Bridging Policy and Practice:

A Qualitative Study of Paternal Postpartum Depression Support in Aotearoa/New Zealand

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Jessica Hausser-See

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Abstract

Paternal postpartum depression remains a critically under-recognised issue in Aotearoa/New Zealand, despite widespread rhetoric around whānau-centred care. This thesis examines the extent to which existing policies and services support fathers' mental health during the perinatal period, arguing that the gap between policy and practice is demonstrated by the absence of policy altogether.

This research was conducted in two stages. In the first stage, a policy and strategy analysis was undertaken to understand what guidance exists for supporting dads' mental health during the perinatal period in Aotearoa/New Zealand. This included reviewing national health frameworks, resources from non-governmental organisations and public-facing information. The second stage involved a qualitative study with seven dads, who participated in semi-structured interviews or an online focus group. Their experiences were analysed thematically and interpreted through Bronfenbrenner's Ecological Systems Theory to understand how their wellbeing was shaped by multiple, interacting layers of context; from personal and relational dynamics to organisational systems and broader cultural norms.

Findings reveal that while fathers experience significant emotional distress and identity disruption during early parenthood, they often feel invisible within a maternal-centric service landscape. At the micro-level, participants reported internalised masculine norms and role ambiguity. At the meso and exo-levels, they described inconsistent engagement by health professionals, limited access to formal support, and structural constraints such as unpaid partner leave. Macro-level norms further reinforced the expectation that fathers act as supporters rather than care recipients. Critically, no national policy or clinical pathways exist to guide routine recognition or support for paternal PPD, and whānau-centred frameworks rarely operationalise meaningful inclusion of fathers.

This thesis calls for targeted policy development, culturally inclusive service delivery, and routine, father-specific mental health screening to close this gap. Addressing paternal mental health is not only vital for the wellbeing of fathers but also for tamariki and whānau outcomes. The findings contribute to community psychology by highlighting how social, cultural, and systemic structures shape wellbeing and by advocating for structural accountability beyond individual resilience.

Acknowledgements

Firstly, I extend my deepest appreciation to my supervisor, Dr. Ririwai Fox for his invaluable guidance cultural grounding and generous support throughout this journey. His insight, encouragement, and belief in my capabilities have been the foundation of this thesis, and I feel incredibly fortunate to have had his mentorship.

I am also grateful to my postgraduate cohort and academic peers for their consistent support, encouragement and kōrero along the way. Your camaraderie, shared struggles and insightful feedback have helped shape not only this research but my growth as a practitioner-researcher.

To my friends and whānau, thank you for the countless ways you have shown up for me. Your love, patience, and sacrifices have carried me through. A special thank you to my son, Dimitri. You are the heartbeat behind this mahi and the reason I keep striving.

To the participants in this research, thank you for your honesty, vulnerability and generosity in sharing your experiences. Your voices are the soul of this work, and it is a privilege to hold and honour your stories here.

Finally, I want to acknowledge the immense privilege of being able to engage in academic study and community-led research. As a student of community psychology, I recognise that access to education and research opportunities is not equitably distributed. I am grateful for the chance to undertake this mahi and remain committed to ensuring that it contributes meaningfully to whānau, community and systems change.

Contents

Chapter One: Paternal Postpartum Depression (PPD)

The transition to parenthood is a major developmental and relational shift. While perinatal care systems have traditionally centred mothers and pēpi (baby), an expanding body of research indicates that fathers can also experience significant psychological distress during pregnancy and the first postnatal year, including symptoms consistent with depression and anxiety (Scarff, 2019). When paternal distress is overlooked, it can adversely affect not only the dad's own wellbeing but also overall whānau (family) functioning, relationship quality and child development (Ramchandani et al., 2005). Prevalence estimates for paternal postpartum depression (PPD) vary widely, ranging from around 4% up to 25% of new fathers. These variations depend on factors like the timeframe of assessment and the measurement methods used (Kumar et al., 2018; Paulson & Bazemore, 2010). Despite growing awareness, paternal PPD remains poorly understood and underreported, largely due to persistent societal stigma, traditional gender norms, and insufficient clinical recognition (Ghaleiha, 2024). Many dads therefore downplay or fail to acknowledge their distress, leading to limited help-seeking and inadequate support (Searson et al., 2025).

A complicating factor is the lack of an agreed upon definition of "paternal PPD", with researchers and health professionals describing and measuring it in different ways (Scarff, 2019). As identified in recent work, paternal mental distress is often described using multiple overlapping terms, such as paternal depression, paternal postnatal depression, and paternal perinatal affective disorder which are inconsistently operationalised across the literature and services (Glynn & Dale, 2015).

Diagnosing paternal PPD is a further challenge, as most assessment tools were originally developed for mothers. For example, the Diagnostic and Statistical Manual of Mental Disorders (fifth edition; DSM-5) defines maternal PPD as "major depression with

onset within four weeks after childbirth", which some researchers simply extend to dads (Glynn & Dale, 2015; Scarff, 2019). In practice, assessment approaches often rely on measures developed for mothers, including the Edinburgh Postnatal Depression Scale (EPDS; (Cox et al., 1987). However, fathers may endorse some EPDS items differently than mothers, which can affect detection (Scarff, 2019; Cameron et al., 2017). Matthey and colleagues (2001a) found that fathers were less likely than mothers to endorse items reflecting overt emotional expression (e.g., crying) and consequently recommended the use of a lower EPDS cut-off score when screening men to improve detection sensitivity. There are also adaptations like the EPDS-Partner (EPDS-P), where the mother reports on the father's mood, and alternative measures such as the Patient Health Questionnaire (PHQ-9) to screen fathers (Scarff, 2019).

Notably, it remains unclear how routinely, if at all, such tools are used for dads in real-world practice in Aotearoa/New Zealand. For instance, well-child providers like Plunket reportedly use the PHQ-3 short screening, but only for mothers, with no validated equivalent for dads (Faulkner & Moir, 2023; Wainwright et al., 2023). Maternal guidelines require symptom onset within one month of birth, yet fathers' depression often has a more gradual onset and can occur any time in the first year postpartum (Madsen & Juhl, 2007). Fathers also tend to display depression in distinctive ways; more irritability, anger, emotional withdrawal or increased substance use, rather than the typical sadness and tearfulness seen in mothers (Matthey et al., 2001b; Paulson & Bazemore, 2010). These gendered differences mean that many cases of paternal PPD might be missed by conventional screening, highlighting the need for better tools tailored to fathers' symptom profiles (Matthey et al., 2001b).

Local evidence, although limited, confirms that paternal depression is a real concern in Aotearoa/New Zealand. The large Growing Up in New Zealand longitudinal study (n = 3,523) found about 2.3% of expectant dads had elevated depressive symptoms during

pregnancy, which increased to 4.3% at nine months postpartum (Underwood et al., 2017a). A smaller study of first-time fathers (n = 116) reported 12% met criteria for PPD by six months postpartum (Howarth & Swain, 2020). While these rates are lower than the 11-16% reported for maternal postnatal depression (BPJ, 2010), they clearly indicate that a meaningful minority of fathers experience significant depression after the birth of a child.

Risk Factors and Impacts

Research has identified a variety of risk factors that increase dads' vulnerability to PPD. A history of mental illness is a major predictor. Fathers with prior depression or anxiety are at significantly higher risk of distress when adjusting to a new pēpi (Bergström, 2013; Deverick & Guiney, 2016; Kumar et al., 2018).

Recent evidence suggests that biological factors may also contribute to paternal PPD. By analogy to maternal PPD (where hormonal shifts in oestrogen, prolactin and oxytocin, are linked to mood changes), it is now believed that new dads undergo notable hormonal changes during their partner's pregnancy and after childbirth, which can affect their emotional wellbeing (Kim & Swain, 2007). For example, some studies indicate that dads can experience declines in testosterone levels postpartum, and these lower testosterone levels have been associated with heightened depressive symptoms in dads (Kim & Swain, 2007; Saxbe et al., 2017). Changes in other hormones like cortisol, prolactin, and vasopressin have also been observed in new fathers, potentially influencing mood and caregiving behaviour (Kim & Swain, 2007; Rilling et al., 2025). While this research is still emerging, such biological adaptations may help explain why some fathers develop symptoms gradually over the first year, differing from the more immediate PPD timeline often seen in mothers.

The impacts of paternal PPD extend beyond the individual father, affecting partners and tamariki (children). Depressed fathers often exhibit reduced engagement, sensitivity and

responsiveness in interactions with their pēpi; behaviours essential for secure attachment and healthy socio-emotional development (Ramchandani et al., 2005; Wilson & Durbin, 2010). Consequently, tamariki of fathers with mental health conditions like depression are more likely to experience emotional or behavioural difficulties. For example, one study found that children growing up with a father who has untreated mental health issues face a 33% to 70% higher likelihood of developing emotional or behavioural problems themselves (Wilson & Durbin, 2010). Another study also noted that higher levels of paternal depressive symptoms were associated with more aggressive behaviour in toddlers and preschoolers (Weitzman et al., 2011).

Beyond tamariki outcomes, there are wider whānau impacts: paternal depression can contribute to increased couple conflict and lower relationship satisfaction, especially when combined with maternal depression. If the mother is also depressed, the father's risk of PPD roughly doubles or triples (Paulson & Bazemore, 2010), and vice versa, paternal and maternal wellbeing are closely interlinked. Financial hardship can further compound these issues; dads facing serious economic pressure are about 1.5 to 2 times more likely to report depressive symptoms compared to those who are financially secure (Kumar et al., 2018; Paulson & Bazemore, 2010). In Aotearoa/New Zealand, while longitudinal data specific to dads is sparse, parallel evidence from maternal cohorts in highly deprived communities shows significantly higher rates of paternal depression (estimated 20-25%) in low-income areas, compared to 10 to 13% in more affluent areas (Ministry of Health, 2021). This socio-economic gradient highlights how poverty and related stressors (e.g., insecure housing, work instability) can erode mental health and make it harder for affected fathers to seek help or be reached by services, an issue examined in greater depth later in this thesis.

The quality of intimate partner relationships is another key contributor to paternal mental health. High levels of couple conflict, and/or low relationship satisfaction and support,

are strongly associated with paternal PPD (Underwood et al., 2017a). Moreover, fathers who separate or divorce shortly after a child's birth appear especially at risk. One study reported that dads who were no longer in a relationship had substantially higher odds of experiencing moderate to severe psychological distress compared with partnered dads (Rusten et al., 2019).

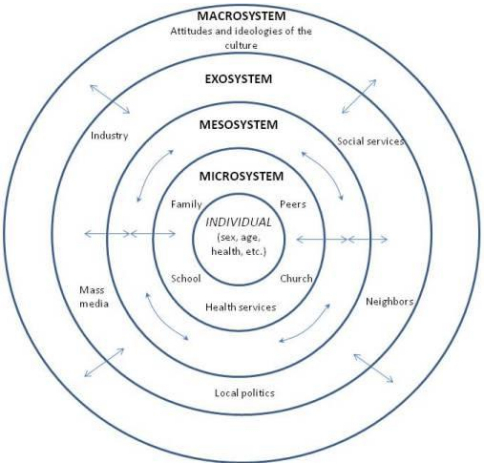
Taken together, these findings point to a persistent structural gap in perinatal care and reinforce the need for detection, prevention and intervention approaches that more explicitly centre paternal mental health, particularly for dads navigating multiple and intersecting stressors.

Bronfenbrenner's Ecological Systems Theory as a Conceptual Framework

Understanding paternal perinatal mental health requires attention not only to individual psychological factors, but also to the broader social, organisational, and cultural contexts in which fathers are embedded (Eriksson et al., 2018). To support this broader perspective, this thesis is guided by Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979), which conceptualises wellbeing as shaped by multiple, interacting layers of influence rather than isolated individual processes.

Figure 1

Bronfenbrenner's Ecological Theory of Development Model



Note. Bronfenbrenner's ecological model depicted as concentric circles representing multiple contexts of influence. From *Bronfenbrenner's Ecological Theory of Development*, Wikimedia Commons, 2012. (https://commons.wikimedia.org/wiki/File:Bronfenbrenner's_Ecological_Theory_of_Development_(English).jpg).

As illustrated in Figure 1, Bronfenbrenner's model focuses on four interrelated systems. The microsystem refers to settings in which the individual has direct, everyday contact, such as intimate partner relationships and interactions with pēpi. Other aspects of the microsystem include experiences of sleep deprivation, caregiving demands and emotional adjustment to parenthood. For dads, this level constitutes their internal emotional responses to becoming a parent, as well as day-to-day dynamics within the whānau.

The mesosystem captures the relationships between these immediate settings. In the perinatal context, this includes interactions between fathers, partners, healthcare providers, and extended whānau or peer networks. For example, how fathers are included (or excluded)

in antenatal appointments, Plunket visits or parenting programmes reflects mesosystem processes that can either support or undermine paternal wellbeing.

The exosystem encompasses contexts that indirectly shape dads' experiences, even when they are not actively involved in them. This includes workplace policies, parental leave entitlements, service design decisions, and organisational priorities within health and social care systems. Although dads may have little control over these structures, they strongly influence access to time, support, and help-seeking opportunities during the perinatal period.

Finally, the macrosystem refers to the broader cultural, societal, and policy environment. This includes dominant norms around masculinity, expectations of fathers as supporters rather than care recipients, and national policy frameworks that shape how perinatal mental health is conceptualised and resourced. Cultural narratives that value stoicism, self-reliance and emotional restraint among men operate at this level, often shaping how fathers interpret their own distress and whether they feel entitled to seek support.

An ecological framework is particularly well suited to the study of paternal perinatal mental health because it highlights how distress can be produced, maintained or alleviated across multiple interacting layers (Edmondson et al., 2010). Rather than locating responsibility solely within individual fathers, draws attention to how relational dynamics, service structures, and sociocultural expectations interact to influence wellbeing (Pilkington et al., 2015). This holistic perspective also aligns with Indigenous worldviews. One prevalent Māori model of health, Te Whare Tapa Whā conceptualises this, describing wellbeing as the balance of interconnected dimensions, tinana (physical), hinengaro (mental and emotional), wairua (spiritual), and whānau. Within this model, wellbeing depends on the balance and interdependence of all four walls; if one dimension is compromised, overall wellbeing is

affected. This framing reinforces the importance of relational and collective contexts in understanding paternal wellbeing (Meredith et al., 2024).

In this thesis, Bronfenbrenner's ecological framework is used as a conceptual lens rather than a rigid analytical template. It provides a way of organising and interpreting both policy and qualitative findings, supporting my analysis of how fathers' lived experiences are influenced by wider systemic conditions. I introduce this framework here because it provides a conceptual lens that I will continue to draw on to analyse risk, barriers, prevention and intervention across interconnected ecological levels rather than as isolated factors.

