, Brunton, Sutcliffe, Hinds, and Thomas (2013), co-parental relationships incorporate multiple aspects of family functioning. Including the sharing of unpaid work, managing the household responsibilities, communicating effectively, sharing decision making processes relative to child rearing and family life, and providing support to each other both within, and outside of the family. This level of co-parental sharing was reported in the daily experiences of the men in this study and is likely to have had a significant positive influence on the mental wellbeing of all of the family members.

Numerous literatures support this proposition, for example, Cabrera, Scott, Fagan, Steward-Streng, and Chien (2012) suggest that shared decision making by both a mother and father is directly linked to better academic and social skills in their children. Pinto, Figueiredo, Pinheiro, and Canário (2016) reported that co-parenting has a positive effect on the development of paternal self-efficacy, resulting in better parenting practices, which in turn contributes to greater self-esteem and overall psychological well-being. Moreover, Fisher, Cabral de Mello, Patel, & Rahman (2006) report that greater father involvement in infant care and household tasks is correlated with lower parental stress and depression in mothers.

Furthermore, in a study examining the determinants of father involvement and parent's convergence on marital satisfaction. Feldman (2000) suggests that three family subsystems, the marital, mother-child, and father-child are all sensitive to mutual influences. Their findings

indicate that parent's convergence on marital satisfaction is related to the father-child interactions, and the partners sharing the burdens of the household. The current study reflects these results, in so much as most of the married/cohabiting father's self-reported high levels of marital satisfaction for themselves, and their partners. They related this satisfaction among other things to their high levels of engagement in household routines and child-rearing activities. Moreover, the fathers in this study who were separated or divorced also reported highly successful relationships with their ex-partners relative to co-parenting factors.

Of the divorced fathers in this study, two had dependent children, for these men co-parenting was as much of a day-to-day norm as those residing with their families. They reported that it was essential to maintain good relationships with their ex-partners, to ensure that they were able to manage their shared parenting arrangements collectively. Pruett and DiFonzo (2014) testify that all family members incur benefits when separated parents choose to share the parenting responsibilities. Reflective of recommendations in Pruett and DiFonzo's (2014) report exploring separated parenting relationships, the parents in this study did not focus their division of parenting responsibilities on the allocation of time. They organised their shared care arrangements by family functionality as it related to their children's best interests (e.g. how each parent's work schedule coincides with the school and activity calendar), alongside accounting for their individual needs, like periods of unwellness.

Predominately the men who participated in this study demonstrated a positive attitude towards their significant others and family life. Kolak and Volling (2007) describe this as communication of expressions that appear to be emotion related. These emotions can be

characterised positively as being empathetic, caring, loving and appreciative, and negatively as marked by irritation, anger and contempt. According to Kolak and Volling (2007), it appears that mainly a father's positive expressiveness makes a unique and interactive contribution to parents ability to negotiate the trials and tribulations related to child rearing. This effect can be observed between the interactions of the fathers and their co-parents in this study. These fathers seem to maintain a positive attitude toward their parenting and interpersonal relatedness. This degree of 'positive expressiveness' likely contributes towards their expressed relationship satisfaction, which in turn could relate to the maintenance of their recovery status.

WELLNESS

According to W.H.O (2004), health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. If you accept this conceptualisation, it follows that (1) well-being is possible for people experiencing mental illness and (2) recovery is a journey that involves working toward better mental health, regardless of the presence of illness (Slade, 2010). Not surprisingly, this concept of health, well-being, and recovery fits well with the lived experiences of the fathers participating in this study. These men and their families do not appear to see recovery as getting rid of their symptoms; they are merely focused on living meaningful and engaged lives. As above, Slade (2010) posits that personal recovery is possible even in the face of current symptoms, and suggests that interventions that support the individual to move towards mental health are as necessary as interventions that look to address the mental illness. A number of the fathers within this study spoke to the relevance of this point. Perhaps it is this degree of self-awareness and subsequent self-management inherent

in the day-to-day effort that these men and their families put into maintaining their wellness, which underlies the positive outcomes for these fathers.

Many of the skills required to manage wellness are only acquired once people begin to believe in their capacity to recover, to develop self-belief (Davidson, 2005). Mead & Copeland (2000) describe this succinctly from the perspective of those who have experienced Mental Disorder:

“It is up to each individual to take responsibility for their own wellness. There is no one else who can do this for us. When our perspective changes from reaching out to be saved, to one in which we work to heal ourselves and our relationships, the pace of recovery increases dramatically” (p. 5).

