

# Stay-at-home-fathers Navigating Depression: A Consensual Qualitative Research Study

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STAY-AT-HOME FATHERS NAVIGATING DEPRESSION:  
A CONSENSUAL QUALITATIVE RESEARCH STUDY

by  
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ABSTRACT  
STAY-AT-HOME FATHERS NAVIGATING DEPRESSION:  
A CONSENSUAL QUALITATIVE STUDY  
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Marquette University, 2015

Evidence suggests that the practices through which men are socialized to become masculine may serve both to restrict their potential in ways that lead to psychological distress, and also to restrict the ways in which they respond to such distress (Addis & Mahalik, 2003; Mahalik, Good, Tager, Levant, & Mackowiak, 2012; O'Neil, 2008). While we are beginning to understand masculine depression (Cochran & Rabinowitz, 2000; Magovcevic & Addis, 2008) and paternal depression (Paulson & Bazemore, 2010; Ramachandani & Psychogiou, 2009), almost nothing is known about how SAHFs experience depression, nor their experiences and beliefs regarding help-seeking and psychotherapy. The trend towards increased SAHFs does not seem to be slowing (Latshaw, 2011; Rochlen, McKelly, Whittaker, 2010), and given the impacts of paternal depression individually, and familially, a greater understanding of this unique population is sorely needed.

To that end, this qualitative study focused on how SAHFs experience depression, including ways in which they have coped, and how they think about help-seeking. Where they have sought help from mental health professionals, this study also explored their experiences of psychotherapy. Results indicated that SAHFs who have experienced depression during their tenure as SAHFs focused on relational distress, isolation, loss of independence, and social stigma as contributing to their depression. They appeared to retain a high value on providing for their families, both in the decision to take on the role of SAHF and in deciding to ultimately seek help for depression. The idea of seeking help as a means to protect and provide for their families appeared congruent with their descriptions of masculinity, which recast the SAHF role as being definitionally masculine. Finally, this growing but still somewhat marginalized group of men appeared to be building social networks both on- and offline to support their sense of identity and as a means for coping with the unique stressors they face. Implications for practice, as well as future areas for research, are discussed.

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## Stay-at-Home Fathers Navigating Depression

### Chapter I

#### Statement of the Problem

##### **Men and Depression**

Depression has long been thought to affect women at about twice the rate of men. Population-based studies such as the National Comorbidity Survey (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelman, Wittchen, & Kendler, 1995) have found a female-to-male ratio of 1.69:1, with male respondents reporting a 12.7% lifetime prevalence rate and female respondents reporting a 21.3% lifetime prevalence rate for major depressive episodes. However, many theoreticians and researchers interested in men's mental health have criticized these findings, arguing that men's rates of depression may be underestimated for a variety of reasons, including clinician bias (Potts, Burnam, & Wells, 1991), and perhaps more importantly, differential symptom patterns within men (Cochran & Rabinowitz, 2000; Pollack, 2005). Indeed, more recent studies have identified a phenotypic variant labeled masculine-depression (Magovcevic & Addis, 2008; Zierau, Bille, Rutz, Bech, 2002). When this form of depression has been included in population-based data, rates of depression between men and women are approximately equal (Martin, Neighbors, & Griffiths, 2013). Whatever the sex differences, if any, in depression, a significant number of men suffer from this often chronic and frequently debilitating condition.

Research has begun to unpack some of the ways in which masculinity may intersect with the experience of depression, including how adherence to masculine roles can impinge upon help-seeking (e.g. Addis & Mahalik, 2003; Mahalik, Good, Tager,

Levant, & Mackowiak, 2012; O'Neil, 2008; Smiler, 2006). As our understanding of masculinity has evolved, a more nuanced view into the positive and negative aspects of maintaining this potentially privileged position have been disclosed. In a general sense, psychological understandings of masculinity have moved from a static, biologically-determined personality trait position (Terman & Miles, 1936), to a social role position (Pleck, 1981), to a view of masculinity that emphasizes its socially-constructed, dynamic nature in which "masculinity" is seen as an institutionally backed form of power independent of gender (Connell & Messerschmidt, 2005). What has become more apparent is the paradoxical nature of masculine power and privilege, in which the socialization practices in place to support masculine ideologies and the social roles required to "perform" masculine behavior and accrue those privileges, also serve to harm both men and the communities in which they live.