Barriers to Recognition and Help-Seeking

Despite a clear need for greater recognition and support, fathers continue to experience several barriers to accessing support. One crucial factor is mental health literacy (MHL): the knowledge and beliefs about mental health that aid recognition, treatment and prevention (Seidler et al., 2018). Among fathers themselves, awareness that PPD can affect men remains limited, which can hinder self-recognition of symptoms and delay help-seeking (Scarff, 2019). Compounding this, some healthcare providers may also have limited awareness of paternal PPD or may rely on screening tools that may not adequately capture the "atypical" presentations in men (Paulson & Bazemore, 2010). The combined effect is that fathers' postpartum mental health difficulties often remain under-recognised, with men less likely to self-identify their distress and providers less likely to detect it in routine care.

Beyond awareness, powerful societal and cultural expectations regarding masculinity also play a role in suppressing fathers' help-seeking. In Aotearoa/New Zealand (as in many cultures), dominant masculine norms emphasise stoicism, self-reliance and the expectation that men should remain emotionally strong, particularly during whānau transitions (Schuppan et al., 2016). Men may feel pressure to appear unfazed and to prioritise their partner's and

pēpi's needs over their own. Many dads internalise the belief that seeking emotional support is a sign of weakness or failure to fulfil the provider/protector role (Copland & Hunter, 2025). Corrigan and colleagues (2006) demonstrated that individuals who internalise public stigma are more likely to experience shame and reduced help-seeking intentions. In the context of fatherhood, this dynamic may lead fathers to feel ashamed of not coping, prompting them to hide symptoms or avoid seeking support. Consistent with this, Seidler et al. (2018) found that adherence to traditional masculine norms and fear of being stigmatised significantly reduce men's willingness to access mental health services. Qualitative studies with new dads further illustrate this, with many fathers describing efforts to suppress anxiety or sadness to avoid burdening their partner, even when doing so harms their own mental health (Copland & Hunter, 2025; Staiger et al., 2020).

Research with postpartum dads highlights a recurring theme of 'fathers not being the priority', for instance Searson et al. (2025) found that services were being experienced as predominantly mother-focused, with fathers reporting limited direct engagement from health professionals regarding their own wellbeing. Collectively, multiple levels of influence, from personal beliefs to healthcare practices to societal norms, interact to keep paternal PPD hidden and untreated. These barriers operate across ecological levels, reinforcing the importance of multi-level approaches to recognition and support (Ghaleiha, 2024).

Prevention and Support Strategies

Recognising paternal PPD is an important first step. The next challenge is identifying and implementing effective strategies for prevention, support, and treatment that fathers are willing and able to engage with. Evidence-based treatments for depression, such as cognitive-behavioural therapy (CBT) and interpersonal psychotherapy (IPT) have been proposed as promising approaches for fathers (Cameron et al., 2017; Paulson & Bazemore, 2010; Seidler

et al., 2018), although empirical evidence specific to paternal populations remains limited (Habib, 2012). However, research indicates that fathers often encounter gendered and service-level barriers to engagement, including perceived mismatch between fathers' needs and the design of available supports (Cameron et al., 2017; Seidler et al., 2018).

Moreover, practical, emotional, and informational support from one's partner, whānau friends, or community significantly reduces stress and helps new dads cope (Singley & Edwards, 2015). Fathers who feel supported and understood report fewer depressive symptoms and greater resilience, whereas those with limited support are more prone to isolation and despair (Letourneau et al., 2012).

Pre-birth programmes such as antenatal classes and parenting education can provide opportunities for expectant dads to build social support networks and prepare for the emotional aspects of parenthood. However, research recommends a more continuous support framework that integrates fathers, rather than isolated or one-off interventions (Fletcher et al., 2019), such as routine check-ins for dads during early postnatal visits by maternity services or referral to father-focused support groups.

Group-based and peer support interventions hold particular promise. Fathers have reportedly responded well to peer support groups; safe, non-judgmental spaces (in person or online) where dads can share experiences, realise they are not alone and learn coping strategies from each other (Shorey et al., 2017). Such groups can reduce feelings of isolation and normalise the challenges of new fatherhood. Community-based organisations in Aotearoa/New Zealand like Kidz Need Dadz, Father & Child Trust, and the national charity Perinatal Anxiety and Depression Aotearoa (PADA) have begun to fill service gaps by providing father-specific resources, support groups, helplines and online forums.

Taken together, the literature suggests that the mere availability of services is insufficient; rather, questions remain regarding how perinatal systems can more effectively recognise, engage, and respond to fathers' mental health needs.

Within this context, cultural and whānau-centred approaches have been identified as particularly important for effective engagement. Research indicates that interventions tend to be more effective when they are accessible and culturally relevant (Abel et al., 2005; Durie, 2004). This means offering support in culturally safe ways (e.g., via iwi-based providers for Māori dads) and framing messaging around collective wellbeing so dads see that caring for their own mental health is part of caring for their whānau (Cammock et al., 2014; Seidler et al., 2018). These considerations are particularly important in the Aotearoa/New Zealand context, where Indigenous and Pacific frameworks offer critical insights into paternal wellbeing.

Cultural Frameworks and Equity Considerations

Research focused on engaging Māori fathers highlights the central and relational role that pāpā have traditionally held within whānau. Prior to colonisation, Māori fatherhood was embedded within collective systems of care, responsibility, and nurturing, rather than being confined to narrowly defined provider roles (Jenkins & Hart, 2011). However, colonial processes and the imposition of Western whānau norms disrupted these roles, contributing to the marginalisation of Māori dads within both social policy and service delivery.

Contemporary literature indicates that many Māori fathers continue to seek support that is culturally grounded, relational and aligned with te ao Māori, rather than individualised or deficit-focused approaches (Angeli-Gordon, 2025). Effective engagement with Māori dads therefore requires services to prioritise trust, partnership and whānau-centred practice that recognises the broader historical and structural contexts that shape paternal experiences (Abel

et al., 2005; Kara et al., 2011). These insights emphasise the importance of paternal mental health supports that affirms cultural identity and collective wellbeing, rather than reproducing models that isolate dads from their cultural and relational foundations.

Similarly, Pacific health frameworks offer a broader understanding of paternal wellbeing that extends beyond Western, individual-focused paradigms. The Fonofale model conceptualise wellbeing as inherently relational, spiritual, and embedded within family and community contexts, emphasising the interconnectedness of mental, physical, spiritual, and social dimensions of health (Cammock et al., 2014). Within these frameworks, dad's wellbeing is understood as inseparable from the wellbeing of their wider 'aiga (family) and community.

Pacific dads may experience distinctive cultural expectations and pressures related to familial roles, leadership and responsibility (Pulotu-Endemann, 2001). Supports that fail to recognise these collective influences risks overlooking key determinants of wellbeing for Pacific fathers. As such, these frameworks enrich the macro-level analysis of paternal mental health by illustrating the need for culturally inclusive models that acknowledge extended whānau networks, spiritual dimensions and collective responsibility, rather than relying solely on individualised clinical approaches (Abel et al., 2005; Pulotu-Endemann, 2001).

The present study

The literature suggests that paternal PPD is a consequential public health issue that has been under-addressed, both globally and in Aotearoa/New Zealand. Fathers' postnatal mental health is influenced by a combination of individual, relational and systemic factors, and current support systems may not adequately meet their needs. This study aims to help bridge the gap between policy and practice by foregrounding fathers' own voices and experiences. Guided by an ecological, whānau-centred perspective, the research will explore

how well current policies and services in Aotearoa/New Zealand are supporting paternal mental health, and how dads themselves navigate and perceive the available supports.

Chapter Two: Methodology

This chapter outlines the research aims, design and methods used to examine paternal perinatal mental health support in Aotearoa/New Zealand. The study had two linked components: a qualitative study exploring fathers' lived experiences during the perinatal period, and a policy analysis mapping current provisions for fathers' perinatal mental health. Bringing these strands together enabled the thesis to examine how formal policy intent is translated (or not) into everyday practice for dads and whānau.

Research Design

The overall design was qualitative, including the collection and analysis of policy and practice guidelines for PPD with semi-structured interviews and a focus group involving fathers in Aotearoa/New Zealand. First, semi-structured interviews and a focus group with dads from Aotearoa/New Zealand were analysed using reflexive thematic analysis. Second, policy and practice documents were analysed to identify what is currently stated, implied and absent in relation to paternal perinatal mental health. The two datasets are then integrated in the results chapter through an ecological lens, enabling a direct policy-practice comparison.

Theoretical and Methodological Orientation

The study was informed by community psychology values, particularly context, voice, and systems-level understanding, to understand the systemic conditions that shape wellbeing (Collins, 2025). Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979) provided a structure for understanding how dads experiences are shaped across interacting layers of context (micro, meso, exo, and macro). This approach supports analysis

of feedback loops between individual experience and broader systems, aligning with community psychology's attention to context, power, and the conditions that enable or constrain wellbeing (Trickett, 2009).

Methodologically, the qualitative component used reflexive thematic analysis, which treats themes as interpretive patterns generated through an active, reflexive engagement with the data (Braun & Clarke, 2006, 2021). Reflexivity was foregrounded throughout analysis, including ongoing attention and consideration to how my positioning and assumptions shaped interpretation.

Part One: Qualitative Study

Participants

Participants were fathers living in Aotearoa/New Zealand who had experienced the perinatal period and were willing to reflect on support, distress, and help-seeking as they adjusted to early fatherhood. A total of seven participants took part: four fathers participated in one online focus group, and three fathers completed individual semi-structured interviews. Participants ranged in age from 32 to 55 years and were based across both the North Island and South Island.

The group included one Cook Islands/Pacific father, two Māori fathers and the remaining participants identified as Pākehā/European. Participants were dads to between one and three tamariki. Most were in paid employment at the time of their perinatal experiences, with two identifying as stay-at-home dads. The dads described experiences of postnatal distress and/or depressive symptoms occurring in relation to their first or second child.

Pseudonyms were used for all participants, and identifying details were removed or generalised to protect confidentiality.

Recruitment

Fathers were recruited through community networks and word-of-mouth channels relevant to early parenting and father support. These networks and channels included social media platforms like Facebook and LinkedIn, in play and well child centers (with permission; see Appendix A). This informal snowball method helped reach fathers who may not be active in formal support groups or online communities. The recruitment flyer (Appendix B) invited dads to participate regardless of whether they had accessed formal mental health services, to capture a range of experiences, including those who had managed distress privately or through informal supports. Interested dads contacted the researcher directly via the email address provided on the flyer. This self-selection approach supported voluntary participation and enabled fathers to engage confidentially without gatekeeper mediation.

Data Collection

Data was collected through semi-structured interviews and one focus group with dads from Aotearoa/New Zealand. The interview and focus group schedules (Appendix C-D) explored dads' experiences of the transition to fatherhood, emotional wellbeing, support needs, encounters with perinatal services and barriers to help-seeking. Interviews and the focus group ranged from approximately 60 to 90 minutes and were audio-recorded with informed consent before being transcribed verbatim for analysis. The semi-structured format enabled consistent coverage of core topics while allowing participants to emphasise what mattered most to them.

Prior to participation, fathers who expressed interest were emailed a participant information sheet (Appendix E), consent form (Appendix F), and debrief sheet (Appendix G) approximately one week before the scheduled interview or focus group. This allowed participants time to review the study information and consider their involvement.

At the beginning of each interview or focus group, I briefly revisited the key points of the information sheet and confirmed consent. For participants who had not returned a signed consent form in advance or who required clarification, the consent form was read aloud, and verbal consent was audio-recorded prior to commencing data collection. This process ensured informed consent was obtained in line with ethical requirements.

Data Analysis

Transcripts were analysed using reflexive thematic analysis (Braun & Clarke, 2021). Analysis began with familiarisation through repeated reading and note-tracking. Initial codes were generated inductively across the full dataset and then refined through iterative comparison between and across participants. The main themes were developed by identifying patterned meanings and relationships between codes and were then reviewed and reworked to ensure internal coherence and clear distinction between themes. Final themes were written as analytic narratives supported by illustrative quotes from the dads.

Qualitative findings were subsequently organised across micro, meso, exo, and macro levels to reflect how individual experiences were shaped by relational, organisational and sociocultural contexts. This ecological organisation of data was applied after theme development to support interpretation and integration with the policy analysis, rather than being used as a rigid coding framework.

Reflexivity

Themes were developed through a recursive process that involved returning to the transcripts to check interpretive fit and to seek disconfirming instances. Thick description and extended participant quotes were used in the results chapter to support transparency of interpretation. Reflexivity was ongoing, including attention to how my positionality shaped

the questions asked, how participants responded and how meanings were constructed during analysis (Braun & Clarke, 2021; Kara et al., 2011).

Ethical Considerations

Ethical approval was obtained through the University of Waikato Health Research Ethics Committee (HREC[Health]2025#42). Participants received an information sheet (see Appendix E) and provided informed consent prior to participation (see Appendix F). Confidentiality was protected through de-identification and the use of pseudonyms. Audio files and transcripts were stored securely, with access limited to the researcher and supervisors.

At the conclusion of each interview and focus group, the debrief information was summarised verbally, including available support resources should participation raise any distress. The debrief sheet was also emailed to all participants following their involvement to ensure continued access to support information. Participation was voluntary, and fathers were reminded of their right to withdraw prior to analysis without penalty. Where organisational materials were provided with conditions (e.g., requests for anonymity), these conditions were respected in reporting.

Part Two: Policy Analysis

Design and Scope

The policy component of this study used qualitative document analysis to describe and interpret the current policy and practice guidance documents relevant to paternal perinatal mental health in Aotearoa/New Zealand (Bowen, 2009). The aim was not to evaluate policy 'success' but to map what guidance exists, what is framed as standard practice and what is left unspecified. This analysis focused on what policies and resources say about dad's mental

health and support pathways, how this relates to dad's reported experiences, and where gaps remain.

Document Identification and Selection

Materials were collected by reviewing references within national frameworks, where I searched relevant organisational websites for paternal or father-related content, and requesting information directly from organisations where policy or guidance was unclear. Inclusion criteria were that materials needed to (a) relate to the perinatal period or early parenting support in Aotearoa/New Zealand, and (b) include explicit or implicit reference to dads, partners or whānau wellbeing where paternal mental health could reasonably be considered. International public health resources were included only where they were actively used in Aotearoa/New Zealand-facing information environments (e.g., widely circulated breastfeeding materials directed at dads).