Self-managed care involves doing all of the things needed to protect ones-self from stressors that trigger the symptoms of illness. This includes many of the ordinary everyday things that people tend to do in the process of living good lives. Like being kind to oneself, getting enough rest, eating well, exercising, having a little fun, and treating one’s self. However, for many the concept of recovery from mental illness is confusing because the predominate expectation is to become free of the illness (Davidson, 2005).

If you take on board W.H.O’s (2004) definition of health as it relates to mental illness, then “cure” becomes the recovery of the person with or without the illness, as opposed to, the recovery of the illness within the person (Davidson, 2005). The former lends its self towards the capacity for one to be the architect of one’s journey. In essence, this can be conceived as having

agency, the belief that one can control the circumstances (or how we react and respond to them) of one's life. All of the fathers within this study spoke to the utmost importance of self-care in their recovery journeys. For each, this process was individualised, but a significant commonality across these stories is the absolute priority given to the self-care. This insight was born out of their prior experience because the actual consequences to these men and their families of not caring for themselves, so were dire.

The necessity for medication compliance also features strongly in most of the narratives within this study. This is interesting because an astonishing number people with SMI do not take their prescription medication as recommended by their prescribers. Presenting as one of the primary reasons for the decompensation of mental health symptoms (e.g. psychosis or mania) that in turn frequently leads to re-hospitalisations (Bellack et al., 2009). The reasons for this vary, but largely people who need to use psychotropic medications are either concerned about the potential side effects, sceptical about the benefits, and or are afraid of becoming dependent. Other factors that contribute to medication non-compliance include; low quality of psychoeducation about the role and function of medications, and, the cohesive nature of the prescriptive process in of itself. Reflecting a limited degree of the consumer involvement in the decision-making process (Bener, Dafeeah, & Salem, 2013).

Not all fathers with SMI require a long-term relationship with psychotropic drugs, however, those that do often find it difficult to maintain compliance over time, perhaps because medical concepts of symptom reduction shapes their concept of recovery. Thus, when the acuity of their symptoms decrease, they stop using the medication. One of the potential benefits

of the findings from this study is for the stories of these fathers to serve as an inspiration to others in similar situations, by helping redefine ideas of recovery. One of the participants describes his experience on medication compliance:

“For two people with the same diagnosis, the medication may work for one person, but not for the other. You just have to go through that whole process, and it can take years of trial and error. It was awful to go through, absolutely awful. You take it, two or three days later, you feel like shit, and the first response is let’s stop taking that because it’s not making you feel good. But with insight from experience, you can say “actually give it time” let your body adjust, it may work! But you can’t tell after only two or three days. As I said, it takes weeks, months, or even like me, years to get it right. But, you know what’s two or three months, or even years if you have a major health concern. I mean if you had a debilitating or life-threatening physical health concern, you would spend time getting it right, right”? [Participant 4]

Another interesting aspect related to the continued well-being of these men and their families is an underlying degree of optimism in their accounts of the tuff times associated with their respective illnesses *“things can get pretty bad, and it’s awful at the time! But it is temporary! We (the family) seem to get better and better at coping” [Participant 5]*. When further unpacking this concept of recovery and wellbeing, Seligman’s theory of Authentic Happiness appears to fit well. It posits five core elements known as the PERMA model that in unison are thought to underscore one’s ability to attain and maintain well-being, to live a “good life” (Seligman, 2010; Slade, 2010).

Each of these core elements was evident to varying degrees in lived experiences of the men within this study. (1) **Positive emotion**, all of these fathers presented with and self-reported positive feelings in the day-to-day context of their usual family life. Each in his way described many experiences that were reflective of emotions like of joy, hope, kindness, gratitude, optimism, enthusiasm, and pride in their daily familial interactions. (2) **Engagement**, most of the men in this study reported a means of personal absorption, something that each of them did that provided a means emersion into the present moment, a type of flow. For some this was for this was evident in their work roles as well as within their reactional contexts such (e.g. reading or writing, exercising, fly-fishing, or photography). (3) **Relationships**, all of these fathers described having strong positive relationships with the significant others in their lives. Accordingly, these associations appeared to provide the social, emotional, and physical connectivity essential for maintenance of personal well-being. (4) **Meaning**, all of these men presented with an underlying sense of purpose and meaning within the context of their lives. For many, this was strongly associated with the role of fatherhood and was evident in the degree of co-parental participation. Furthermore, most of these fathers had pursued education and or professions that helped to inform and maintain the value driven direction of their personal and shared goals. (5) **Accomplishment**, at the time of being interviewed all of these men presented as having being motivated to achieve, to attain a sense of mastery and competence within both their personal and professional contexts. There was an air of pride or perhaps even satisfaction evident at having arrived at this point in their lives, with their relationships intact.