So called "hegemonic" masculinity has been described as the pattern of practice that has allowed men's perceived dominance over women to continue (Connell & Messerschmidt, 2005), and has been defined as including traits such as assertiveness, competitiveness, independence, and control (Dec Oster & Heimer, 2006). This "hegemony" is not without costs, however, and authors have described some of the ways in which adherence to these traditionally masculine roles can lead to gender-related stress and strain. Pleck (1981) noted that the masculine role includes some dysfunctional elements (e.g., reliance on violence), and that masculine strain can derive from not meeting the role (i.e., discrepancy strain), from trauma experienced during induction into the role (i.e., trauma strain), and from overly rigid reliance on the role (i.e., dysfunction strain). O'Neil, meanwhile, has also described the ways in which masculine socialization

requires adherence to restrictive, contradictory, and difficult-to-achieve norms that ultimately results in the “restriction of a person’s human potential or the restriction of another person’s potential” (O’Neil, 2008, p. 362). Some authors have argued that traditional masculine norms regarding the importance of emotional control, dominance, winning, self-sufficiency, and pursuit of status are imposed upon *all* men living in the United States (Hammer, Vogel, & Heimerdinger-Edwards, 2013; O’Neil, 2008; Wetherell & Edley, 1999).

Along with this evolving understanding of masculinity and masculine-related gender strain or conflict, has come awareness of the significant need for mental health services for men, and at the same time the significant barriers and underutilization of these services by men. Men are less likely than women to seek help for problems as wide ranging as substance abuse, physical disabilities, traumatic life events, and depression (Addis & Mahalik, 2003). Men reporting greater masculinity-related conflict experience greater psychological distress (Cournoyer & Mahalik, 1995), have greater difficulty with interpersonal intimacy (Fischer & Good, 1997), and have higher rates of depression (Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996). Additionally, men who identify with more traditional masculine conceptions (e.g., status-seeking, independence, winning, dominance) hold more negative views regarding utilizing mental health and career counseling services (Addis & Mahalik, 2003; Rochlen & O’Brien, 2002). Men seem to perceive more stigma in seeking help than women (Vogel, Wade, & Hackler, 2007), and this stigma increases in men with higher levels of identification with traditional masculine norms (Hammer, Vogel, & Heimerdinger-Edwards, 2012).

In addition, Rochlen (2005) has pointed out that a frequently mentioned challenge in working with men psychotherapeutically is the incongruence between the “culture of therapy” and the “culture of masculinity.” Ideal therapy clients have been described as “emotionally expressive, comfortable with ambiguity and vulnerability, and able to ask for help” (p. 628), as contrasted with men’s socialization, which tends to promote the avoidance of emotional expression, a masking of vulnerability, and the need for self-reliance and toughness (e.g. Addis and Mahalik, 2003; Good, Thompson, & Brathwaite, 2005).

Summarizing, it is evident that the practices through which men are socialized to become masculine may serve both restrict their potential in ways that lead to psychological distress, and also to restrict the ways in which they respond to such distress. Social pressures connected to the establishment and maintenance of the masculine role may, in fact, lead to a double bind, in which men most in need of help for depression are least likely to seek it (Good & Wood, 1995). A striking piece of evidence for this contention can be seen by noting that while men may be less likely to be diagnosed with depression than women, they are four to 15 times more likely to complete suicide (Canneto & Cleary, 2012; Vannatta, 1997). This discrepancy points to the urgent need to more fully understand how it is that men experience depression and the process of seeking help.

### **Fatherhood**

One particular point of interest in studying men’s depression is in relation to parenthood. The transition into parenthood can be psychologically difficult for both men and women, and recent scholarship has focused on the link between fatherhood and

depression (Cox, 2005; Paulson & Bazemore, 2010; Ramchandani, Stein, Evans, O'Connor, 2005). The evidence suggests that between 10-24% of fathers may suffer from prenatal and postpartum depression (Paulson & Bazemore, 2010). This finding is concerning both for the men directly impacted by depression, and for their children: Research has indicated that paternal depression has detrimental impacts on children longitudinally, including increased association with eventual psychiatric disorders (Ramachandani & Psychogiou, 2009; Ramachandani, Stein, O'Connor, Heron, Murray, & Evans, 2008). Fathers experiencing depression have described the onset of difficulties being connected with situations in which their role or position has appeared fragile, vulnerable, or contradictory (Madsen, 2009). This potential for fragility is situated within a context of changing roles and expectations for fathers, moving from the authoritarian father of the early 20<sup>th</sup> century, through the breadwinner, to the engaged and equal-partner "new father" or "generative father" of today (Lamb, 1995; Madsen, 2003; Madsen, Lind, & Munck, 2002). These changing father-roles represent one aspect of the ever-changing nature masculinity (Connell & Messerschmidt, 2005), and fatherhood is a domain in which masculine norms are expressed and transmitted (Shows & Gerstel, 2009). Given the connection between masculine role conflict and depression (O'Neil, 2008), fathers represent a unique intersection through which to better understand how strain related to this evolving masculine role may eventuate in depression.