Data Sources

Guidelines, policies and materials were requested from six sources via email (see Appendix H), four organisations and services responded. First, national frameworks and strategies relevant to perinatal, early years and mental health care were reviewed. Second, organisational materials from key perinatal and early parenting providers were sourced, including internal clinical guidance shared in response to a direct enquiry. At the request of one major well-child provider, identifiable details of their internal guidance and public information pages are anonymised in this thesis. Third, Official Information Act (OIA) responses were used to clarify the presence or absence of national policies and pathways within Te Whatu Ora/Health NZ. Fourth, community and non-government organisation resources (e.g., father-focused organisations and public-facing breastfeeding resources

directed at dads) were included to capture the wider information environment that fathers may encounter outside statutory services.

Analytic Approach

Analysis proceeded in three steps. First, each document was summarised in an extraction table capturing its purpose, audience and any direct statements about paternal mental health, screening or support pathways. Second, documents were coded for recurring patterns of inclusion and omission (e.g., whether dads were treated as care recipients, supporters, or absent), and for the presence of operational guidance (e.g., expectations for screening, referral, follow-up, or workforce training). Third, coded findings were synthesised into narrative results organised around key policy domains, such as national policy and pathways, whānau-centered frameworks, organisational guidance, NGO supports, and macro-cultural messaging. This synthesis formed part one of the results chapter and provided the reference point for later policy-practice integration.

Summary

In summary, I have undertaken a qualitative research project that integrates a policy analysis on fathers' perinatal experiences, combining policy analysis with reflexive thematic analysis of the fathers' accounts. An ecological framework supported interpretation across interacting layers of context, and the final integration enabled a direct comparison between policy intent and dads lived experiences.

Chapter Three: Results

This chapter presents findings from two components of the study: (1) a reflexive thematic analysis of interview and focus group data, and (2) a policy analysis examining current paternal perinatal mental health provisions in Aotearoa/New Zealand. Qualitative

findings are organised across the micro, meso, exo, and macro ecological levels (Bronfenbrenner, 1979; Trickett, 2009).

Part One: Dads' Experiences

Part one presents interview and focus group themes which were generated through reflexive thematic analysis and deductively mapped to the level where each experience was primarily situated (micro, meso, exo, macro). While presented by level, dads' accounts often reflected cross-level interaction.

Micro-Level: Individual Experiences of Early Fatherhood

At the micro level, fathers' accounts centred on the internal emotional and cognitive adjustments associated with early fatherhood. Three interrelated themes were identified: identity disruption following the transition to fatherhood, cognitive overload and loss of mental space, and role ambiguity and perceived "uselessness" in early caregiving.

Identity shift: "Nothing will be the same". Across interviews and the focus group, dads described the transition to parenthood as a profound disruption to their sense of self. Becoming a dad, whether for the first or subsequent time, required a psychological re-orientation that many found confronting. Participants spoke of an abrupt realisation that life had fundamentally changed, often without clear guidance or preparation for what this shift would entail: Liam described a moment of recognition that captured this sense of rupture; "Driving home one night I realised life had changed and I had to reset who I was as a dad". Similarly, Noah reflected on identity loss as an extended process rather than a single moment, explaining:

> I equate a lot of it to loss of identity, like you lose yourself a lot… My wife talks about that as well, because she feels like she lost herself a bit… you're still in the

thick of it… and friends said ‘we were ourselves again’… and I was like, when did that come in?

These accounts reflect the internal renegotiation of identity that occurs as dads take on new roles and responsibilities. While participants expressed pride and commitment to being involved fathers, this was often accompanied by uncertainty, self-doubt and a sense of being emotionally unprepared. “No one really prepares you for how hard it is mentally. You expect the tiredness and all that, but not the emotional side of it” (Wiremu). The absence of spaces in which dads’ emotional transitions were acknowledged or normalised intensified this experience, leaving many to navigate the shift largely on their own. Wiremu explained that; “it felt very isolating and overwhelming.”

Cognitive overload and loss of headspace. Many of the dads described persistent mental fatigue resulting from the combined demands of paid work, disrupted sleep and caring for a newborn. Participants frequently referred to a sense of constant cognitive pressure, characterised by racing thoughts, irritability, and diminished emotional capacity. Several dads noted that even brief periods away from caregiving responsibilities provided noticeable relief. Noah explained how small windows of respite restored his sense of clarity; “If you have space away, you get headspace… my brain works again. Even short kindergarten days gave me some headspace.”

These accounts highlight how dad’s capacity to cope was closely tied to their immediate environments and access to restorative time. When opportunities for rest or psychological distance were limited, distress intensified. Participants became more self-critical, emotionally reactive and overwhelmed, suggesting that individual wellbeing was strongly shaped by broader contextual pressures rather than personal resilience alone.

Role ambiguity and perceived "uselessness". A common word used by the dads to describe their perceptions of the infant months was "useless", often referring to not knowing how to contribute in meaningful ways. This was not described as a lack of care or willingness, but as uncertainty about what they could do as dads, particularly when their partner was distressed, recovering from birth or struggling emotionally. Eli captured the shared nature of this experience through humour, noting, "We had this dad group called the Useless Nipples," while also acknowledging that fathers can "feel lost and just struggle." For several participants, the emotional impact stemmed from recognising that practical support could not always relieve what their partner was experiencing internally. As Hemi reflected, "you can't fix what's actually going on inside them and… that… can make you feel incredibly helpless." Allan echoed this sense of limited efficacy, explaining,

> I wouldn't know how to really help… like yes, I can help with the baby and do the practical things around the house, but there's nothing I can really do to… shift the way that she feels… when she's struggling, and that's the part that makes you feel quite helpless as a dad.

This perceived helplessness was often heightened around the birth itself and the immediate postnatal period, where dads described feeling emotionally overwhelmed and unprepared for the magnitude of change. Wiremu described how "you're never really quite prepared for that day when the new arrival comes along," and how the reality of birth made the transition feel "pretty daunting," particularly amid a "very traumatic" and challenging birth experience. The broader adjustment to parenthood was similarly described as experiential and uncertain; as Noah put it, "you don't know how to be a parent until you're a parent." Together, these accounts highlight the steep learning curve fathers described during early parenthood.

A small number of accounts also highlighted that guidance for dads was not always readily available, which contributed to uncertainty about what supportive involvement looked like in the early months.

Meso-Level: Relational and Interpersonal Contexts of Support

At the meso level, dads' experiences were influenced by their immediate relational environments, particularly interactions with partners, whānau, peers and health professionals. Three interconnected patterns were evident: emotional self-silencing within partner relationships, limited direct engagement by health professionals, and reliance on informal peer support. Together, these dynamics influenced how dads' distress was expressed, contained, or supported in everyday relational contexts.

Emotional silencing within partner relationships. Several fathers described deliberately suppressing their own emotional needs in order to prioritise their partner's wellbeing during the postnatal period. This pattern was often framed as protective or necessary, particularly when partners were experiencing visible distress or recovering physically from childbirth. Dads spoke of an implicit understanding that their role was to "hold things together," which limited opportunities to voice their own struggles. As Hemi reflected "I didn't want to add anything to what she was already dealing with. She was exhausted and emotional, so I just kept my stuff to myself".

Moreover, Allan reflected on how this dynamic became entrenched over time; "You just kind of get into that mindset where you think, 'She's got it harder, so I shouldn't complain.' And then you stop talking about how you're actually feeling". While participants expressed empathy for their partners, this relational pattern often resulted in emotional isolation, even where communication was otherwise described as strong. Eli described how attempts to express the difficulty of the transition were sometimes met with frustration,

“When I said, ‘holy fuck this is so hard’, she kind of didn’t respond very well… it made her mad sometimes that I was being negative, and she said it made her doing her job harder”. Over time, this silencing reduced opportunities for mutual support and contributed to internalised distress.

Limited recognition by health professionals. Dads highlighted a lack of consistent engagement from health professionals across antenatal and postnatal interactions. While many participants attended appointments and were physically present during care, they often described feeling peripheral to the interaction, with attention directed primarily towards mum and baby. Hemi captured this sense of marginality succinctly, noting, “So I did go along to them but often felt like the odd wheel.” He elaborated that although he did not resent the mother-centred focus, there was “definitely not anything I recall in terms of… here’s some things for you to be considering,” describing an absence of guidance directed towards the dads’ experiences or needs. Liam similarly described attending appointments where a “midwifery partnership” model was used, yet despite consistent involvement, he recalled limited engagement with him beyond practical questions, “one of them might pay me a little bit of attention… I don’t remember hearing anything about my role as a support.”

For some dads, this lack of recognition extended to wellbeing and mental health. Eli described that postnatal conversations frequently included mental health check-ins for his partner, while he remained largely unacknowledged:

> I did notice that they asked my partner about her mental health a few times, but they didn’t ask me. Even when my partner raised that I was struggling, I didn’t get asked about it post that at all. They don’t ask dads about that stuff.

When he attempted to raise concerns, he described limited response: “Like I said, I tried to talk to them, but I didn’t really get… any kind of feedback.”

In some cases, dads contrasted this with the relative safety of other support contexts. Eli, for example, described therapy as a space where he could voice distress without judgement, “At the early stage, I was in therapy… I can say really… dark stuff… and she wouldn’t judge me, whereas I didn’t feel I could tell my partner.” While this excerpt speaks to relational safety, it also highlights how fathers’ emotional support often occurred outside perinatal care, rather than being invited within it. These accounts indicate that fathers were not consistently engaged within routine perinatal interactions.

Reliance on informal peer support. In the absence of consistent recognition within formal perinatal interactions, many dads described relying on informal support networks to make sense of early parenthood and manage distress. Peer connection was valued less as “formal support” and more as a way to vent, normalise experiences and feel understood by someone outside the immediate pressures of the household. Noah, for example reflected that:

> …[Things] would have been worse without someone to talk to… it was difficult to talk [to his partner because] she was busy… and also doing mornings, evenings and sometimes a lot during the night as well… [It would have helped] to be able to vent to someone and just have a bit of banter… someone outside of the situation.

He also described the temporary relief that came from knowing other parents were experiencing similar struggles: “it would have helped… to know that someone else is doing the same things and struggles… different struggles, but same sort of idea with being a parent.”

For Eli, peer connection emerged through an antenatal group that continued via a group chat. Although the chat was not framed as a mental health space “none of the… dark stuff,” it still enabled sharing of difficulties and offered reassurance through comparison. He further explained that “reading other people’s experiences helped a little bit”, particularly

because it affirmed that "your experience is normal" and that "it's okay to have a hard time… other people also suck at this." Collectively, these accounts show that peer connection helped normalise early parenting challenges. However, peer support remained contingent on fathers' access to appropriate networks and was not consistently available in structured or proactive ways. Eli explicitly noted the absence of local options: "it would have been nice if there was something, like, local… like, actually talking to people…but Reddit was good in that respect."

Exo-System Level: Services, Workplaces, and Structural Conditions

At the exo-system level, dads' experiences were influenced by organisational and structural contexts that sat outside their immediate relationships but had a direct impact on their wellbeing. Three interrelated themes were identified: limited access to perinatal services for dads, workplace constraints and early return to employment, and reliance on self-navigation through fragmented support systems. Together, these themes describe the structural conditions fathers reported as shaping their access to support.

Limited access to perinatal and postnatal services. In this study, dads consistently described perinatal and postnatal services as oriented primarily toward mums and infants, with limited invitation for dads to participate as parents with their own needs. Even when dads attended appointments and were physically present, they often experienced themselves as outside of the interaction. Allan stated, "everything's set up for mum and baby. You're there, but it doesn't feel like the services are actually for you."

Fathers described limited system-level entry points that signalled services were also "for dads," and several noted uncertainties about where they could go if they needed support themselves. Noah, when reflecting on the idea of seeking father-specific support, he stated "there's not really anything in town" adding that he "wasn't going to look up people online",

and that even when he tried to connect informally “I didn’t really get… any kind of… guidance.” Similarly, Wiremu shared that he “didn’t know where I’d even go if I needed help. There wasn’t anything obvious that said: This is for dads too.”

Overall, these accounts indicate that dads’ access to support depended heavily on the visibility of father-specific entry points within services. Where this was missing, dads described falling back on self-directed and informal routes (e.g., online forums), leaving paternal distress easy to overlook within routine perinatal care.

Workplace pressures and early return to employment. Limited partner leave emerged as a significant constraint on fathers’ wellbeing and access to support. In the focus group, one dad described having “a funny job” and being unable to take time off, explaining that he “had to get back to work” after only a few days and was starting at “4am” most mornings (Liam). Another participant described the trade-offs of attending appointments, noting he “couldn’t really take time off and not get paid,” and worried about “a bad rep at work” or resentment from colleagues if he prioritised antenatal visits (Allan). Majority of the dad’s interviewed returned to paid employment within days or weeks of their child’s birth, often while still adjusting emotionally and physically to disrupted sleep and new caregiving responsibilities.

Dads also spoke about how limited partner leave and unpaid time off made sustained involvement difficult. As one participant explained “I was back at work pretty much straight away. You’re exhausted, but you don’t really have a choice” (Allan). In the focus group, participants contrasted Aotearoa/New Zealand with contexts where leave is more clearly allocated to fathers; “we know in some countries like Denmark and Sweden or something they make it a month or more for dad and a year or three for mum” (Liam). Participants are all agreed this kind of parental leave is ideal “Boy do I wish we had something like that”

(Liam, Wiremu), and extended paid leave would've made the transition to parenthood a lot easier. Wiremu noted:

> I think… parental leave is a significant thing because… that's a period that I experienced with baby blues and the need to be present and around… your world's turned upside down at home and everything, so you need to be there [home with whānau] to offer support in a practical sense and an emotional sense so, for me [extended] parental or dad parental leave would have made things significantly different.

Eli was particularly blunt about how the current settings communicate expectations, describing the situation as "bullshit" and arguing that it effectively signals that "one parent takes care of the baby and the other goes back to work". Alongside these constraints, several dads described the anxiety that came with trying to hold employment, income, and family wellbeing at once. One father reflected that he was "worried about losing my job and losing my income," and described ongoing "money worries" alongside the emotional strain of the first year (Liam). Taken together, these accounts suggest that dad's participation and help-seeking were shaped not just by motivation, but by the practical realities of work, leave settings and financial insecurity that limited both time at home and access to support.

Self-navigation and fragmented support pathways. In the absence of clear, dad-inclusive pathways, dads often described having to "piece together" (Eli) support themselves, with access shaped more by chance and personal capacity than by routine service provision. In the focus group, when asked whether they had heard of any supports for new dads, Wiremu responded emphatically: "None. No, not for me. I didn't about hear anything, really." Wiremu also shared how overwhelming the process of seeking support was, "There are bits

of support out there, but you have to stumble across them. No one really points you in the right direction".

For some, informal online spaces became a substitute for local or professional support. For example, Allan shared: "you end up googling stuff at two in the morning, trying to work out what's normal and what's not." Eli described reaching a point:

> [I] posted on Reddit once… [because I] just didn't know how [I] could do it… and it had like 120 replies from other dads… the helpful part was I felt like I was normal… I'm not, like, evil or anything.