Most of the Fathers within this study spoke about the significant impact working and providing a good income had on maintaining their overall well-being. This is not surprising given the finding that when asked what a good father meant, all of these men listed being a good provider as a crucial element. There is a considerable body of evidence that supports the notion that being in gainful employment is good for your mental health (Mead & Copeland, 2000; Modini et al., 2016; OECD, 2012). Most people with mental illness including those with severe and persistent presentations wish to engage in meaningful work (Harvey, Modini, Christensen, & Glozier, 2013). Ultimately a key for these fathers and their families relative to their and or their partner's employment status was the level of education these fathers and or their spouses had attained. Higher levels of educational attainment are consistently associate with higher-quality jobs, better household incomes, improved mental/ physical health, and increased levels of job and life satisfaction (Medgyesi & Zólyomi, 2016; White, John, Cheverie, Iraniparast, & Tyas, 2015).

SUPPORT

Links between levels of psychological well-being and degrees of social engagement are well established, dating back as far as Durkheim's 1951 study of suicide (Furze, 2008). Of particular significance to the psychological well-being of the fathers within this study is the tireless support they receive from their partners and co-parents. Research demonstrates that the social support provided by cohabiting partners, either martial or non-marital is beneficial for emotional well-being. This general conclusion is apparent across measures of depression, life satisfaction, well-being, and mortality from suicide (Amato, 2014).

The majority of participants within the current study reflected on the essential role their spouses played in maintaining their well-being. These fathers reported that their partners were vital sources of companionship, intimacy, and social support, as one of the participants explained. *“One of the most important things in my life is being a husband and a co-parent, it keeps me well, because I have this a role to fulfil” [Participant 02]*. This narrative not only reflects the interconnectedness of their relationship, but it also alludes to the institutional nature of their partnership. In so much as the expectations and responsibilities of the ‘husband’ or ‘father’ role is demarked (Amato, 2014).

Mostly the fathers within this study reported that their primary source of social and emotional support came directly from family members, particularly spouses. This is consistent with other research findings (Pernice-Duca, 2008; 2010) exploring the social networks of people with Serious Mental Illness (SMI). Pernice-Duca (2010) report’s that in comparison to the general population the support systems of people with SMI are usually made up of small close kin networks. Her study revealed that support and reciprocity with family members are essential elements of personal support. Fathers within the current study describe relationships with their partners, parents, and parents-in-law as close, and mutually supportive. One of the men in the study explains the importance of his support network and the necessity of doing something for the sake of others. *“The failsafe for us is that if things get bad, I’ll go and stay at my parent’s. It’s not for me; I would be quite happy to stay at home, in bed, being horrible and awful. But to give my wife a break, and so the children aren’t exposed to the worst of it. So, Just knowing that there is that backstop, that works for us as a family” [Participant 4]*.

Reciprocity in social relationships is an essential element in the development and maintenance of interpersonal relationships (Pernice-Duca, 2010). This quality was manifest throughout the narratives of the men in this study. These fathers expressed giving mostly time as their primary means of interacting with their family members. This was evident in their stories of shared activities, playing, reading, dressing up, singing, being silly together, or just chatting about the day during the school run, or around the dinner table.

One of the participants recounted how he (as a father who did not live with his children), maintained the closeness of his bond and participated in the day-to-day routine of co-parenting. Through engaging his ex-wife and children in a daily phone conversation (for the children this was about the best and worst thing that had happened in their day). This illustrates how the giving of time, not only meets the emotional needs of one's children, but it also fulfills social and personal expectations of self as a good parent and co-parent. Doing so maintains the equity in these relationships, and helps to increase the self-esteem of this father by reinforcing his image of self as a giver, as well as the receiver of support from his family (Pernice-Duca, 2010).

Most of the men in the current study explained the support they received from their families by giving an example of having been exposed to good role models and having grown up in nurturing family contexts. Most of these men describe this as having been loved and feeling accepted as children; their parents were described as warm people who were there when needed. Many of these fathers stipulated that their parents have provided structure and guidance. For the most part, these fathers felt safe and secure growing up. One of the men explained that his parents had presented him with a model of what a good relationship looks like, not a perfect

relationship, but one with tensions and arguments. He stated that just having that stability and the fact that, their family got through hard times together had furnished him with the determination get through his adversities and grow from the experience. In essence, the environment that most of these men were brought up in contributed to their resilient natures.