The study of masculinity, parenthood, and depression may be particularly salient for an increasing minority of parents, the stay-at-home father (SAHF). The U.S. Census Bureau (2002) reported an 18% increase from 1994 to 2001 in the number of fathers who stay at home with their children. This number has continued to climb, with the U.S.

Census Bureau (2006, 2012) estimating that between 2006 and 2012, the number of men who have remained out of the labor force for more than 1 year to take primary responsibility for their children while their wives work has grown from 143,000 to 176,000. Other research has indicated that these estimates are overly conservative, and have suggested that the true numbers of primary-caregiving fathers may actually range between 200,000-1.4 million (Latshaw, 2011). These men may have a less traditional and more flexible understanding of masculinity (Colombo, 2008; Rochlen, Suizzo, et al, 2008), which could be a protective factor regarding depression. On the other hand, these individuals are at the vanguard of defining new masculine roles, and their perceived violation of masculine role norms may lead to prejudice and backlash (Blashill & Powlishta, 2009; Moss-Racusin, Phelan, & Rudman, 2010; Rochlen et al., 2010). Such backlash may inculcate feelings of isolation. Social isolation is a common predictor of paternal depression (Boyce, Condon, Barton, Corkindale, 2007; Condon, Boyce, & Corkindale, 2004; Deater-Deckard, Pickering, Dunn, & Golding, 1998; Leathers, Kelly, & Richman, 1997), and SAHFs appear to experience a great deal of isolation both from other men and from the stay-at-home mothers with whom they interact (Harrington, Deusen, & Mazar, 2012; Latshaw, 2011; O'Brien 2012).

While we are beginning to understand masculine depression and paternal depression, almost nothing is known about how SAHFs experience depression, nor their experiences and beliefs regarding help-seeking and psychotherapy. The trend towards increased SAHFs does not seem to be slowing (Latshaw, 2011; Rochlen, McKelly, Whittaker, 2010), and given the impacts of paternal depression individually, and familially, a greater understanding of this unique population is sorely needed. To that

end, this study focused on the how SAHFs experience depression, including ways in which they cope and how they think about help-seeking. Where they have sought help from mental health professionals, this study also explored what has been helpful and harmful within these contacts.

### **Definition of Terms**

Before providing a review of the literature, a more in-depth rationale for the study, and an outlay of the methodology, a brief definition of key terms will be explicated.

**Masculinity.** A wider discussion of the history of masculinity will follow in the literature review; however, it is useful to briefly discuss here the meaning of this term. Masculinity has been defined in its “hegemonic” form as a reliance on emotional stoicism, risk taking, status seeking, and the avoidance of anything that could be considered feminine or homosexual (e.g., David & Brannon, 1976; Levant, 1996; O’Neil, Helms, Gable, David, & Wrightsman 1986). However, masculinity is also a fluid construct, consisting of “nested layers of highly situated and contested social practices” (Addis, Mansfield, Syzdek, 2010, p. 81), and is determined in part by the particular social surround (Pleck, 1995; Wade, 1998).

For the purposes of this study, I sought to investigate how SAHFs themselves define masculinity, and thus kept the notion of masculinity as a socially determined identity that may be defined in multiple ways (Connell & Messerschmidt 2005). Rather than defining masculinity at the outset, I was interested instead in how this particular sub-group of men defines masculinity for themselves.

**Depression.** The term depression encompasses a variety of conditions that differ in severity, duration, and symptom pattern. The International Classification of Diseases (ICD; World Health Organization, 2008) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-V*; American Psychiatric Association, 2013) define two broad classes of mood disorders including depressive disorders and bi-polar disorders. The depressive disorders include major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified (NOS). Additionally, the *DSM-V* includes depressive disorders due to a medical condition, substance-induced mood disorder, and mood disorder not otherwise specified (*DSM-V*, 2013, 5<sup>th</sup> Ed.).

Depression is diagnosed based on the extent to which a person endorses symptoms associated with a depressive episode. A major depressive episode consists of the presence, for at least two weeks, of five or more of the following symptoms: depressed mood, diminished interest in all or most activities, weight loss or change in appetite, sleep difficulties including insomnia or hypersomnia, psychomotor agitation or retardation, loss of energy, feelings of worthlessness or inappropriate guilt, decreased concentration, and thoughts of death or suicide (*DSM-V*, 2013, 5<sup>th</sup> Ed.).