Where dads did approach primary care, the support they received was described as inconsistent and sometimes superficial. Eli framed this as highly practitioner-dependent, stating that "sometimes you'll get a GP who'll run you through… all the options… Sometimes you get a GP who'll be like, take this Lorazepam and leave now." He added that some practitioners "don't put a whole bunch of effort into… being real thorough" and described the discussion as having "not a whole lot of depth", "not very specific to… parenting", with no questions about "being a dad or how my kid was going."

Where support was accessed, it was frequently experienced as contingent on individual capacity, time, and awareness. Overall, dads' accounts suggested that locating support often relied on personal initiative and informal pathways rather than clear, routinely signposted options.

Macro-Level: Cultural Norms, Public Discourse, and Systemic Framing of Fatherhood

At the macro level, dads' experiences were shaped by wider cultural narratives and public-facing messaging that influenced how fatherhood, masculinity and perinatal wellbeing were understood. Two interrelated themes were evident: first, the persistence of gendered

expectations that dads should remain steady, self-reliant and emotionally contained; second, the positioning of dads primarily as supporters of mums and babies rather than as parents with their own support needs. Together, these themes help illustrate how fathers' emotional strain can become normalised, minimised or rendered less visible within the broader perinatal landscape, even when dads are highly involved in day-to-day caregiving.

Gendered expectations of masculinity and emotional restraint. In this study, dads' felt impacted by gendered expectations that men should be steady, capable and emotionally contained, especially when their partners were recovering from birth or visibly struggling. Several dads described a "fix-it-myself" stance toward distress, where emotional difficulty was approached as a problem to solve rather than something to share. As Hemi put it, "I think guys generally have this sort of fix-it-myself mentality… we want to fix it and often we can't". Hemi then linked this to broader social learning, "the culture of the time was very much, you get on with it, do it yourself, asking for help is a sign of weakness". In practice, this meant distress was often managed privately, with fathers trying to stay functional and useful rather than naming what they were carrying.

The experience of silencing mental distress was not only felt internally but reinforced externally. Noah described a clear "barrier" when trying to talk with mothers in parenting spaces, where women could vent to each other, but when he spoke up the response was, "what have you got to complain about? You're just the dad". He pushed back on this framing by emphasising the extent of his caregiving, "I'm doing it day in, day out… I'm here doing the exact same thing as you. I'm just not breastfeeding" (Noah). This kind of dismissal mirrors the wider socio-cultural message that fathers' emotional strain secondary, or less legitimate, even when they are deeply involved. It also helps explain why some dads described a quick retreat into emotional self-management, keeping quiet, minimising and pushing through. As one participant put it "I just kept my stuff to myself" (Hemi). For some,

the expectation to "just keep going" became a kind of internal script during the hardest periods. When reflecting on whether he would have used an online dad support group, Noah answered that:

> [I] knew [I was] struggling… but also felt like there isn't really a way out… so I just kind of got to keep going forward… I lasted about five months… I wasn't built that way. I'm just doing it. It's necessary.

Taken together, these excerpts show how macro-level masculine norms (endurance, self-reliance, emotional restraint) can translate into self-silencing at the very time fathers may most need proactive, normalising support.

Fathers positioned as supporters - not care recipients. Dads were commonly positioned as the practical supporters of mums and babies rather than as parents whose own adjustment and wellbeing might also need attention. This framing tended to emphasise "helping" through concrete tasks and logistical support. One participant, Liam who had worked in a dad-support role, described how support messages to dads were often communicated as a list of practical actions and prompts to "help mum" before and after birth, such as encouraging dads to be "right there and helping heaps straight after baby" and offering examples like making cups of tea for breastfeeding or helping with infant care. While these kinds of messages can be useful, they also reflect a broader assumption that dad's primary contribution is instrumental.

This supporter framing was echoed in how dads experienced routine care interactions. Noah described feeling positioned at the edge of professional conversations:

> It's like dad is like [I'm the] support staff or something… like sit in a chair over here and then it's like mum and baby talking to the [well-child provider], talking to the doctor… sometimes [that] is the right thing.

In this sense, dads were present, but their presence did not necessarily translate into being actively engaged as parents with their own needs or questions.

Several dads described how this dynamic became internalised in the early months, shaping what they felt they should prioritise. Eli explained that "in the first six months… it is the dad's job to… keep the house working and… keep mum fed so she can breastfeed," reflecting that within this arrangement "it wasn't as important for me to get help." This captures how the supporter role can quietly become a hierarchy of needs, where mums' wellbeing is understandably centred, but dads distress becomes easier to minimise or postpone.

At the same time, dads' accounts show that being placed in a "helper" role did not necessarily make the experience feel more straightforward or empowering. Several described feeling uncertain about what meaningful support looked like when their partner was struggling emotionally. Taken together, these accounts help clarify how fathers can be simultaneously included and overlooked; included as supporters, yet less visible as people who might also need support.

Dads' accounts across ecological levels illustrate how early parenthood was navigated within relational, organisational and sociocultural contexts that were not always experienced as explicitly father inclusive. While the qualitative findings highlight how distress, role ambiguity and help-seeking were managed in practice, they also raise questions about the broader policy and service environment within which these experiences occurred. The following section therefore examines the current policy and practice landscape relating to paternal perinatal mental health in Aotearoa/New Zealand to consider how system-level settings may shape the visibility, recognition, and support of fathers' wellbeing during the perinatal period.

Part Two: Policy Findings

This section outlines the current policy and practice guidelines relating to paternal perinatal mental health in Aotearoa/New Zealand. It examines national policies, organisational guidance, and community resources to assess how fathers' mental wellbeing is recognised and supported within the perinatal system.

Absence of Dedicated Paternal Mental Health Policy

An Official Information Act (OIA) response from Te Whatu Ora/Health NZ confirms that Aotearoa/New Zealand does not have any national policies, guidelines or clinical pathways relating specifically to paternal mental health. At present, there are no requirements for health professionals to screen dads, nor are there any validated assessment tools formally adopted for paternal mental health within the public system. Likewise, there are no established protocols outlining how providers should respond to dads who show signs of distress and no dedicated referral pathways that support fathers in accessing mental health care during the perinatal period. Te Whatu Ora/Health NZ stating, "Health NZ holds no formal service protocols, pathways, or targeted policies for paternal mental health around childbirth". This absence also extends to the workforce, with no mandated training for practitioners on how to recognise, assess, or support PPD.

In contrast, maternal perinatal mental health is supported by established national guidance and routine screening practices. Midwives, GPs, and Well Child providers commonly screen mothers using the EPDS (Cox et al., 1987).

Whānau-Centred Frameworks: Implicit, not Explicit

Aotearoa's perinatal system is guided by a range of strategic and service frameworks that emphasise whānau-centred care, including Well Child Tamariki Ora (Cutfield et al.,

2019), Kahu Taurima (Asher et al., 2023), the Child and Youth Strategy 2024-2027 (Ministry of Social Development, 2024), and broader national mental health and addiction strategies. This positioning is also reflected in the New Zealand Health Plan/Te Pae Waenga (Health New Zealand, 2025), which emphasises equity, improved access to care, and responsiveness to populations with greater needs across the health system.

Although these frameworks prioritise whānau wellbeing, early intervention and culturally responsive practice, dads are mentioned only indirectly as part of the wider whānau. Importantly, none of these documents provide guidance on how to assess or support fathers' mental health, nor do they outline any expectations for midwives, nurses, or general practitioners to check in with fathers regarding their emotional wellbeing. In practice, the whānau-centred rhetoric does not translate into father-specific action. While Kahu Taurima identifies the whānau as the central unit of support, it offers no operational detail on how paternal mental health should be identified or addressed (Asher et al., 2023). As a result, these frameworks create the potential for inclusive practice but provide no structural mechanisms to ensure that dads' mental health needs are recognised or met.

Parental Leave Policy and Structural Constraints

In Aotearoa/New Zealand, paternity leave settings create a structural context that makes it difficult for fathers to remain present and supported during the early postnatal period. Partners are currently only entitled to up to two weeks of unpaid parental leave, which means many dads return to work almost immediately after the birth of their pēpi (Ministry of Business, Innovation and Employment, 2025). This early return to paid employment often occurs during a period when emotional adjustment is still unfolding and when vulnerability to postnatal distress is known to increase for fathers. Limited leave reduces opportunities for bonding, contributes to ongoing fatigue and financial pressure, and restricts contact with

perinatal services, many of which operate during standard working hours (OECD, 2023). As a result, dads are less visible within the health system and are unlikely to be identified or supported unless they actively seek help themselves.

This absence stands in contrast to international approaches. In the United Kingdom, recent reforms mean that partners of women receiving perinatal mental health care are offered mental health assessments and support through the National Health Service (NHS), reflecting an explicit recognition that fathers' wellbeing is integral to family outcomes (Boseley, 2018; Huang et al., 2020; Williams, 2019). Australia has targeted initiatives such as the SMS4dads programme and father-specific counselling services during the perinatal period, reducing barriers to help-seeking (Fletcher et al., 2019; Gidget Foundation Australia, 2024). Nordic regions provide extended paid partner leave, which supports fathers to stay involved in caregiving and remain connected with health and support services during the postnatal months (OECD, 2023). These international exemplars highlight how different policy settings can create supportive conditions for paternal wellbeing. In contrast, paternal leave policies in Aotearoa/New Zealand position dads primarily as workers rather than caregivers.

Organisational Guidelines and Practice

In response to a direct enquiry regarding paternal mental health, one of the primary tamariki and whānau providers in Aotearoa/New Zealand confirmed that it "does not have a specific policy relating to the screening or support of paternal mental health or postnatal depression". The organisation explained that, rather than operating under a formal policy framework, it currently relies on a small number of non-policy resources to address dads' involvement during the perinatal period. These include a publicly accessible information page intended for dads and an internal clinical guidance resource available to staff. This guidance explicitly acknowledges that dads may be overlooked when practitioners focus primarily on

the mother and encourages staff to engage the dads more intentionally during contacts with whānau. It advises practitioners to include fathers in conversations, to remain attentive to potential concerns raised informally during interactions, and to use existing screening tools such as the PHQ-3 or the EPDS if concerns are identified. The guidance also recommends that practitioners provide appropriate support through sharing resources, facilitating connections with community groups or services, and encouraging contact with a general practitioner when needed.

While this guidance represents an important attempt to mitigate the inadvertent exclusion of fathers, it remains advisory rather than policy-driven and does not establish a systematic or routine approach to paternal mental health care. Screening is discretionary rather than universal, relies on concerns being raised during conversation, and is not embedded as a standard component of perinatal or postnatal contacts with fathers. Furthermore, the guidance does not outline formal referral pathways specific to paternal mental health, nor does it specify expectations for follow-up or monitoring of fathers' wellbeing over time. As such, paternal mental health support remains contingent on individual practitioner awareness and initiative, reinforcing the broader policy-practice gap identified across the perinatal system.

Non-Governmental Organisations Supports and Community-Level Engagement

In the absence of a national policy framework for paternal postnatal mental health, much of the existing support for dads in Aotearoa/New Zealand is provided through non-governmental and community-based organisations. Perinatal Anxiety and Despression Aotearoa (PADA) organisation plays a central role in this space by producing educational and policy-oriented resources that explicitly acknowledge dads' vulnerability to anxiety and depression during the perinatal period. Drawing on evidence from the Growing Up in New

Zealand longitudinal study (Underwood et al., 2017b), PADA highlights that a meaningful proportion of fathers experience depressive symptoms during pregnancy and the postnatal period, with prevalence increasing in the months following birth (PADA, 2025a).

PADA indicates that it relies on publicly available information, noting one specific resource available online, and use this alongside other public information which are intended to help both professionals and whānau recognise the signs of paternal distress. On PADA's main website (PADA, 2025b), they describe the EPDS as a tool developed to identify women who may be experiencing postpartum depression. The accompanying screening questionnaire is presented as a measure of mood during pregnancy and the first 12 months following birth. While the EPDS questionnaire is made available online and can be completed anonymously, PADA explicitly states that the tool is not intended to provide a diagnosis and only trained health professionals should undertake clinical assessment. When elevated scores are identified, users are advised to seek support through general practitioners, midwives, Well Child Tamariki Ora providers, or national helplines.

Although this health awareness-raising approach may increase awareness and encourage help-seeking, it relies on self-identification and individual follow-up rather than routine or proactive engagement. Consequently, while the availability of the EPDS on PADA's website represents an important informational and awareness-raising resource, it does not constitute a formal or systematic approach to screening, assessment, or ongoing support for paternal postnatal mental health, particularly given its framing within maternal perinatal care. Dads' access to such supports therefore remains largely informal and self-directed, often dependent on individual help-seeking after exposure to information, rather than routine referral through perinatal services.

Macro-Cultural Framing of Fatherhood

Public-facing breastfeeding resources directed at dads offer a revealing insight into the broader macro-cultural framing of fatherhood within perinatal health promotion. While these materials are situated within breastfeeding promotion, similar positioning of fathers as supporters rather than care recipients has been noted across wider perinatal health messaging. Across a range of materials, including international public health graphics and dad-focused breastfeeding support resources, dads are positioned primarily as the supporters of mothers. These resources emphasise what dads can do as practical contributions, such as assisting with infant care, protecting mums' wellbeing and how to reduce maternal stress. All while implicitly positioning mums as the primary parent and emotional centre of the caregiving relationship (Great Fathers, 2021b; WHO, 2023a, 2023b).

At the same time, some father-focused organisations provide separate resources that directly acknowledge PPD and encourage help-seeking, including guidance on recognising distress and accessing support (Great Fathers, 2021a). Taken together, these resources suggest that dads' mental health is not entirely absent from the broader parenting-information landscape, but it is often addressed in standalone pages rather than being integrated into mainstream perinatal health promotion materials. This separation matters analytically, because it means that dads' emotional wellbeing may remain peripheral in routine maternal-infant health messaging, even when father-specific resources are available elsewhere.

Gaps between Policy and Practice

Our analysis of the current policy landscape in Aotearoa/New Zealand reveals a critical issue, which is that no formal policy exists in relation to paternal postnatal mental health. There is no nationally mandated approach to screen dads for mental health difficulties during the perinatal period, nor are there established referral pathways specifically designed to support dads who experience PPD or anxiety. Additionally, there is no requirement for

professional training focused on recognising or responding to paternal mental health concerns, and no national guidelines outlining expectations for paternal wellbeing support. The absence of policies and provisions means that paternal mental health is neither monitored nor supported at a national scale.