From a psychological perspective, the concept of a role model is perhaps best defined as within the context of social learning theory as “modelling” (Bandura & Walters, 1977) where people learn through observing others’ behaviours, attitudes and outcomes. Thus, the example set by the parents of these fathers, by working through their problems and teaching them values like honesty, and perseverance, were observed by these men as children and integrated into the way that they overcome adversity in their adult lives with their children, and partners.

Regarding ongoing support from health professionals, most of the fathers within this study reported their General Practitioner (Gp) as their primary point of contact. The fact that the majority of these fathers at the time of writing this thesis were not involved with Specialist Mental Health services is an indicator of their relative positions along the recovery continuum. And, secondly, a testament to the validity and effectiveness of the measures these men and their families have in place to maintain their well-being.

Gp’s play a significant role in the continuing care for people who experience mental illness irrespective of severity and chronicity. This is particularly important when people have been discharged from Specialist Mental Health Services, as the Gp is often by default required to perform a case-management type function, in conjunction with family to ensure the necessary

supports are in place (D.O.H, 2006). Moreover, reflective of some of the fathers within this study, there are many people in the community affected by serious mental illnesses who manage their condition within their communities, without the support of Specialist Mental Health Services. For these people, their Gp is the only point of contact for any form of mental health care, thus, Gp's represent an essential service for support, information, and referral (D.O.H, 2006). In an Aotearoa/ New Zealand context the Minesrty of Health initiated a new project to encourage Public Health Organisations (including Gp's) to develop mental health plans to improve outcomes for their consumers (M.O.H, 2017).

Finally, none of the fathers taking part in this study reported that any of the Specialist Mental Health Services that they had engaged with in the past (e.g. community or inpatient adult mental health services) had enquired after the welfare of there children. The services that they were offered did not extend to their children, or lead to any referrals for assistance as a family coping with mental illness. These findings are consistent with a body of research looking to integrate the needs of children of parents with mental illness into the delivery of mental health services, both nationally and internationally (Fudge & Mason, 2004; Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014; Mental Health Commission, 2012; Pfeiffenberger, D'Souza, Huthwaite, & Romans, 2014; Picone, 2010; Reedtz, Lauritzen, & van Doesum, 2012).

CHAPTER 6: CONCLUSIONS

The men within this study demonstrated that to live a good and meaningful life, as a father, partner, and co-parent with a Serious Mental Illness (SMI). One needs to take personal responsibility and accountability for caring for oneself. For these fathers, this involved a willingness to doing anything, and everything possible to manage their physical, emotional, and for some, spiritual selves. Including, taking medications as prescribed, eating, sleeping, exercising, taking time out, being aware of triggers, seeking help when needed, and developing an understanding that one can act to relieve troubling feelings and perceptions.

For most of these fathers clear, effective communication appeared to mediate the sustainability of their relationships. This communicative skill was exemplified in their readiness to talk with and listen to their families, their willingness to be vulnerable in self-disclosure, and in their capacity to consider the experiences and perspectives of others. At times of illness and stress, this skillset enabled most of these fathers to be open to feedback, regarding monitoring the presence of their symptoms. Along with, allowing them to develop a transparent, cohesive, and collaborative plan as a family, a “how to proceed during times of unwellness”. Overall, being able to communicate openly and honestly also allowed these families to normalise their experience, and to make meaning from their shared adversity. The quality and nature of the communication contributed to the overall functionality of these family units. Moreover, reflective of findings in marital research (Bloch et al., 2012) it is probable that some of the fathers within this study were helped to manage their emotional reactivity during times of illness

and stress, at least in part, due to their partner's heightened ability to downregulate their negative emotionality.

The successful manner in which these fathers maintained their co-parent (and for most partner) relationships, appeared to be associated with the equality of role divisions amongst these families. This was evident in the distribution of the unpaid work, the managing of household responsibilities, and the sharing of decision-making processes relative to child rearing and family life. These fathers and their co-parents supported each other both within, and outside of the immediate family unit. This level of co-parental sharing is likely to have had a significant positive influence on the mental wellbeing of all of the family members, contributing to the ability of these men to sustain their relationships. Doing so has likely resulted in these men, their co-parents, and for some, their partners, feeling more self-confident and capable as parents, perpetuating a self-propelling cycle. Furthermore, the potential risk conferred to the children of these men by exposure to their SMI is likely to have been considerably reduced. Because, these men have nurtured their relationships, ensuring that whenever possible, they have been emotionally engaged and physically accessible for their children, and for their co-parents.