As the literature review to follow will indicate, men have shown a reluctance to endorse traditional symptoms of depression for a variety of reasons, and evidence indicates that some men may experience a phenotypic variant of depression consisting of more externalizing symptoms than those described by the *DSM* (Gjerde, Block, & Block, 1988; Levit, 1991; Magovcevic & Addis, 2005; Pollack, 1998). For that reason, this study sought to include both traditional *DSM*-type descriptions of depression, as well as those

characterized as “masculine” or “masked” depression. Because of the qualitative nature of this study, and our interest in inductively developing an understanding of SAHF experiences, these definitions were not presented to participants in order not to prime their responses. The literature review that follows will more fully explicate what is meant by masked depression and masculine depression.

**SAHF.** The US Census defines a SAHF as “a married father with children under 15 years of old who has remained out of the labor force for more than one year primarily so he can care for his family while his wife works outside the home” (US Census, 2008). Unfortunately, this definition excludes many men who act as SAHFs including gay, single, divorced, or cohabitating fathers, those caring for a child with a long-term disability, and those fathers who worked as little as one week or looked for work at any point in the last year (Latshaw, 2011). Other authors have defined a SAHF as a man who has been at home as primary caregiver for at least 6 months (Merla, 2008), or who has been at home for at least one year as primary caregiver but may have had external employment (Doucet, 2004). Some studies have not specified length of time in the SAHF role, but have operationalized SAHFs as working fewer than 20 hours per week while the partner works more than 32 hours (Fischer & Anderson, 2012). Other studies have included any father who self-identified as being a SAHF (Rochlen et al., 2008, 2010).

For the purposes of this study, and based on the recommendations of Latshaw (2011), participants were included if they self-identified as stay-at-home fathers for children still living in the home, whose partner or spouse was identified as the primary wage-earner. Additionally, participants must not have been working in a paid capacity more than 10 hours per week, and must have had partners/spouses who were working

outside the home for 32 hours per week or more. Finally, participants also needed to have experienced a depressed mood, continuously, for at least two weeks during their time as a SAHF.

### **Rationale for the Study**

As noted above, paternal depression has significant negative impacts on both the individual who experiences depression, as well as his children and family (Paulson & Bazemore, 2010; Ramachandani & Psychogiou, 2009; Ramachandani et al., 2008). This fact is compounded by the difficulty posed by men's reluctance to seek help for mental health concerns including depression (Addis and Mahalik, 2003; Vogel, Wester, and Hammer, 2013), and the fact that men as a group may experience phenotypic variants or altogether masked depressive episodes (Magovcevic & Addis, 2008; Martin et al., 2013; Shepard, 2002).

A compelling claim for studying SAHF's perceptions of the intersection between masculinity and depression has been made by the British sociologist David Morgan, who stated that "one strategy for studying men and masculinities would be to study those situations where masculinity is, as it were, *on the line*" (1992, p. 99). SAHFs represent a growing but relatively new adoption of a traditionally feminine role, and by studying their experiences with depression and help-seeking, we may thus not only begin to understand the unique challenges they face, but also something more about the evolving face of masculinity itself. SAHFs are a growing reality in American family life (Doucet, 2004, 2006; Latshaw, 2011, Rochlen et al., 2010; US Census, 2008); however, there is a paucity of studies on SAHFs broadly, and none specifically examining their experiences with depression.

Further, several prominent authors have voiced the need for in-depth, qualitative understandings both of masculine depression and the treatment preferences and experiences of men (Mahalik et al., 2012; Möller-Leimkühler & Yucel, 2010; Shepard, 2002; Whorley & Addis, 2006). As seen in the literature review to follow, most of the research that has been conducted on masculinity and depression has involved White, middle-class males in fairly traditional roles, and thus the need for studying diverse aspects of masculinity as they relate to depression is evident. Such study of diverse masculinities should include not only racially, ethnically, and culturally minority men, but also those newer forms of masculinity that may not be captured by traditional or hegemonic forms (e.g. Branney & White, 2008; Valkonen & Hanninen, 2012), which would clearly include SAHFs.