In other areas, relevant policy frameworks exist but are not consistently enacted at the level of routine service delivery. Whānau-centred models of care are embedded across perinatal and early childhood services and explicitly position whānau wellbeing as a core principle. However, these frameworks rarely translate into routine, or systematic engagement with dads, as individuals with their own mental health needs. Similarly, while some organisations have developed guidance encouraging engagement with dads, it does not ensure consistent implementation across services. Commitments to equity are also evident at a strategic level, yet these commitments are rarely implemented in ways that explicitly address the experiences and needs of dads during the perinatal period (PADA, 2025b, 2025a).

At the same time, there are areas where practice exists in the absence of policy, particularly within the community and non-government sectors. A range of father-focused initiatives, peer support groups and online communities have emerged to support dads navigating early parenthood and PPD. These initiatives often provide practical, emotional and relational support that are valuable and accessible. However, because they operate outside formal policy frameworks, their availability is uneven and frequently dependent on geographic location, funding and informal referral routes.

These policy gaps are further reinforced by broader structural conditions that shape the way dads engage with perinatal services. Government policies in Aotearoa/New Zealand, which allow for limited partner parental leave, hinder opportunities for dads to remain present during the early postnatal period and reduce opportunities for contact with health providers

(Ministry of Business, Innovation and Employment, 2025). Traditional gender expectations continue to frame fathers primarily as supporters and providers, rather than as caregivers or potential recipients of care, a narrative that is reinforced through public mother-centric health messaging. As a result, dads often have limited routine contact with postnatal support services, reducing opportunities for early identification of distress and contributing to the ongoing invisibility of paternal mental health within service systems (OECD, 2023).

Summary of Policy and Practice Guidelines

Taken together, the policy analysis suggests that while Aotearoa/New Zealand's perinatal system reflects strong whānau-centred intent, explicit mechanisms to support paternal mental health appear limited. Dedicated national policy, routine screening expectations, clear referral pathways, and consistent workforce guidance remain largely absent. Where supportive activity does exist, it is typically advisory, locally variable, or located within the non-government sector. In this context, paternal wellbeing may be acknowledged in principle but is not yet systematically embedded within routine perinatal care.

Chapter 4: Discussion

This research set out to examine how paternal PPD is supported in Aotearoa/New Zealand, and whether gaps between policy and practice might be contributing to fathers' needs being overlooked. The findings indicate that this is not simply a problem of implementation but reflects a broader absence of explicit policy. An Official Information Act inquiry confirmed that no national policies, guidelines or clinical pathways exist in Aotearoa/New Zealand specifically for paternal mental health; there are no requirements to screen fathers, no standard assessment tools adopted and no dedicated referral protocols for

dads in the perinatal period. This vacuum at the policy level means that it's impossible to "bridge" a policy-practice gap, because the policy side of the bridge is missing entirely.

Compounding this issue is a stark contrast between the rhetoric of Aotearoa/New Zealand's whānau-centred service ideals and the reality of service provision. National strategies repeatedly espouse whānau-centric and inclusive care, implying that fathers are part of the equation (Ministry of Health, 2021; Ministry of Social Development, 2024). In practice, however, these frameworks only mention dads in passing and offer no explicit guidance on how to include or support their mental wellbeing. As a result, the well-intentioned commitment to "whānau wellbeing" does not translate into father-specific action or accountability. The present study's findings vividly illustrate this disconnect, with fathers describing feeling "in the room but not seen" by professionals. Participants of the present study also noted that health providers almost exclusively directed mental health questions to mothers, implicitly positioning dads' emotional state as irrelevant, unless a crisis arose. Any support fathers did receive was ad hoc and dependent on individual practitioners' personal initiative. Thus, dads' experiences were highly variable, where some dads encountered empathetic staff who offered practical advice, while others were completely ignored. Such missed opportunities in routine care are a predictable outcome of the lack of structural expectations, with no policy or training in place, many providers simply do not consider paternal mental health part of their roles. In short, despite all the talk of holistic, whānau-centred care, the lived reality for many fathers was that their wellbeing remained peripheral to the healthcare system.

Bringing the Findings Together

When considered together, the policy analysis and qualitative findings point to a consistent pattern: Aotearoa/New Zealand's perinatal system contains strong whānau-centred intent, but few explicit mechanisms that make paternal wellbeing visible, acknowledged or

routinely supported. Nationally, the policy analysis identified no dedicated paternal perinatal mental health policy, clinical pathways, training expectations or father-specific referral guidance. Where dads appear in broader frameworks, they are usually referenced indirectly as part of whānau rather than as service users, leaving inclusion possible in principle but uneven in delivery.

This gap is reflected across ecological levels through my qualitative analysis of dads' experiences. At the micro level, early fatherhood was described as involving identity disruption, cognitive overload and role ambiguity, expressed through feelings of helplessness and uncertainty, particularly when partners were distressed or recovering. In the policy and information landscape, fathers are most consistently addressed through practical "supporter" messaging. While explicit acknowledgement of paternal mental health tends to sit in separate father-focused resources rather than being integrated into mainstream perinatal promotion. The micro-level findings suggest why this matters: practical guidance can support "what to do," but does not necessarily prepare dads for what they may feel or legitimise their need for support.

At the meso level, dads' experiences show how distress can be constrained within close relationships and routine care interactions. Many dads described self-silencing to avoid adding to their partner's emotional load. In antenatal and postnatal settings, they often felt sidelined, with limited guidance directed toward their role or wellbeing. This sits alongside the policy finding that at least one major provider has internal guidance encouraging staff to include dads and use brief screening tools if concerns arise, yet dads' accounts indicate that wellbeing check-ins remained largely directed towards mums, with paternal distress was rarely invited into view unless an individual practitioner noticed and followed up.

At the exo-system level, dads described structural barriers that limited access even when support existed in theory. This included unclear entry points, patchy local options, variable experiences in primary care and heavy reliance on self-navigation (including online spaces). These accounts mirror the policy analysis, which showed that whānau-centred intent is not matched by explicit father-specific pathways; consequently, dads often described having to "stumble across" help rather than being routinely signposted. Workplace pressures and limited partner leave compounded this, reducing time at home during the most intense adjustment period and limiting contact with services operating during work hours.

At the macro level, dads' narratives sat within wider gendered expectations that men should be steady, self-reliant, and emotionally contained. Public-facing resources often reinforced a 'helper' framing, positioning dads as supporters of the mums and babies, while paternal mental health information, when available, was often housed separately. These societal messages and system silences created reinforcing conditions for distress to be minimised or managed privately.

Overall, the integrated findings suggest the policy-practice gap is less about the complete absence of support and more about the absence of system signals, routine questions, clear entry points and consistent pathways that legitimise dads' wellbeing needs during the perinatal period. These patterns set up the next chapter, which interprets how whānau-centred policy intentions are mediated by organisational realities and macro-cultural norms, and considers what changes would be needed for paternal mental health support to become visible, consistent, and equitable in everyday perinatal care.

Policy Implications and Service Gaps

These findings have significant implications for policy and practice. Foremost, there is an urgent need to develop explicit policies or guidelines for paternal PPD at the national

level. Establishing a formal policy framework would set clear expectations for dads to be included in perinatal mental health screening, assessment, and support (Searson et al., 2025; Wainwright et al., 2023). Currently, midwives, GPs, and Well Child providers universally screen mothers (e.g., using the EPDS questionnaire) as part of standard care, but no comparable requirement exists for fathers (Cox et al., 1987; Faulkner & Moir, 2023). Closing this gap will likely involve mandating similar check-ins or screenings for dads and creating referral pathways for those who need support.

It is telling that one of the country's major whānau health organisations acknowledged it has no specific policy for paternal mental health, relying only on a general information webpage and an internal "clinical guidance" for staff as a stopgap. While that internal guidance is a step in the right direction, it remains advisory and not embedded into standard practice. Screening fathers is left to discretion and happens only if a provider happens to notice a problem. No formal training, routine inquiry, or follow-up for dads is ensured by this approach. Consequently, paternal PPD care continues to hinge on individual awareness rather than a systematic response. A national policy would legitimise fathers' mental health as a core component of perinatal care, moving it from an optional extra to an expected part of whānau-centred practice.

In addition to high-level policy change, this study highlights several service-level gaps that need addressing. Even without a national policy, there are immediate improvements services can implement to better support fathers. For example, perinatal healthcare providers (midwives, nurses, doctors) can be trained to engage with fathers during appointments. Simple actions like asking the dads how they are feeling, educating them about PPD symptoms and inviting their questions can make a meaningful difference (Fletcher et al., 2019). Dads in the present thesis were never asked about their own wellbeing. Developing standard clinical protocols or checklists that include fathers, such as ensuring both parents are

queried about mental health and adjustment at postpartum check-ups, would help normalise father-inclusive practice (Seidler et al., 2018). Likewise, referral pathways should be established so that if a dad does present with signs of depression or anxiety, practitioners know how and where to direct him for help (Singley & Edwards, 2015). Currently, this is largely absent, a dad identified as struggling might simply be told to see his GP, since there are little to no specialised support systems in place.

Another gap of note for new dads is tailored services, resources and support programmes for new dads. Due to the absence of robust public services, much of the support for dads has come from community or non-governmental organisations. For instance, PADA has developed informational resources that acknowledge fathers' vulnerability to PPD and even provides an online self-screening tool (the EPDS questionnaire) on its website (PADA, 2025a, 2025b). However, while these are valuable efforts, they rely on fathers first recognising their own distress and seeking help. PADA's own website cautions that the screening tool is not for diagnosis and advises high-scoring dads to contact professionals, effectively shifting the next step back onto the individual. In practice, this means many dads will only get support if they actively reach out or stumble across an online resource. Such an approach will inevitably miss a large proportion of fathers who need help, particularly those who are less proactive or lack awareness of PPD.

Integrating resources like the EPDS into the mainstream health system could greatly expand their reach. Fathers interviewed in the present study even suggested that well-child providers could routinely distribute father-focused mental health pamphlets or encourage dads to use self-assessment tools during visits, rather than hoping they find them on their own. Additionally, establishing peer support groups, father-specific parenting classes, or helplines under the umbrella of existing family services could provide dedicated spaces for dads to seek help. The key point is that support for fathers should shift from informal and

incidental to structured and accessible (Singley & Edwards, 2015). The current patchwork of goodwill efforts and online tips is not an adequate substitute for a systematic support system.

It is also important to recognise the cultural dimensions of these service gaps. A truly whānau-centered policy for paternal mental health must incorporate Māori and Pasifika perspectives on whānau wellbeing. Historically, Māori models of health view fathers as an integral part of the whānau unit with important caregiving and relational roles (Cram, 2017; Kara et al., 2011). Colonisation and Western-centric social policies have disrupted these roles, often marginalising Māori fathers in health services (Moewaka Barnes & McCreanor, 2019). Similarly, Pasifika health frameworks, such as the Fonofale model, emphasise that an individual's wellbeing is inseparable from whānau and 'aiga (community) support structures (Southwick et al., 2013). Many Pasifika dads face distinct cultural expectations and pressures, and they benefit from approaches that are communal and inclusive rather than individualistic (Tamasese et al., 2005). Neglecting fathers' mental health not only contradicts the principles of whānau wellbeing but also risks failing Māori and Pasifika families in culturally specific ways. Therefore, any new policies or programmes targeting paternal PPD should be developed in consultation with Māori and Pasifika communities to ensure they uphold cultural values and strengthen whānau networks. In practice, this could mean providing kaupapa Māori parenting support options or ensuring that services for dads are delivered in culturally safe, responsive ways (Reweti, 2023). Addressing the paternal PPD gap is not just a matter of equity between mothers and fathers, but also equity across cultures. A one-size-fits-all approach will not be effective for all Aotearoa/New Zealand whānau.

An Integrated Ecological Approach

Ultimately, bridging the support gap for fathers will require an integrated approach that operates across multiple levels of the system. This study adopted an ecological lens to

map how influences at the personal, interpersonal, community and policy levels interact to shape dads' experiences. The ecological perspective reveals that the many challenges faced by fathers are not isolated to one domain, they are the product of interdependent factors spanning from the micro-level (individual mental health and whānau dynamics) to the macro-level (health system structure and societal norms). For instance, at the individual level a dad may struggle to articulate his emotions (perhaps due to stigma or gender norms), at the interpersonal level he may lack support or communication within his whānau, at the organisational level health services may overlook him, and at the policy level there is no mandate ensuring he is noticed at all. These layers interact dynamically across time, feeding back into each other and shaping individual development (Bronfenbrenner, 1979).

Since the issue is multi-leveled, the solution must be ecological as well. Policymakers should officially recognise paternal PPD in strategies and allocate resources to father-inclusive initiatives at the macro level. This could include extending partner leave provisions and ensuring mental health services are funded to deliver dad-specific services. Notably, other countries have begun to move in this direction, for example, the UK's NHS recently introduced mental health checks and support for new dads as part of its family services (Boseley, 2018), and Australia has rolled out programs like SMS4dads and free dad-focused counselling via the Gidget Foundation (Fletcher et al., 2017). These international examples show that formal recognition of fathers' mental health needs is feasible and effective.

At the service level, healthcare organisations in Aotearoa/New Zealand (hospitals, Well Child/Tamariki Ora providers) should integrate dads into their standard protocols. Providers should routinely invite fathers into conversations, screen them with appropriate tools (adjusted for male presentations of depression), and refer them to support when necessary (Seidler et al., 2018). Practitioners need the skills and confidence to engage fathers

empathetically and the knowledge of where to get a dad further help if needed (Scarff, 2019), therefore the workforce would also need to engage in greater training.

At the community level, strengthening peer support networks and public awareness is vital. Normalising the conversation around paternal PPD, through antenatal classes, parenting groups, and media can reduce stigma and encourage dads to seek help early (Searson et al., 2025). Community organisations, including Māori and Pasifika-led services, have a role to play in creating father-friendly spaces and resources. At the whānau level, interventions can encourage open communication between partners and empower whānau to look after both parents' mental health after a baby arrives (Das & Hodkinson, 2019; Singley & Edwards, 2015).

Limitations

Despite its contributions, this study has several important limitations that must be acknowledged. Notably, none of the participating fathers had a child under one year old at the time of interviewing. This means the study did not capture the perspectives of dads in the immediate postpartum period (Paulson & Bazemore, 2010).

Fathers were reflecting on past experiences, which may introduce recall bias (Sedgwick, 2012). Their recollections might differ from real-time experiences, so the intensity or nature of early postnatal challenges could be diluted in hindsight.

In this study, participants were all self-selected volunteers willing to discuss paternal mental health; as such, they may share characteristics (e.g., a willingness to reflect or seek support), which is likely not representative of all new fathers. The cultural mix (primarily Pākehā/European, with two Māori and one Pasifika dad) provided some diversity, yet other groups (for example, Asian New Zealanders or single fathers) were not represented. The accounts presented here are most applicable to dads in circumstances similar to those

interviewed and should be interpreted as contextually situated rather than representative of the wider paternal population, particularly given the limited representation of some cultural groups.