Fathers within this study described relationships with their partners, parents/ in-laws and for some friends, as close, and mutually supportive. The key to the closeness and functionality of these support networks appears to be in the reciprocity of these relationships. Overall, it seems that these fathers feel that their contributions to their support networks were respected and appreciated, generating a mutual sense of personal worth, which likely acted to reinforce the interconnectedness of their social networks. Many of these fathers reflected on the regular and

mutual participation apparent within their support networks (e.g. parents/in-law, friends, employers) in their day-to-day life. Consequently, at times of need, it is likely that these fathers and their supporters were more ready, willing, and able to give and or receive help because the relationships are rooted in a foundation of reciprocity.

RECOMMENDATIONS

Reflective of the findings from and this study and consistent with other research (Mead & Copeland, 2000., Davidson, 2005., Slade, 2010., Jacob, 2015), fathers who are subject to SMI could benefit from engaging in a mental health self-management programs. This is in line with a recovery perspective of mental illness, which holds that recovery is a journey, not a destination. The emphasis of these interventions is to encourage people to move forward and set new goals as a means of increasing involvement in things that give meaning to their lives. Recovery self-management programs such as the Wellness Recovery Action Plan™ (WRAP) are peer-led processes, within which participants identify internal and external resources for facilitating recovery, and then use these resources to develop individualised plans for successful living. Within Aotearoa/New Zealand these programs are facilitated by Non-Governmental Organisations like Progress to Health <http://www.progresstohealth.org.nz/> It is recommended that all clinicians working with fathers (or mothers) with a mental illness irrespective of the degree of severity, actively encourage and support their clients to engage in the process of self-managed care.

Also, it is widely recognised that parenting behaviour is one of the key mechanisms through which parental mental illness translates into problematic outcomes for children. Consequently, interventions that focus upon improving parenting skills can significantly decrease the risk to the children of parents with a mental illness of developing psychological problems (Beardslee, 2011., Price-Robertson, 2015., Ramchandani & Psychogiou, 2009). Parenting programs have been shown to have a positive impact on emotional and behavioural problems of children; research suggests that group based parenting interventions are effective at the increasing the psychosocial well-being of both children and their parents (Barlow et al., 2012). Parenting programs impact on parent's well-being, by being strength-based, and because they are aimed at changing parental attitudes and practices in a supportive and non-judgmental manner, thereby enhancing parenting capacity (Barlow et al., 2012). Unfortunately, in an Aotearoa New Zealand context, there are limited parenting programs that cater to the needs of parents with clinical mental health or psychiatric problems. The Triple P Positive Parenting Program has been adapted to meet this need in an Australian context but has not yet made it across the Tamsin Sea. Therefore, it is recommended that researchers and clinicians within Aotearoa/New Zealand focus their attention on developing interventions reflective of the adaptation made to the Triple P Parenting Program, by the Australian Central Coast Children and Young Peoples Mental Health Team. This adaptation retains the basic sessions of the Triple P Program but adds to it, *the impact of mental health on parenting*, and *children's fears, friendship and schooling*. They follow up this intervention with home visits, allowing facilitators to give direct assistance (Phelan et al., 2013).

Furthermore, research supports the concept that educating children about their parent's mental illness is beneficial for their overall well-being. The main rationale for providing education is that it gives young persons the necessary language to communicate about their experiences and needs, and in doing so is thought to reduce anxiety, confusion, isolation, and to increase children's coping skills (Reupert and Maybery, 2010). It has been shown that different family members including children want information about mental illness (Marston et al., 2014). Reader et al., (2000) suggest that we start with the assumption that children like adults seek to organise their experiences into some form of coherence, to understand the significant aspects of their worlds. Reflective of previous research, and the fact that a number of the fathers within the current study either spoke to the importance of talking with children about their mental illness, or avoided having these conversations, out of fear of distressing their children. A recommendation put forward from this research. Is that researchers and clinicians in an Aotearoa/New Zealand context, work together to further develop and implement interventions, which support children to understand and cope with their parent's mental illnesses. These interventions could mirror those found to be efficacious in other countries such as Australia, Europe, and North America. For example, Family Focused Interventions, Peer-support programs, Online Interventions, and Bibliotherapy (Reupert and Maybery, 2010).

In order to integrate a focus on the needs of the children and families of fathers (or mothers) with SMI into the delivery of Adult Mental Health Services, it is imperative that the needs of children are infused into the administrative process. Whereby, conversations about parenting need be integrated into routine practice, within all adult mental health services (Pfeienberger et al., 2014). In line with the Royal Australian and New Zealand College of

Psychiatrists (2009), this study makes the following recommendations. That Adult Mental Health Services ensures a family-focused approach to the well-being, care, and recovery of its clients. Through ensuring that a comprehensive assessment of all adult clients is undertaken that; (1) identifies all children of parents with mental illness, (2) assesses the current circumstances of all parent-child relationships, regardless of gender or primacy of care, (3) assesses the parents capacity to provide physical and emotional care, and (4) assesses the direct effect the parents mental illness has upon their children.