Another reason to use qualitative methods for such a study is due to the fluctuating, complex, and meaning-laden nature of masculinity itself (Connell & Messerschmidt, 2005). In their review of the research on men and masculinity, Whorley and Addis (2006) reported that 60% of studies were correlational, and only 1.5% used clinical samples. This reliance on correlational methods has several disadvantages, including reducing a complex set of social practices (e.g., the development and maintenance of gender roles) into simplified, two-or-more variable linkages. Perhaps most importantly, the reliance on correlational methods presumes the existence of relatively stable, trait-like characteristics, calcifying individuals' experiences of masculinity into a snapshot, limited form. Opposing such reductive calcification, there is a need for research examining how it is that masculine norms, roles, and conflicts evolve and change over time and context, and how these changes might relate to the

development, experience, maintenance, and resolution of unique forms of depression. To that end, qualitative methods are ideal for developing such in-depth and inductive understandings, particularly of a unique group of men at the vanguard of developing new masculine roles.

This study contributes to the literature on masculinity and depression through an in-depth examination into SAHF's experience of depression, and their patterns, barriers, and reflections on help-seeking through examining the following areas: 1) SAHF descriptions of depression during their tenure as SAHF; 2) perceptions of, and barriers to, help-seeking for depression; 3) SAHF perceptions of helpful and harmful practices in psychotherapy sought for depression.

In this study, the researcher interviewed SAHFs who endorsed having experienced depression during their tenure as SAHFs. Data were analyzed using Consensual Qualitative Research (CQR; Hill, Thompson, and Williams, 1997; Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). CQR is discovery-oriented, giving primacy to participants' words and experiences as they naturally occur. Given the uncharted territory regarding SAHFs and depression, CQR provided an ideal means for developing such knowledge inductively. CQR research strives to develop detailed descriptions of individual processes and experiences, which are in their infancy in terms of the literature on masculinity and depression, and which are absent in regards to SAHFs and depression.

### **Research Questions**

The primary research questions for this study were as follows:

*Question 1: How do SAHFs describe their experiences of depression during their tenure*

*as primary caregivers?*

*Question 2: How have these SAHFs considered help-seeking in relation to depression?*

- *What are SAHF's thoughts regarding pursuing mental health treatment?*
- *What barriers do SAHFs perceive to pursuing such care?*
- *What has facilitated their seeking such care?*

*Question 3: If they have pursued mental health treatment, what are SAHF's experiences with engaging in psychotherapy for depression?*

- *Describe helpful/harmful practices experienced in therapy,*
- *What would SAHFs want other SAHFs to know regarding treatment?*

*Question 4: How do SAHF's think about their own masculinity, and how has this perception changed since taking on the role of SAHF?*

SAHFs represent a growing sub-population of men, about whose specific mental health concerns and perceptions of treatment we know very little. Given the impacts that depression, untreated, can have both on the depressed individual as well as children within his care, it is important to begin to bring these experiences into the open. It is hoped that the results of this study will provide more detailed information for fathers, therapists, primary care physicians, and pediatricians regarding what to look for in, and how to best help, SAHFs who are experiencing depression. It is also hoped that by clarifying and illuminating such experiences, other SAHFs may feel less stigma in speaking about and seeking help for their own struggles with depression.

## Chapter II

### Review of the Literature

To frame the proposed study of depression and help-seeking among stay-at-home fathers (SAHFs), a literature of relevant studies will follow. This review will include an explication of five major frameworks through which male depression has been studied. It will then discuss the literature on barriers to help-seeking among men, before discussing the nascent literature on SAHFs, including demographics and descriptions of the role and stigma experiences. Given the lack of empirical study on depression among SAHFs, it will include a brief discussion of depression in fathers more generally. Finally, a theoretical background and rationale for using the proposed methodology (CQR) will be included before moving to a description of the current study.

#### **Male Depression Frameworks**

**Sex-differences framework.** Depression in men has been studied through a number of lenses, the first of which is the sex-differences framework. This framework assumes that the best way to understand depression in men is through comparison with women on depression-related variables. Research arising from this framework tends to emphasize depression as a unified illness in both men and women, but has sought to identify phenotypic variations (that is, differences in the way depression is expressed) and demographic differences between the sexes.

**Prevalence.** There have been a number of large-scale epidemiological attempts to establish the distribution and prevalence of depression, and one of the most consistent findings is that women seem to suffer from depression at twice the rate as men. The Epidemiological Catchment Area study (ECAS) (Robins & Regier, 1991) comprised of 19,182 subjects sampled from five population centers in the United States, found that male respondents (N=8311) were estimated to have a 3.6% lifetime prevalence rate of

major depressive episode, and a 2.6% lifetime prevalence rate of major depression.