Related to the above points, the recruitment challenges in reaching fathers of very young infants highlight a limitation in scope. It's possible that dads in the first year postpartum were less available or willing to participate, perhaps due to time pressures or not identifying their feelings as "PPD" yet. This absence is itself telling, those most in need might also be the hardest to involve in research, but it means this study captures more of the retrospective reflections on PPD rather than contemporaneous accounts (Baxter et al., 2008). The support needs or emotional states could evolve over time, so the data may understate the urgency or crisis that can occur in the earliest phase of fatherhood. Future research could specifically target fathers with infants under 12 months to fill this gap.

The study design provides a snapshot of fathers' experiences and policy context at one point in time. Paternal postpartum depression and support systems are evolving issues; policies may change and individual coping can fluctuate. The qualitative interviews captured perceptions after the fact, not a longitudinal follow-up. As such, we cannot determine how fathers' wellbeing or support utilisation might change over a longer period, which limits our understanding of long-term trajectories or outcomes (Lewis, 2015). Moreover, because this research combined policy analysis with personal accounts, differences in timing between when policies were in effect and when fathers experienced PPD could influence findings. Some participants might have gone through their postpartum period before recent policy changes or initiatives, so their experiences might reflect past policy environments.

Additionally, as a researcher, I have been continually mindful of how my own background and assumptions could influence the study and its outcomes. I do not share the exact experience of being a father with PPD, and as a female researcher, I had to consider

how my gender and perspective might affect participants' comfort in sharing or my interpretation of their stories. Throughout the project I engaged in reflexive practices, for instance, discussing interpretations with my supervisors to acknowledge and mitigate personal bias. Nonetheless, complete elimination of researcher influence is impossible (Braun & Clarke, 2021). My positionality, including my cultural lens, professional interest in mental health policy, and personal values inevitably influenced the questions I asked and how I understood the data. This self-awareness is important to disclose, I recognise this limitation does not invalidate the findings, but it underlines that the themes identified are co-constructed between participants' accounts and my interpretation. Ultimately, I acknowledge that the analysis is shaped by my interpretive positioning within this research context.

Future Directions

This research set out to map the disconnect between policy intentions and fathers lived experiences, and it became evident that fathers' marginalisation in perinatal mental health care is a systemic issue. The lack of any formal paternal mental health policy is both a cause and a consequence of societal blind spots regarding dads in Aotearoa/New Zealand. It is not enough to assume that because the whānau is mentioned in policies, dads will be cared for by default. Clarity in policy is needed to drive clarity in practice. Until fathers are explicitly included at the policy level, their inclusion on the ground will remain inconsistent and optional. The implications of continuing with the status quo are significant are that many dads will go on struggling in silence, with ripple effects on partners, tamariki, and wider whānau. Research shows that when a father's mental health goes unaddressed, it can contribute to poorer outcomes for tamariki, such as behavioural or emotional difficulties, and heighten whānau stress (Ramchandani et al., 2005; Wilson & Durbin, 2010). Thus, ignoring dads is not a benign oversight, it actively undermines whānau wellbeing, ironically the very thing that whānau-centred care seeks to promote.

On a positive note, the growing discourse and the fathers' voices in this study indicate a readiness for change. The participants' courage in sharing their experiences is itself a call to action. They have illuminated the cracks in the system and pointed to what supportive care could look like: where a dad can say someone asked how I'm doing too, or I felt part of the process. Responding to this call will require commitment from policymakers, health services and communities alike. This discussion emphasises that bridging the gap for paternal mental health involves building something new, a foundation of policy, training and cultural recognition that dads need and deserve support. By doing so, Aotearoa/New Zealand can honour its whānau-centred values in practice, ensuring that men who become fathers are not left to walk the postnatal journey alone, but are instead met with understanding, resources, and aroha (love) at every step. The outcome of such change stands to benefit not only fathers themselves, but also mothers, tamariki, and the collective wellbeing of our communities. Truly embodying the proverb "He tāngata, he whānau, he hapori" (the person, the family, the community) in our approach to perinatal care (*He Tāngata Principle*, 2025).

References

Abel, S., Gibson, D., Ehau, T., & Leach, D. T. (2005). Implementing the Primary Health Care Strategy: A Maori Health Provider Perspective. *Social Policy Journal of New Zealand*, (25), 70–87.

Angeli-Gordon, J. M. (2025). Ancestral Parenting: Reclaiming Māori Childrearing Practices in the Wake of Colonial Disruption. *Genealogy*, *9*(2), 36. https://doi.org/10.3390/genealogy9020036

Asher, I., Turner, N., & Dowell, T. (2023). *Ensure all children access the healthcare they need* (Policy Brief; CPAG 2023 Policy Brief on Healthcare Access). Child Poverty Action Group. https://static1.squarespace.com/static/60189fe639b6d67b861cf5c4/t/650e6ba1f3fb5435edaa4c00/1695443875705/2023+Policy+Brief+on+Healthcare+Access.pdf

Baxter, S. D., Hardin, J. W., Smith, A. F., Royer, J. A., & Guinn, C. H. (2008). Children's dietary recalls from three validation studies: Types of intrusion vary with retention interval. *Applied Cognitive Psychology*, *22*(8), 1038–1061. https://doi.org/10.1002/acp.1399

Bergström, M. (2013). Depressive Symptoms in New First-Time Fathers: Associations with Age, Sociodemographic Characteristics, and Antenatal Psychological Well-Being. *Birth*, *40*(1), 32–38. https://doi.org/10.1111/birt.12026

Boseley, S. (2018, December 2). NHS to introduce mental health checks for new fathers. *The Guardian*. https://www.theguardian.com/society/2018/dec/02/nhs-to-introduce-mental-health-checks-for-new-fathers

Bowen, G. A. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*, *9*(2), 27–40. https://doi.org/10.3316/QRJ0902027

BPJ. (2010). *Postnatal depression—Depression in the antenatal and postnatal periods*. Bpac Nz. https://bpac.org.nz/bpj/2010/nataldep/postnatal.aspx?utm_source=chatgpt.com

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Harvard University Press. https://doi.org/10.2307/j.ctv26071r6

Cameron, J. L., Eagleson, K. L., Fox, N. A., Hensch, T. K., & Levitt, P. (2017). Social Origins of Developmental Risk for Mental and Physical Illness. *The Journal of Neuroscience*, *37*(45), 10783–10791. https://doi.org/10.1523/JNEUROSCI.1822-17.2017

Cammock, R. D., Derrett, S., & Sopoaga, F. (2014). An assessment of an outcome of injury questionnaire using a Pacific model of health and wellbeing. *The New Zealand Medical Journal*, *127*(1388), 31–39.

Collins, C. R. (2025). Systemic Psychological Insecurity: A Framework for Understanding Well-Being in Unstable Societies. *Review of General Psychology*, *29*(3), 293–310. https://doi.org/10.1177/10892680251357266

Copland, F. S., & Hunter, S. C. (2025). Paternal perinatal mental health support: Fathers' perspectives on barriers, facilitators, and preferences. *Discover Mental Health*, *5*(1), 39. https://doi.org/10.1007/s44192-025-00165-x

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The Self–Stigma of Mental Illness: Implications for Self–Esteem and Self–Efficacy. *Journal of Social and Clinical Psychology*, *25*(8), 875–884. https://doi.org/10.1521/jscp.2006.25.8.875

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry*, *150*(6), 782–786. https://doi.org/10.1192/bjp.150.6.782

Cram, F. (2017). Kaupapa Māori Health Research. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 1–18). Springer Singapore. https://doi.org/10.1007/978-981-10-2779-6_30-1

Cutfield, W. S., Derraik, J. G. B., Waetford, C., Gillon, G. T., & Taylor, B. T. (2019). *Brief Evidence Reviews for the Well Child Tamariki Ora Programme* (A Better Start National Science Challenge).

Das, R., & Hodkinson, P. (2019). Tapestries of Intimacy: Networked Intimacies and New Fathers' Emotional Self-Disclosure of Mental Health Struggles. *Social Media + Society*, *5*(2), 2056305119846488. https://doi.org/10.1177/2056305119846488

Deverick, Z., & Guiney, H. (2016). *Postnatal Depression in New Zealand- Findings from the 2015 New Mothers' Mental Health Survey*. ResearchGate. https://www.researchgate.net/publication/382360999_Postnatal_Depression_in_New_Zealand-_Findings_from_the_2015_New_Mothers'_Mental_Health_Survey

Durie, M. (2004). An Indigenous model of health promotion. *Health Promotion Journal of Australia*, *15*(3), 181–185. https://doi.org/10.1071/HE04181

Edmondson, O. J. H., Psychogiou, L., Vlachos, H., Netsi, E., & Ramchandani, P. G. (2010). Depression in fathers in the postnatal period: Assessment of the Edinburgh Postnatal Depression Scale as a screening measure. *Journal of Affective Disorders*, *125*(1), 365–368. https://doi.org/10.1016/j.jad.2010.01.069

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, *16*(4), 414–433. https://doi.org/10.1057/s41285-018-0065-6

Faulkner, J., & Moir, C. (2023). Whānau Āwhina Plunket nurses' views on the use of the PHQ-3 postnatal depression screening tool: A survey. *Journal of Primary Health Care*, *15*(1), 24–29.

Fletcher, R., Knight, T., Macdonald, J. A., & StGeorge, J. (2019). Process evaluation of text-based support for fathers during the transition to fatherhood (SMS4dads): Mechanisms of impact. *BMC Psychology*, *7*(63). https://doi.org/10.1186/s40359-019-0338-4

Fletcher, R., May, C., Kay Lambkin, F.-, Gemmill, A. W., Cann, W., Nicholson, J. M., Rawlinson, C., Milgrom, J., Highet, N., Foureur, M., Bennett, E., & Skinner, G. (2017). SMS4dads: Providing information and support to new fathers through mobile phones – a pilot study. *Advances in Mental Health*, *15*(2), 121–131. https://doi.org/10.1080/18387357.2016.1245586

Genesoni, L., & Tallandini, M. A. (2009). Men's Psychological Transition to Fatherhood: An Analysis of the Literature, 1989–2008. *Birth*, *36*(4), 305–318. https://doi.org/10.1111/j.1523-536X.2009.00358.x

Ghaleiha, A. (2024). *Fathers' help-seeking and support: The importance of relationships for mental wellbeing* [The University of Waikato]. https://researchcommons.waikato.ac.nz/entities/publication/9141d82b-dc31-4be4-8725-dada1ad05e90

Gidget Foundation Australia. (2024). *Supporting the Mental Health of New and Expectant Parents*. https://www.gidgetfoundation.org.au/

Glynn, L., & Dale, M. (2015). Engaging dads: Enhancing support for fathers through parenting programmes. *Aotearoa New Zealand Social Work*, *27*(1/2), 59–72. https://doi.org/10.3316/informit.187023262934284

Goodyear-Smith, F., & Ashton, T. (2019). New Zealand health system: Universalism struggles with persisting inequities. *The Lancet*, *394*(10196), 432–442. https://doi.org/10.1016/S0140-6736(19)31238-3

Great Fathers. (2021a). *Depression in dads*. Parents and Depression. https://www.greatfathers.org.nz/post-natal-depression

Great Fathers. (2021b). *How to be a great dad | Great Fathers*. Greatfathers. https://www.greatfathers.org.nz/copy-of-couple-relationship

Habib, C. (2012). Paternal perinatal depression: An overview and suggestions towards an intervention model. *Journal of Family Studies*, *18*(1), 4–16. https://doi.org/10.5172/jfs.2012.18.1.4

He Tāngata Principle. (2025, October 24). New Zealand Government. https://www.digital.govt.nz/standards-and-guidance/privacy-security-and-risk/privacy/data-protection-and-use-policy-dpup/read-the-dpup-principles/he-tangata-principle

Howarth, A. M., & Swain, N. R. (2020). *Predictors of postpartum depression in first-time fathers*. https://doi.org/10.1177/1039856220924324

Huang, C. L., Yang, S.-C., & Chiang, C.-H. (2020). The Associations between Individual Factors, eHealth Literacy, and Health Behaviors among College Students. *International Journal of Environmental Research and Public Health*, *17*(6), 2108. https://doi.org/10.3390/ijerph17062108

Jenkins, K., & Hart, H. M. (2011). Traditional Maori Parenting: An Historical Review of Literature of Traditional Maori Child Rearing Practices in Pre-European Times. *Te Kahui Mana Ririki*.

Kara, E., Gibbons, V., Kidd, J., Blundell, R., Turner, K., & Johnstone, W. (2011). Developing a Kaupapa Māori Framework for Whānau Ora. *AlterNative: An International Journal of Indigenous Peoples*, *7*(2), 100–110. https://doi.org/10.1177/117718011100700203

Kim, P., & Swain, J. E. (2007). Sad Dads: Paternal Postpartum Depression. *Psychiatry (Edgmont)*, *4*(2), 35.

Kumar, S. V., Oliffe, J. L., & Kelly, M. T. (2018). Promoting Postpartum Mental Health in Fathers: Recommendations for Nurse Practitioners. *American Journal of Men's Health*, *12*(2), 221–228. https://doi.org/10.1177/1557988317744712

Letourneau, N. L., Dennis, C.-L., Benzies, K., Duffett-Leger, L., Stewart, M., Tryphonopoulos, P. D., Este, D., & Watson, W. (2012). Postpartum Depression is a Family Affair: Addressing the Impact on Mothers, Fathers, and Children. *Issues in Mental Health Nursing*, *33*(7), 445–457. https://doi.org/10.3109/01612840.2012.673054

Lewis, S. (2015). Qualitative Inquiry and Research Design: Choosing Among Five Approaches. *Health Promotion Practice*, *16*(4), 473–475. https://doi.org/10.1177/1524839915580941

Madsen, S. A., & Juhl, T. (2007). Paternal depression in the postnatal period assessed with traditional and male depression scales. *The Journal of Men's Health and Gender*, *4*(1), 26–31. https://doi.org/10.1016/j.jmhg.2006.10.017

Matthey, S., Barnett, B., Kavanagh, D. J., & Howie, P. (2001a). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners. *Journal of Affective Disorders*, *64*(2), 175–184. https://doi.org/10.1016/S0165-0327(00)00236-6

Matthey, S., Barnett, B., Kavanagh, D. J., & Howie, P. (2001b). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners.

Journal of Affective Disorders, *64*(2), 175–184. https://doi.org/10.1016/S0165-0327(00)00236-6

Meredith, C., McKerchar, C., Haitana, T., & Pitama, S. (2024). *Whāia te iti kahurangi:* Seeking perinatal mental health equity. Māori offer solutions for the health system. *Mental Health & Prevention*, *36*, 200362. https://doi.org/10.1016/j.mhp.2024.200362

Ministry of Business, Innovation and Employment. (2025). *Parental leave | Employment New Zealand*. https://www.employment.govt.nz/leave-and-holidays/parental-leave

Ministry of Health. (2021). *Maternal Mental Health Service Provision in New Zealand: Stocktake of district health board services*.