LIMITATIONS

A significant limitation of this study was its small sample size. Additionally, the men who responded were all European New Zealanders mostly well educated, and of similar social status, thereby limiting the diversity of these findings. Future research would benefit from exploring this issue through a wider lens. Another factor to consider is the reliance on self-report as the only means of data collection, as people's perspectives of a single context can often be different. For example, the partners and or children's' experience of their father's or spouses mental illness may differ (Reupert & Maybery, 2009). Furthermore, in undertaking this study, the researcher was the sole analyst of these fathers' experiences. As such, the findings represent the researcher's perception of the participant's responses to the questions asked, and the themes constructed from the narratives.

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APPENDIX: 1

A Study of Resilient Dads

Kia ora, if you are a father who lives with serious mental illness and actively parents, then I would love the opportunity to talk with you.

This study looks to explore the ability of some dads to cope in the face of this challenge. If you are one of these fathers, I would like to invite you to share your story.

As Parents, we are our children's link to the past, and their bridge to the future.

Completing an interview would take about 60-90 minutes. If you would like to take part, text or email me. I will arrange to call you back and ask you a few questions to make sure you are eligible for the study. Then I will provide you with an information sheet, a copy of the interview questions and the consent form. I would also organise a time and place for our interview that is best suited to you.

Interested? Contact Jonathon Ashe

Text 021xxxxxx or Email

XXXX@students.waikato.ac.nz

This research has been approved by the University Of Waikato School Of Psychology Ethics Committee

APPENDIX: 2

24 August 2016

Mental illness among fathers

University of Waikato masters student Jonathon Ashe is conducting research into how men sustain their relationships and manage their parenting responsibilities through times of illness and stress.

A father himself, Mr Ashe is seeking local dads who have experienced a serious mental illness and continue to actively parent to help him with his research.

“Historically much of the research into parenting has focused on mothers; this is perhaps because many theories of child development stress the key role of mothers over fathers. However it is widely recognised that a good bond with both parents provides the best possible outcomes for children,” says Mr Ashe.

For some fathers, however, serious mental illness impacts on the capacity to manage their responsibilities as a parent, and gets in the way of maintaining functional relationships with children.

“It is the unique ability of some dads with serious mental illness to adapt in the face of this challenge that my research seeks to explore. If you are one of these dads, I would like to invite you to share your story with me in the hope of helping others who face similar struggles,” he says.

Mr Ashe is studying towards a Master of Social Sciences in conjunction with a Postgraduate Diploma in Clinical Psychology under the University’s Faculty of Arts & Social Sciences.

To assist with the research involves completing an interview which takes about 60-90 minutes. If you are interested in being involved or would like more information about the research, please email Mr Ashe directly at jpa15@students.waikato.ac.nz.

ENDS

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Rebecca Robinson | Marketing and Communications Coordinator
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Friday, September 9, 2016

COMM

Seeking dads to talk about stress

University of Waikato masters student Jonathon Ashe is conducting research into how men sustain their relationships and manage their parenting responsibilities through times of illness and stress.

A father himself, Mr Ashe is seeking local dads who have experienced a serious mental illness, and continue to actively parent, to help him with his research.

"Historically, much of the research into parenting has focused on mothers. This is perhaps because many theories of child development stress the key role of mothers over fathers. However it is widely recognised that a good bond with both parents provides the best possible outcomes for children," said Mr Ashe.

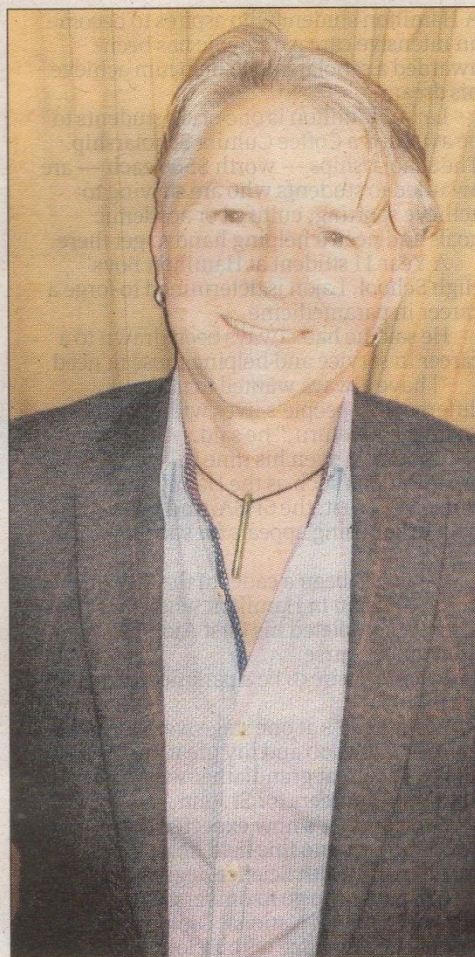
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Assisting with the research involves completing an interview which takes about 60-90 minutes.