Female respondents (N=10,971) were estimated to have an 8.7% lifetime prevalence rate of major depressive episode, and a 7.0% lifetime prevalence rate of major depression, representing a female to male ratio of 2.41:1 and 2.69:1, respectively.

Another large-scale inquiry, the National Comorbidity Survey (NCS; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshelman, Wittchen, & Kendler, 1995) attempted to mitigate potential gender-bias in reporting of symptoms by including a nonresponse survey in which initial non-respondents were offered a financial incentive to participate; those who did so reported significantly higher rates of both lifetime and current depression, consistent with research that has shown that persons with psychiatric disorders are under-represented in surveys (Allgalunder, 1989; Kessler et al., 1995). Results from this study parallel the Epidemiological Catchment Survey, with male respondents (N=4009) reporting a 12.7% lifetime prevalence rate and female respondents (N=4089) reporting a 21.3% lifetime prevalence rate for major depressive episodes, a female to male ratio of 1.69:1. These results show a comparative narrowing of the difference in lifetime prevalence rates for depression between men and women, and this effect is thought to be the result of interviewers having instructions intended to counteract the proposed tendency of men to forget or minimize depressive symptoms (Kessler et al., 1994). It is also possible that the follow up non-response survey pulled more men with histories of depressive episodes into the results, thus raising the overall prevalence rates for men as compared with the ECAS (Robins & Reiger, 1991). Another important finding is that there were no consistent sex difference in either chronicity or acute recurrence of depression within this sample. In other words, while women appear more likely than men

to have an initial depressive episode, the characteristics of these episodes seem to be similar between the sexes, a finding that has been confirmed in additional investigations looking at course and chronicity of depression (e.g. Kendler, Gardner, & Prescott, 2006; Simpson, Nee, & Endicott, 1997).

*Coping strategies.* Research has also examined sex-differences in depression in terms of coping styles. A finding that has consistently emerged is that men and women seem to have different ways of responding to depressive affect and negative mood, with women showing greater propensity toward rumination and men showing more externalizing responses (Butler & Nolen-Hoeksema, 1994; Twenge & Nolen-Hoeksema, 2002; Tamres, Janicki, & Helgeson, 2002). Difficulties with emotion regulation strategies (or coping styles) including reappraisal, problem solving, acceptance, or attentional redeployment have all been related to elevated levels of depression (Aldao, Nolen-Hoeksema, & Schweizer 2010, Campbell-Sills & Barlow 2007) in both men and women. In a review of the literature on the intersection between gender, emotion-regulation, and psychopathology, Nolen-Hoeksema points out that rumination has been shown to predict symptoms and diagnoses of major depression (Aldao et al., 2010; Nolen-Hoeksema, 2012), and has pointed to the different rates of rumination between men and women as helping explain their different rates of depression diagnoses. A series of meta-analyses examining sex-differences in coping behaviors for depression supports this contention, with women being significantly more likely to engage in rumination and wishful thinking (a type of rumination) than men (Tamres et al., 2002) and in general using a wider range of emotional regulation strategies than men including rumination, reappraisal, problem solving, acceptance, and social support (Nolen-Hoeksema & Aldao, 2011).

However, a clear difficulty with the sex-differences approach is in pulling apart the biological from the socially influenced nature of gender. Some research has attempted to control for socialization of gender, suggesting that while women report higher levels of depression, rumination, and neuroticism than men, lower levels of socialized masculinity (i.e. low instrumentality/agency) *regardless* of gender are also predictive of these variables (Wupperman & Neumann, 2006). This finding is important in demonstrating that sex differences in depression and emotion regulation strategies may be more likely socialized than biologically based.

It is also important to note that even though the studies cited above have found significant differences in coping strategies utilized by women and men, the effect sizes for these differences tend to be small. In the Tamres et al (2002) meta-analysis, for example, effect sizes ranged from -.04 to -.32. Thus, it seems that women and men are more similar than different in their use of coping strategies, and this variable alone does not seem to account for differences in depression. Given the equivocal results implicating coping strategies in the establishment of depression, researchers have attempted to define other models for sex differences in depressive etiology.