Ministry of Social Development. (2024). *Child and Youth Strategy 2024-2027* [Strategy document]. New Zealand Government. https://www.msd.govt.nz/about-msd-and-our-work/child-wellbeing-and-poverty-reduction/index.html

Moewaka Barnes, H., & McCreanor, T. (2019). Colonisation, hauora and whenua in Aotearoa. *Journal of the Royal Society of New Zealand*, *49*(sup1), 19–33. https://doi.org/10.1080/03036758.2019.1668439

OECD. (2023). *Parental leave systems*. OECD Family Database. https://www.oecd.org/en/data/datasets/oecd-family-database.html

PADA. (2025a). Depression in Fathers. *PADA - Perinatal Anxiety & Depression Aotearoa*. https://pada.nz/depression-in-fathers/

PADA. (2025b). *PADA*. Perinatal Anxiety & Depression Aotearoa. https://pada.nz/

Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and Postpartum Depression in Fathers and Its Association With Maternal Depression: A Meta-analysis. *JAMA*, *303*(19), 1961. https://doi.org/10.1001/jama.2010.605

Pilkington, P. D., Milne, L. C., Cairns, K. E., Lewis, J., & Whelan, T. A. (2015). Modifiable partner factors associated with perinatal depression and anxiety: A systematic review and meta-analysis. *Journal of Affective Disorders*, *178*, 165–180. https://doi.org/10.1016/j.jad.2015.02.023

Pulotu-Endemann, F. K. (2001). [Health framework] (Fonofale Model of Health). Mental Health Commission. https://static1.squarespace.com/static/67204f61044c573ddab4795f/t/6899690eb71d0f1a6f7a8054/1754884366679/fonofalemodelexplanation.pdf

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. G. (2005). Paternal depression in the postnatal period and child development: A prospective population study. *The Lancet*, *365*(9478), 2201–2205. https://doi.org/10.1016/S0140-6736(05)66778-5

Reweti, A. (2023). Understanding how whānau-centred initiatives can improve Māori health in Aotearoa New Zealand. *Health Promotion International*, *38*(4), 1–13. https://doi.org/10.1093/heapro/daad070

Rilling, J. K., Lee, M., Zhou, C., Jung, E., Arrant, E., Davenport-Nicholson, A., Zhang, X., & Ethun, K. (2025). Hormonal changes in first-time human fathers in relation to paternal investment. *Hormones and Behavior*, *171*, 105740. https://doi.org/10.1016/j.yhbeh.2025.105740

Rusten, N. F., Peterson, E. R., Underwood, L., Verbiest, M. E. A., Waldie, K. E., Berry, S., Carr, P. A., Grant, C., Pryor, J., Nicolson, J., & Morton, S. M. B. (2019). Psychological Distress Among Resident and Nonresident Fathers: Findings From New Zealand's Who Are Today's Dads? Project. *Journal of Family Issues*, *40*(3), 293–314. https://doi.org/10.1177/0192513X18808827

Saxbe, D., Schetter, C. D., Simon, C. D., Adam, E. K., & Shalowitz, M. U. (2017). High paternal testosterone may protect against postpartum depressive symptoms in fathers, but confer risk

to mothers and children. *Hormones and Behaviour*, *95*, 103–112. https://doi.org/10.1016/j.yhbeh.2017.07.014

Scarff, J. R. (2019). Postpartum Depression in Men. *Innovations in Clinical Neuroscience*, *16*(5–6), 11.

Schuppan, K. M., Roberts, R., & Powrie, R. (2016). Paternal Perinatal Mental Health: At-Risk Fathers' Perceptions of Help-Seeking and Screening. *The Journal of Men's Studies*, *27*(3), 307–328. https://doi.org/10.1177/1060826519829908

Searson, C., Oxlad, M., & Sawyer, A. (2025). "Nobody asked me, as a dad, how I was coping": Exploring Australian new fathers' paternal postnatal support experiences and needs. *Clinical Psychologist*, *29*(2), 131–144. https://doi.org/10.1080/13284207.2025.2494512

Sedgwick, P. (2012). What is recall bias? *BMJ*, *344*, e3519. https://doi.org/10.1136/bmj.e3519

Seidler, Z. E., Rice, S. M., Oliffe, J. L., Fogarty, A. S., & Dhillon, H. M. (2018). Men In and Out of Treatment for Depression: Strategies for Improved Engagement. *Australian Psychologist*, *53*(5), 405–415. https://doi.org/10.1111/ap.12331

Shorey, S., Dennis, C.-L., Bridge, S., Chong, Y. S., Holroyd, E., & He, H.-G. (2017). First-time fathers' postnatal experiences and support needs: A descriptive qualitative study. *Journal of Advanced Nursing*, *73*(12), 2987–2996. https://doi.org/10.1111/jan.13349

Singley, D. B., & Edwards, L. M. (2015). Men's Perinatal Mental Health in the Transition to Fatherhood. *Professional Psychology: Research and Practice*, *46*(5), 309–316. https://doi.org/10.1037/pro0000032

Southwick, M., Kenealy, T., & Ryan, D. (2013). *Primary Care for Pacific People: A Pacific and Health Systems approach* (Pacific Perpsectives). Ministry of Health.

Staiger, T., Stiawa, M., Mueller-Stierlin, A. S., Kilian, R., Beschoner, P., Gündel, H., Becker, T., Frasch, K., Panzirsch, M., Schmauß, M., & Krumm, S. (2020). Masculinity and Help-Seeking Among Men With Depression: A Qualitative Study. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.599039

Tamasese, K., Peteru, C., Waldegrave, C., & Bush, A. (2005). Ole Taeao Afua, the New Morning: A Qualitative Investigation Into Samoan Perspectives on Mental Health and Culturally Appropriate Services. *Australian & New Zealand Journal of Psychiatry*, *39*(4), 300–309. https://doi-org.ezproxy.waikato.ac.nz/10.1080/j.1440-1614.2005.01572.x

Trickett, E. J. (2009). Community Psychology: Individuals and Interventions in Community Context. *Annual Review of Psychology*, *60*(1), 395–419. https://doi.org/10.1146/annurev.psych.60.110707.163517

Underwood, L., Waldie, K. E., Peterson, E., D'Souza, S., Verbiest, M., McDaid, F., & Morton, S. (2017a). Paternal Depression Symptoms During Pregnancy and After Childbirth Among Participants in the Growing Up in New Zealand Study. *JAMA Psychiatry*, *74*(4), 360–369. https://doi.org/10.1001/jamapsychiatry.2016.4234

Underwood, L., Waldie, K. E., Peterson, E., D'Souza, S., Verbiest, M., McDaid, F., & Morton, S. (2017b). Paternal Depression Symptoms During Pregnancy and After Childbirth Among Participants in the Growing Up in New Zealand Study. *JAMA Psychiatry*, *74*(4), 360–410. https://doi.org/10.1001/jamapsychiatry.2016.4234

Wainwright, S., Caskey, R., Rodriguez, A., Holicky, A., Wagner-Schuman, M., & Glassgow, A. E. (2023). Screening fathers for postpartum depression in a maternal-child health clinic: A program evaluation in a midwest urban academic medical center. *BMC Pregnancy and Childbirth*, *23*(1), 675. https://doi.org/10.1186/s12884-023-05966-y

Weitzman, M., Rosenthal, D. G., & Liu, Y.-H. (2011). Paternal Depressive Symptoms and Child Behavioral or Emotional Problems in the United States. *Pediatrics*, *128*(6), 1126–1134. https://doi.org/10.1542/peds.2010-3034

WHO. (2023a, August 1). *Encouraging breastfeeding and work-life balance for parents in Estonia: Flexibility is key*. WHO. https://www.who.int/europe/news/item/01-08-2023-encouraging-breastfeeding-and-work-life-balance-for-parents-in-estonia--flexibility-is-key

WHO. (2023b, August 3). *Norway's ongoing journey to optimize breastfeeding support*. WHO. https://www.who.int/europe/news/item/03-08-2023-norways-ongoing-journey-to-optimize-breastfeeding-support

Wikimedia Commons. (2012). *Bronfenbrenner's Ecological Theory of Development* [Graphic]. https://commons.wikimedia.org/wiki/File:Bronfenbrenner's_Ecological_Theory_of_Development_(English).jpg

Williams, M. (2019, January 16). *NHS Long Term Plan* [Blog]. NHS. https://www.longtermplan.nhs.uk/blog/landmark-move-will-save-lives/

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical Psychology Review*, *30*(2), 167–180. https://doi.org/10.1016/j.cpr.2009.10.007

Appendix A – Permissions

Sample Observation/Permission Request Email (e.g., to Kidz Need Dadz)

Subject: Request for Permission to Observe and Co-Facilitate Existing Support Group – Thesis Research

Mōrena/Kia ora [Organisation Name] team,

Ko Jessica tōku ingoa and I am a master's student in Community Psychology programme at the University of Waikato. I am currently undertaking a thesis project that explores the policy-practice gap in support services for fathers experiencing postpartum depression in Aotearoa New Zealand (please see recruitment flyer attached).

As part of this project, I hope to attend and (if appropriate) observe one of your existing support group sessions for fathers. This observational component is intended to help me better understand the practical support offered, the accessibility of services, and the lived experiences of participating fathers. My observations of the group dynamics will NOT be turned into a focus group and will remain under the organisations (your) control. Observations are for contextual understanding only, not for data collection.

Moreover, we can utilise this group setting as a recruitment point for potential participants who may wish to take part in focus groups or interviews - not to conduct research on the group itself.

All participation would be voluntary, and no identifying information would be recorded during the observation. Any participants interested in attending the focus group will give informed consent separately through contact with myself.

Debrief sheets and information about the project can be provided upon request. A summary of the research can be shared with your team, and I am happy to work with you to ensure that any involvement aligns with your expectations and group values.

The project has ethics approval from the University of Waikato Human Research Ethics Committee (HREC(Health) Approval Number: 2025#42). Please let me know if you would be open to discussing this further or require any additional documentation.

Ngā mihi nui,

Jessica Hausser-See

Jh824@students.waikato.ac.nz

Master of Applied Psychology (Community)

University of Waikato

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Ngā mihi nui,

Jessica Hausser-See

Jh824@students.waikato.ac.nz

Master of Applied Psychology (Community)

University of Waikato

Appendix B – Recruitment Flyer

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Calling All Dads!

Are you a new dad who has felt down or depressed after the birth of your child?

WE WANT TO HEAR YOUR STORY TO HELP IMPROVE SUPPORT FOR FATHERS. **JOIN** A DISCUSSION OR INTERVIEW – CONFIDENTIAL, **ON YOUR TERMS**

Haere mai ki te tautoko i te oranga o nga papa
Supporting Kiwi Dads' Wellbeing Together

Interested?

Please email:

jh824@students.waikato.ac.nz

Koha for participation

Research conducted by Jessica Hausser-See, Master's Candidate, University of Waikato.
HREC(Health) Approval Number: 2025#42

Appendix C – Interview Schedule

Opening:

- "Thank you for taking the time to speak with me today. I really appreciate your willingness to share your story in more depth. As we discussed, I'll be asking about your experience around the time your child was born and afterward, especially in relation to accessing support and services.

There are no wrong answers – I'm here to learn from you. We may go over some sensitive topics, but you're always in control of what you share. If anything distressing comes up or you need a break, that's absolutely fine. I also have some support contacts to offer if you'd like them afterwards."

- Ask if they would like to open this space with a Karakia.
- Whakawhanaungatanga (relationship building): such as a quick recap of participant's background (e.g., "Last time we met you mentioned you have a 18-month-old son, right?"). Possibly a light first question: "How are you and your family doing this week?" (to ease in).

Safety Plan Statement:

"If at any point during the interview you disclose serious distress, or risks to yourself or others (including family harm, suicidal thoughts, or violence), I may pause the interview and gently check in on your safety.

If risk appears imminent or concerning, I am ethically obliged to ensure safety – which may mean referring you to appropriate services such as 1737, crisis mental health, or family violence support services.

I will also consult with my academic supervisor (Ririwai Fox) who provides professional oversight for this research. Any issues requiring follow-up will be handled with care and in confidence."

- In case of imminent risk: "I really appreciate you being open with me about this. From what you've said, I'm concerned about safety. I'd like to support you in getting some help — can we call or text a service together, like 1737?"
- Consult supervisor **within 12–24 hours** if a disclosure of violence, suicidal ideation, or potential harm to others is made.

1. **Early Experiences as a Father:**

- "Can you tell me a bit about your family and life around the time your baby was born?"(Prompts: number of children, living/work situation, general stressors.)
- "What stands out about the early days of becoming a dad?"
- "Were there any challenges in adjusting to this new role?" (Prompts: time off work, changes in daily routine, sleep, relationships.)

2. **Support Seeking:**

- "When did you first notice that you were feeling not quite yourself, in terms of mood or mental health, after becoming a dad?"
- "What do you think might have contributed to you feeling this way? Any particular stressors or triggers?"

  (Could be baby's health issues, relationship strain, financial pressure, past mental health history, etc.)
- "When you needed support, did you know where to go or who to talk to?"
- "Did anyone talk to you about your own wellbeing, or offer support? For example, did you talk to a doctor or counsellor at any point?"

3. **Impact on Daily Life and Relationships:**

- "How did these things going on at the time impact your daily life and your role as a father?"
- "How about your bonding with your baby – do you think it was affected? If so, in what way?"
- "Did anyone in your whānau/family or friend circle notice something was going on? What did they do?"

4. Experiences with Services:

- "Can you walk me through the journey of any help or support you sought? For example, did you talk to a doctor or counsellor at any point?"
- "What prompted you to seek help, or what held you back from seeking help earlier?"
- (For those who sought help: maybe partner insisted, or saw a pamphlet, or reached breaking point, etc. For those who delayed: thought it would pass, felt embarrassed, didn't know where to go.)
- "What services did you engage with (if any) around the time of your baby's birth?"
- "What was helpful or unhelpful about those services?" (Prompts: Plunket, GP, counsellor, NGO or peer support groups.)

  "Were they understanding? Did they provide any useful advice or referral?"

5. Barriers to Support:

- "What got in the way of getting the support you needed?"
- (Prompts: stigma, work hours, not feeling included, cost, location.)
- "Did you have a preference over in-person or zoom/virtual services?"
- "What was it like going the first time? Were you nervous? What made you stick with it (or not)?"
- "Do you think being a man affected how you dealt with this, versus if a mother has PPD? In what way?"

- "Were you ever concerned about what people would think if they found out you were struggling?" How did you handle that concern?"