■ Those interested in being involved can contact Mr Ashe at jpa15@students.waikato.ac.nz



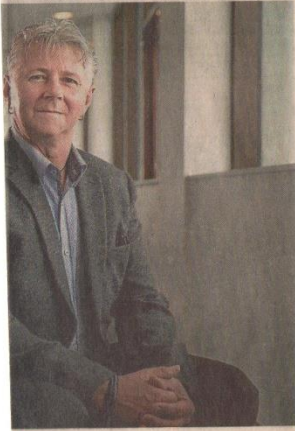
University of Waikato masters student
Jonathon Ashe.

Photo / supplied.

APPENDIX: 4

News

calls for dads with mental illness



DONNA-LEE BIDDLE

Almost every study on parents with mental illness centres on mothers.

A local university student is going against that grain.

Jonathon Ashe is in his first year of clinical psychology at the University of Waikato and he wants to speak to dads with an acute mental illness.

He said there is no current research in New Zealand that explores a father's experience with mental illness.

"I'm interested in looking at the positive outcomes of what these men do well and how they cope in the face of adversity," Ashe said.

"The research done with

fathers, which hasn't been a lot, tends to specifically be in relation to men's experiences with mental illness," Ashe said.

"There're only three studies that I'm currently aware of, none based in New Zealand, that focus on the risk and vulnerabilities mental illness puts upon the children or looks at the children's perspectives."

Ashe said mental illness is a particular area of interest for him and as a dad, he knows it's important for children to have a good bond with both parents.

"I guess in similar ways across both mothers and fathers, [mental illness] makes us less emotionally available, for instance, for our children."

"So those issues, when we develop our attachment to our parents, can be impacted by the emotional availability to the parent and the way we react and respond to them."

"I do work across acute mental illness with our mental health

services here in the Waikato and I work with a number of men who are fathers and who are faced with these difficulties and this type of adversity."

"Predominantly, I'm looking for the fathers that do manage to sustain or maintain relationships with their children while they have a serious mental illness, whether it be schizophrenia, bipolar or a major mood affective disorder."

The research will be part of Ashe's master's degree and he hopes to speak with 15 to 20 fathers from Waikato or Auckland.

"It may be that they have a full-time relationship with the mum or they may only see their children once a fortnight."

"But as long as they're always involved with their kids and their relationship is successful or they perceive it as successful, then that's who I hope to speak with."

"This is an opportunity for those fathers who manage to sustain those relationships to help the

people who are in similar positions to themselves who aren't able to do that."

"And what I want to do is find out what works for these dads and generalise it for other fathers or mothers, because a lot of it is generalisable across the sexes."

Ashe said there could be many reasons why some fathers have more successful relationships than others.

"That could be higher education levels, support by extended family or whānau."

"It could be involvement in sports groups, church groups or the nature of the relationships between the co-parents."

"Talking about your experiences with somebody else can help develop an insight into what's going on for yourself."

The research interviews will take between 60 to 90 minutes.

If you are interested in being involved, or would like more information, email Jonathon Ashe at jpai5@students.waikato.ac.nz

Waikato University student Jonathon Ashe hopes to speak with 15-20 fathers.

PHOTO: CHRISTEL YARDLEY/FAIRFAX NZ

APPENDIX: 5

Participant Information sheet

Kia ora my name is Jonathon Ashe, and I am undertaking a postgraduate diploma in clinical psychology at Waikato University. My area of interest is the impact that Serious Mental Illness (SMI) has on being a dad and how one continues to parent through these challenging circumstances. As a dad coping with SMI your experiences, thoughts, and opinions matter! Consequently, I would like to invite you to share your story with me.

In gathering your story: The interview is expected to take approximately 60- 90mins and I would like to audio record it so that I have an accurate account of your views and opinions. I would also like to use a cultural adviser to assist me in the analysis of your interview, where appropriate. The aims of the interview are to (1) understand your perspective as a father with SMI, in regards to what helps you to be a good parent. (2) To listen and learn from your experiences of bringing children up in the context of your illness. (3) To understand what enables you to be the best dad you can be. (4) To explore potential family/whanau, individual, and general factors that may underlie the success of your relationships. And (5) to investigate what recognition, advice, education and support you may have received to parent in the face of this challenge.