***Etiology.*** Kendler, Gardner, and Prescott (2006), having previously established a developmental model of depression in women (Kendler, Gardner, & Prescott, 2002), developed a comparative model of the development of depression among men. These authors utilized data from a two-wave study of male-male and male-female twins from the Virginia Twin Registry, in which interviews were conducted with 5,629 twin pairs at least one year apart. The current study utilized data from the 2,935 male-male twin pairs who completed both interviews. As in their study with female twin pairs (Kendler et al.,

2002), 18 predictor variables organized into “tiers” approximating five developmental periods were examined. Using structural equation modeling to examine the predictor variables, the best-fitting model accounted for 48.7% of the variance in liability to last-year depression, and results suggested three primary pathways for the development of depression in men. The first path, internalizing symptoms, was made up of genetic risk factors, neuroticism, low self-esteem, early-onset anxiety, and past history of major depression. A second pathway, labeled externalizing symptoms, comprised genetic risk factors conduct disorder, and substance misuse. The final pathway, adversity and interpersonal difficulty, comprised predictor variables of low parental warmth, childhood sexual abuse and parental loss, low education, lifetime trauma, low social support, history of divorce, past history of major depression, marital problems, and stressful life events.

This model shared many similarities with the model developed for women (Kendler et al., 2002), suggesting that risk factors and their developmental course are largely congruent between the sexes. In men, genetic risk factors for major depression uniquely predicted risk for early-onset anxiety and conduct disorder. Childhood parental loss appears to have more diverse and potent impacts for men as compared to women: For women childhood parental loss predicted risk for substance misuse, while for men such loss predicted all four early adolescent risk factors (neuroticism, low self-esteem, early-onset anxiety, and conduct disorder) in addition to low educational achievement, substance misuse, and dependent stressful life events. In addition, low self-esteem seems to be a more potent variable in men than in women for predicting depression. In women low self-esteem predicted low educational attainment, while for men this variable contributed to risk for five downstream variables.

The finding that self-esteem and early parental loss has greater impacts on men than women accords with several theoretical approaches to understanding depression in men. Psychoanalytic models in particular (Blazina, 2001; Pollock, 1998, 2005; Diamond, 2006) suggest that early abnegation of male children's need for caregiver affirmation and emotional attunement may lead to problems in self-esteem, which have ripple effects toward developing both problematic masculine behavior and depression. The finding that self-esteem is particularly salient as a predictor for depression among men is also germane to the study of SAHFs, as some research suggests that loss of the traditionally masculine role of breadwinning leads to decreased self-esteem (Staines, Pottick, & Fudge, 1986).

The clearest conclusion that can be drawn from the literature on coping strategies and etiological pathways for depression from the sex-differences framework is that females tend to rely on rumination more than men in response to depressive affect. The etiological pathways share more similarities than differences for women and men, though women may experience greater levels of first-onset depression. Biological differences are thus far inconclusive, and most of the research thus far cannot differentiate between socialized and biological explanations for the observed differences.

*Symptom differences.* Sex-differences in depression between men and women have also been examined at the symptom level, or the ways in which different sexes experience depression. Angst and colleagues utilized the DEPRES study dataset, covering representative samples from six European countries, to examine differences in depressive symptoms between men and women (Angst, Gamma, Gastpar, Lepine, Mendelwicz, & Tylee, 2002). Results indicated that women felt the effects of depression

most notably in terms of their quality of sleep and general health, while men felt the effects most notably in their decreased ability to work. Frank, Carpenter, and Kupfer (1988) also observed differential symptom patterns, with women reporting more appetite and weight increase, more somatization, and increased anger and hostility, while men demonstrated higher scores on a measure of assertion of autonomy, and a more rapid treatment response. Kahn, Gardner, Prescott and Kendler (2002), meanwhile, examined gender differences in the symptoms of depression in opposite-sex dizygotic twin pairs. Results indicated that women were more likely to experience symptoms of fatigue, hypersomnia, and psychomotor retardation, while men were more likely to experience insomnia and agitation. Unlike some of the earlier studies, there were no significant sex-differences in appetite or weight change or impairment. This study is particularly useful in examining gender differences due to being able to control to a much greater degree “nurture” based variables such as early family life, socioeconomic status, and cultural factors.

Utilizing grounded theory, Danielsson and Johansson (2005) conducted a qualitative study into the impact of gender on experiences of depression. These researchers conducted interviews with 8 female and 10 male patients at a healthcare center in northern Sweden, and found that both gender and sociodemographic background influenced the experience of depression. For all participants, the perception of high-demands and expectations underlay narratives of depression. Demands differed by gender and sociodemographic category: For women with low-education, the family was foremost, while for middle-class men work engagement was most salient. Interestingly, highly educated women and men with low income resembled each other in

their dual commitment to, and perceptions of demands from both family and professional pursuits. Men in well-paid careers with high educational levels gave highest priority to work and had difficulty refraining from work even when physically ill. Both women and men reported physical symptoms, and indicated that these symptoms had initially brought them in for treatment. Few participants recognized their physical symptoms as potentially being linked to depression. Narratives of physical ailments differed by gender, with men tending to describe more intense physical symptoms (centering on the heart, chest pain) than women (stomach-oriented focus).