6. Peer Support:

- "Have you been part of any support groups for dads?"
    - "If yes, what was your experience like?"
    - If not, "is it something you would consider?"

7. Cultural Relevance of Support:

- "Did your culture or community shape the kind of support you sought or received?"
    - "For example, sometimes culture shapes whether we talk about mental health or who we turn to for help. Was that the case for you?"
- "Were there cultural practices, whānau, or networks that helped?"
- "Is there anything that could have made the support you got more culturally appropriate or comfortable for you?"

8. Service Improvement:

- "If you interacted with any services (like Plunket or a parenting class), did they ever give you information on father's mental health or ask you how you were doing?"
- "What could services do better to support new dads?"
- "If you could design a service for new fathers, what would it include?"

9. Policy Inclusions:

- "Did you feel included by the *maternity* or *postnatal care system* as a father? For instance, during antenatal classes or Plunket visits?"
- "What's your perspective on paternity leave or support for fathers at workplace – did you get any time off or flexibility? If not, do you think that impacted your mental well-being?"

  (This can indirectly speak to policy support for dads.)

Anything Else:

- "Is there anything we haven't covered that you feel is important about your experience or that you want to add?"
- "Any message you'd like to send to policymakers or healthcare providers about fathers' mental health?"

Closing:

- Open space for positive reflection of their parenting journey.
- "Thank you for sharing today. Your insights are really valuable."
- Reminder: confidentiality is essential – "what's shared here stays here."
- Provide debrief sheet and walk through key support contacts.
- Offer an opportunity: "After this, if you remember something later or feel you want to add or change anything, you can contact me, and we can include that."
- If they indicated interest in seeing their transcript or a summary: "I will send you [transcript/summary] when it's ready, and you can let me know if you have any corrections or concerns."
- Debrief: "How are you feeling right now after talking about all this?" (If signs of distress, engage in a longer debrief and ensure they have support; if they seem okay, still encourage self-care: "Do something nice for yourself today, you've done a big thing talking about this.")
- End on a positive note and close with a Karakia.

(End of Interview Guide. The interviewer will adjust language and depth based on each participant's comfort and narrative. The goal is to let the participant lead as much as possible in telling their story, with the above questions as gentle guidance.)

Appendix D – Focus Group Schedule

Introduction/Warm-up: (Facilitator will begin with mihimihi/introductions)

- "Let's start by getting to know each other a bit. Can you share your first name, how many kids you have and their ages, and maybe one thing you enjoy about being a dad?"

  (This helps break the ice and get everyone comfortable talking.)
- "Today we're here to talk about dads' experiences with postnatal support – what helped, what didn't, and what could be improved. You don't need to share anything deeply personal. This is about what services and systems are doing well or could do better. We'll keep things confidential here." (Reminder of ground rules: respect, confidentiality, taking turns, etc.)
    - Note: Reinforce voluntary participation and confidentiality expectations.
    - Note: that this is NOT a therapy group and if any topic becomes uncomfortable, anyone can leave the room/take a break or pass on the question/topic.
- Ask if anyone wants to start with a Karakia, if not I will say one.

Key Questions (Policy & Support-Oriented):

2. **Transition to Fatherhood**
    - "Think back to when your child was born or the early months afterward. Lets all say one or two words that would sum up that period for you"

      (Possible prompts: sleep deprivation, adjusting to new responsibilities, supporting partner, work-life balance, etc.)
3. **Support Pathways & Access**
    - "How did you first hear about any kind of support for new dads?"

- "What types of support did you know were out there – or not know about?"
- "Did anyone ever talk to you directly about your mental wellbeing as a dad?"
- **If someone didn't seek help:** "What kept you from seeking help, if you didn't? (e.g., didn't know where to go, felt you should 'tough it out', stigma, etc.)"

4. **Experience with Support Services/Groups**
    - "Were services like Plunket or your GP helpful in supporting you as a dad?"
    - "Do you feel fathers are included or acknowledged by the health system during the postnatal period? Why or why not? Any examples?"
      (Encourage sharing of any instances where they felt included vs. overlooked by professionals.)
    - "Did you feel included in those conversations, or were they mainly directed at mum and baby?"
    - "Are there any specific things that the group or service did seem especially good/helpful? Conversely, anything that you wish they did differently?"
      (Possible discussion: the importance of meeting other dads, peer support, any structured program or just talking, cultural appropriateness, convenience, etc.)
5. **Support Groups and Community Resources**
    - "Have you ever attended a dad's group or parenting programme? If yes – how did you find it?"
    - "What made you stay or leave?"
    - "What would make those groups more inviting or relevant to you?"
6. **Barriers and Stigma**

- "What kinds of things might stop dads from reaching out for support?" (Prompts: time, stigma, work schedules, lack of information.)
- "Did any of you feel hesitant to talk about what you were going through with friends or family? What made it hard or easier to open up?"

7. **Cultural Factors and Identity Considerations** ***(if appropriate based on group composition)***
   - "Do you feel your cultural background influenced your experience with parenting support?"
     (This could bring up things like: traditional roles, expectations from family, use of traditional support networks, etc. For Māori participants, they might discuss whānau or taha wairua; for Pasifika, concepts of family support, etc.)
   - "Are there community supports that work well for you or your whānau?" (e.g., church, marae, elders)
8. **Ideas for Improvement:**
   - "If you could design the ideal support system for new fathers, what would it include?"
   - "What's one thing health services or parenting organisations should do differently?"
     (Encourage concrete ideas: e.g., "screen dads at postnatal visits", "advertise dad-specific support", "more flexible work leave for fathers", "couples' postnatal check-ins", etc.)
9. **Policy Awareness (light touch):**
   - "Have you ever heard of any official policies or campaigns about fathers' mental health? (For example, did you see any info pamphlets for dads or anything in antenatal classes?)"

- "Do you feel there is enough public awareness that dads can get PPD too?"

Wrapping Up:

- "Is there anything we haven't talked about that you feel is important to mention about your experience as a father dealing with these challenges, or about support for dads?"

Risk Management Strategy (Verbal & Procedural)

Before the group begins:

- Reinforce voluntary participation and confidentiality expectations.
- Note that this is not a therapy group. If any topic becomes uncomfortable, anyone can pass or take a break.

If a participant becomes distressed:

- Acknowledge with care and offer a break or quiet space.
- Gently redirect the discussion toward neutral or strengths-based themes.
- Offer debriefing space afterwards and remind them about the support contact sheet (attached to debrief).

If a participant discloses risk of harm to self or others:

- The facilitator will pause the group and follow internal protocol:
  - Listen calmly without judgment.
  - If imminent risk is disclosed, advise the participant that confidentiality may be broken to ensure safety.
  - Provide them details for appropriate support (e.g., 1737, family violence services, or crisis mental health team).
  - Consult supervisor (Ririwai Fox) within 24 hours for any escalation or follow-up.

Conclusion:

- "Thanks for sharing your whakaaro. It takes courage to speak, and your insights are deeply appreciated."
- Reminder: confidentiality is essential – "what's shared here stays here."
- Provide **debrief sheet** and walk through key support contacts.
- End on a hopeful note: "Let's go around one last time – what's something positive about being a dad that you'd like others to hear?"
- Offer Karakia and group Koha.

  (End of Focus Group Guide. The facilitator will remain flexible and attentive, following up on interesting points participants raise and managing time to cover key topics.)

Appendix E – Participant Information Sheet


DAD'S MENTAL HEALTH

Project: Bridging Policy and Practice: A Qualitative Study of Male Postpartum Depression Support in Aotearoa/New Zealand

KIA ORA - WE'RE INVITING DADS TO SHARE THEIR STORIES

Have you ever felt down or anxious after becoming a father? This study aims to improve support for dads in the postnatal period. Your experience matters.

You can choose to:

- Join a focus group (1.5-2 hours)
- Do a one-on-one interview (45–60 mins)
- Allow observation of a support group you attend

You decide what you take part in.

Your Rights:

- Voluntary – take part only if you want to
- Confidential – your identity will be protected
- Withdraw anytime – no explanation needed
- Support available – mental health resources provided
- Koha: $30 (group), $50 (interview)

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Researcher: Jessica Hausser-See (MAppPsyc student, University of Waikato)
Supervisor: Ririwai Fox – ririwai.fox@waikato.ac.nz
Contact: jh824@students.waikato.ac.nz | +64 225945009
Ethics Approval #: HREC(Health)2025#42

DAD'S MENTAL HEALTH

Project: Bridging Policy and Practice: A Qualitative Study of Male Postpartum Depression Support in Aotearoa/New Zealand

Why Participate?

- Share your story and be heard
- Help improve support systems for dads
- Learn about resources from other fathers
- Make a difference for future parents

Questions or concerns?

Contact Jessica:
jh824@students.waikato.ac.nz
+64 225945009
OR
the UoW Human Ethics Committee:
humanethics@waikato.ac.nz

This research project has been approved by the Human Research Ethics Committee (Health) at the University of Waikato as HREC(Health)2025#42. Any questions or concerns about the ethical conduct of this research may be sent to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address: Human Research Ethics Committee (Health), University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240)

Support Resources for Dads

🧠 Mental Health Services

Need to Talk? – Free call or text 1737

- 📱 24/7 confidential mental health support
- 🧍 Speak with a trained counsellor any time
- 🆓 Free from any NZ number

Depression.org.nz

- 💻 Online tools, self-assessments, and info on PND (including for men)
- 🌐 Website: www.depression.org.nz
- 📞 Free helpline: 0800 111 757

👫 Parenting & Family Support

PlunketLine (Te Whatu Ora)

- 📞 24/7 parenting advice: 0800 933 922
- 🏷️ Not just for mums – supports all parents
- 🌐 Website: www.plunket.org.nz

Māori Health Providers

- 🧭 Many iwi-based health providers offer whānau ora and rongoā Māori services
- 🔍 Find local providers via www.teora.maori.nz

Pasifika Futures & Health Providers

- 🌐 Support via Pasifika community organizations
- 🔍 Search your region: www.pasifikafutures.co.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

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Appendix F – Participant Consent Form

Participant Consent Form

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Bridging Policy and Practice: A Qualitative Study of Male Postpartum Depression Support in Aotearoa/New Zealand

Researcher: Jessica Hausser-See, master's student, University of Waikato
Supervisor: Ririwai Fox

HREC(Health) Approval #: 2025#42

Please read the following statements and tick ✓ to indicate you agree. If you have any questions or concerns, please discuss these with the researcher before signing. You do not have to agree to all components to participate in some parts (you can opt out of an activity if you wish).

Please complete both sides

- ☐ **I have read (or been explained) and understood the Participant Information Sheet dated //2025 for the above research project.** I have had the opportunity to ask questions about the study and my questions have been answered to my satisfaction.
- ☐ **I understand that my participation is voluntary,** and I am free to withdraw at any time before [withdrawal date or 3 weeks post-interview] without giving a reason. I understand that if I withdraw, any data I have provided will be removed if possible.
- ☐ **I understand the procedures and what my participation involves.** I understand I may participate in a focus group, an interview, and/or observation. I agree to the activities I have initialled below:
  - _____ (Initial) I agree to be observed in an existing support group session (if applicable).
  - _____ (Initial) I agree to take part in a focus group discussion with other fathers (approx. 1–1.5 hours).
  - _____ (Initial) I agree to take part in a one-on-one interview (approx. 1 hour).

(You may initial all that apply. Even if you initially agree, you can later choose not to do an activity – just let the researcher know.)

This research project has been approved by the Human Research Ethics Committee (Health) at the University of Waikato as HREC(Health)2025#42. Any questions or concerns about the ethical conduct of this research may be sent to the Secretary of the Committee, email humanethics@waikato.ac.nz, postal address: Human Research Ethics Committee (Health), University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240).

Appendix G – Participant Debrief Sheet

Bridging Policy and Practice: A Qualitative Study of Male Postpartum Depression Support in Aotearoa/New Zealand

Researcher: Jessica Hausser-See

Contact: jh824@students.waikato.ac.nz | +64 225945009

Ngā mihi nui – thank you for participating!

Your insights will help improve support for fathers in New Zealand who are navigating emotional challenges during the postnatal period. We deeply appreciate your time and willingness to share.

What Happens Next?

- Your data will be transcribed and de-identified.
- Only researchers will access your info.
- Your words may be quoted anonymously in research outputs.
- You can withdraw your data within 3 weeks of participation.

Contact us!

If you have any questions, concerns, or want to see a summary of the findings later, please contact me:

jh824@students.waikato.ac.nz

+64 225945009

Feeling Affected? Support Is Available

Support Resources for Dads

🧠 Mental Health Services

Need to Talk? – Free call or text 1737

- 📱 24/7 confidential mental health support
- 👨‍💼 Speak with a trained counsellor any time
- 🆓 Free from any NZ number

Depression.org.nz

- 💻 Online tools, self-assessments, and info on PND (including for men)
- 🌐 Website: www.depression.org.nz
- 📞 Free helpline: 0800 111 757

👨‍👧‍👦 Parenting & Family Support

PlunketLine (Te Whatu Ora)

- 📞 24/7 parenting advice: 0800 933 922
- 🍼 Not just for mums – supports all parents
- 🌐 Website: www.plunket.org.nz

Māori Health Providers

- 🧭 Many iwi-based health providers offer whānau ora and rongoā Māori services
- 🔍 Find local providers via www.teora.maori.nz

Pasifika Futures & Health Providers

- 🌐 Support via Pasifika community organizations
- 🔍 Search your region: www.pasifikafutures.co.nz

Appendix H – Recruitment Email

Recruitment Email to Organisations (e.g., Plunket, Te Whatu Ora)

Subject: Request for Support with Participant Recruitment – Thesis Research on Male Postpartum Depression

Mōrena/Kia ora [Organisation Name] team,

Ko Jessica tōku ingoa and I am a master's student in Community Psychology programme at the University of Waikato. I am currently undertaking a thesis project that explores the policy-practice gap in support services for fathers experiencing postpartum depression in Aotearoa New Zealand (please see recruitment flyer attached).

The research focuses on identifying current organisational policies and support pathways and understanding how these are experienced by fathers (HREC Approval Number: 2025#42).

I am reaching out to seek your support with recruitment. I am looking to connect with fathers who:

- Are aged 18 or over
- Have recently had a child
- Have experienced symptoms of postnatal depression or mental distress
- Have accessed (or considered accessing) support services

Participants would be invited to take part in a focus group or individual interview, with all ethical and confidentiality considerations in place. I would be happy to provide further information, including the Participant Information Sheet and consent materials.

I would greatly appreciate your advice on whether recruitment through your organisation would be possible, and if so, what process you would recommend.

Ngā mihi nui,

Jessica Hausser-See

Jh824@students.waikato.ac.nz

Master of Applied Psychology (Community)

University of Waikato