If you choose to participate in my research, you have the right to

1. Decline to answer any particular question(s).
2. Withdraw from the study without penalty at any time.
3. Decline to be audio recorded and request the recorder be turned off at any time.
4. Decline the use of a cultural advisor for transcript analysis.
5. Request that any material is erased up to three weeks following the interview.
6. Ask any questions about the research at any time during your participation.
7. To request a copy of your interview transcript for your feedback.
8. Request a summary of the research findings

Confidentiality: Your privacy will be protected by the use of a participant number or a pseudonym; care shall be taken to ensure any other potentially identifiable information such as any unique context(s) specific to yourself are omitted from the final thesis document. Any information gathered shall at all times remain secure and confidential unless there is an issue of safety relative to yourself or any other individual. Following the completion of the thesis, any individually identifiable information shall be destroyed. This research has been approved through the human research ethics process of the Waikato University School of Psychology. Any questions about the ethical conduct of this research may be addressed by the convenor of the Psychology Research and Ethics Committee (Dr Rebecca Sargisson, Tel: 07 838 4466 ext 378673, email: rebeccas@waikato.ac.nz)

The Results: The purpose of this research is to meet the requirements of a Masters of Social Sciences (MSocSc) The final Thesis will be available online at the research commons.waikato.ac.nz and in the Psychology department. Participants can choose to receive a summary of the research findings by indicating as such on the consent form. This research looks to add to the pool of knowledge around what is currently understood about fathering with an SMI. Consequently, it is possible that journal publications could result from this research.

What Next: If you would like to participate in this research, please text or email me, I will arrange to call you back and ask you a few questions to make sure you are eligible for the study. Then I will provide you with an information sheet, a copy of the interview questions and the consent form. I would also organise a time and place for our interview that is best suited to you.

If you have any questions regarding the research, please feel free to contact my supervisor or me.

Jonathon Ashe, BsocSc (Psyc Hons)
859 3595 or 02108500384
jpa15@students.waikato.ac.nz

Dr Carrie Barber, PhD., Senior lecturer
07 837 9221
cbarber@waikato.ac.nz

APPENDIX: 6

Interview schedule (participant copy)

This schedule outlines what I would like to talk to you about during our interview. I am interested in hearing about your experiences of parenting, and how you cope with the role of being a dad through times of wellness and recovery, as well as how you manage through times of illness and stress. I would like this interview to be more of a talk, a korero about what ordinarily happens in your day to day life with your kids and whanau/family. I would like to know how you as a father cope with your illness.

1. To start with how many children do you have, what are their ages, are they boys or girls?
2. Could I ask you a little about your history?
3. Could you tell me your story about becoming a dad?
4. How do you feel about being a dad, what does it mean to you?
5. In what ways are you involved in the daily routine(s) of bringing up your kids?
6. What kinds of things do you regularly do with your kids?
7. Do you have a set of household rules for your children?
8. How did you decide on these?
9. Could you please tell me about your illness?
10. Do you think your illness impacts your ability to be a dad?
11. Do you have a whanau/family plan that you put in place when you are having a hard time?
12. How do you explain these times of illness to your kids?
13. What do you think keeps you healthy, and how do you maintain your wellbeing?
14. What social supports or community activities are you and or your children/whanau involved with?
15. Can you tell me about your experiences with Mental Health services?
16. To finish our korero (talk) could you tell me a story about a special time you have spent with your kids?

APPENDIX: 7

Participant consent form

[Both the researcher and the participant should retain a completed copy of this form]

Name of person interviewed: _____

I have received a copy of the Information Sheet describing the research project, and I have read it (or have had it read to me) so that I understand its contents. Any questions that I have, relating to the research, have been answered to my satisfaction. I understand that I can ask further questions about the research at any time during my participation and that I can withdraw my participation at any time, or request that any material is erased up to three weeks after the interview.

During the interview, I understand that I do not have to answer questions unless I am happy to talk about the topic. I can stop the interview at any time, and I can ask to have the recording device turned off at any time.

When I sign this consent form, I will retain ownership of my interview, but I give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet.

I understand that my identity will remain confidential in the presentation of the research findings, **Please complete the following checklist. Tick [✓] the appropriate box for each point.**

- I wish to view the transcript of the interview.
- I wish to receive a summary of the findings.
- I am happy for the researcher to use a cultural advisor for the anonymous analysis of my transcript where appropriate.

Participant :
Signature :
Date :
Contact Details :

Researcher :
Signature :
Date :
Contact Details :