One interesting implication of this study is the concordance between highly educated women and men with low-educational levels on perceiving high demands from both work and family roles as contributing to their depression. For both of those positions, there may be issues having to do with gendered role strain leading to depression. In the case of men in the low-educational bracket, depression emerging from dual family and work demands may be related to discrepancy strain based on not living up to the traditional masculine role as provider. This sort of strain could be particularly germane to stay-at-home fathers who find themselves in the role due to their partner's higher earning potential, a common reason given for entering the role (e.g. Rochlen et al., 2008).

Summarizing sex-differences in symptom patterns, women appear to experience more psychomotor retardation symptoms including increased sleep, as well as somatic complaints, while men were more likely to endorse having agitated symptoms, concerns related to work, and insomnia. Again, however, it is difficult to differentiate the effects of sex from those of gender role socialization in considering these differences. It may be

that men are more likely to endorse the specific symptoms delineated due more to perceptions of social expectations than underlying sex-differences.

Of note for the current study, further research might benefit from investigating the similarities and differences in depression specifically in men and women who are operating outside of the dominant gender social role, such as childless women in high-powered occupations, and stay-at-home fathers.

**Masked depression framework.** An alternative framework through which men's depression has been studied is that of a hypothesized "masked depression." This approach assumes that many men presenting with externalizing problems such as anger, substance abuse, and interpersonal conflict are in fact experiencing underlying depression. The key assumption underlying this framework is that restrictive masculine role norms can both exacerbate depression while at the same time making depression more invisible due to prohibitions against men expressing sadness, grief, and depressive affect.

Clinicians and researchers working within this framework have noted that while men experience symptoms consistent with DSM-V demarcations of depression, many men exhibit masculine-specific features of depression that stem from externalizing defenses (Gjerde, Block, & Block, 1988; Levit, 1991). Depression has been hypothesized to be "masked" (or hidden) through expression of anger, irritability, or withdrawal in response to perceived narcissistic injuries (Pollack, 1998), or through a cycle of internal rumination and substance abuse (Nolen-Hoeksema, 2002). Men are more likely to engage in externalizing disorders including problematic anger, substance abuse, and antisocial personality disorder, which authors have suggested may be a means for expressing

underlying depression (Cochran & Rabinowitz, 2000). Additionally, the discrepancy in rates of depression between men and women are smaller in countries that are less tolerant of antisocial or high-risk behavior (Rosenthal, Goldblatt, & Gorton, 1995), which is consistent with the notion that these behaviors may in fact be masking depression. When these externalizing behaviors are not as readily sanctioned, it is possible that symptoms more consistent with the underlying depression are endorsed and expressed. It remains an open question whether the culture of modern fatherhood is permissive of these typically externalizing behaviors or not, and how this permissiveness (or lack thereof) affects expressions of depression among, especially, stay-at-home fathers.

Several authors have conducted grounded theory studies to investigate men's experience of depression, finding tentative support for the masked depression construct (Brownhill, Wilhelm, Barclay, & Schmeid, 2005; Chuick, Greenfeld, Greenberg, Shepard, Cochran, & Haley, 2009). These studies have indicated that men experience both typical and atypical symptoms of depression, in a cyclical, intensifying pattern that often requires external intervention to disrupt, and that their experiences of socialization makes them reluctant to talk about their depressive symptoms or seek help (Brownhill et al., 2005; Chuick et al., 2009). Atypical symptoms are thought to be evidence for masked depression, and are consistent with other literature that has highlighted men's increased irritability (Bjork, Dougherty, Moeller, 1997; Pan, Neidig, & O'Leary, 1994), alcohol and substance abuse (Mahalik & Rochlen, 2006; Miller, Klamen, Hoffmann, & Flaherty, 1996), and increased frequency and intensity of interpersonal conflict (Pollack, 1998). Utilizing men who have been diagnosed with depression, however, presents problems for the masked depression framework, inasmuch as the "masking" should theoretically lead

to an exclusion of a depression diagnosis. These studies, in fact, may more readily support the notion of a masculine-type depression, which will be explicated in the following section.

In fact, the difficulty in establishing a true masked depression is necessarily the case given the nature of our current nosological system and the lack of any reliable biomarkers for depression. That is, the DSM system relies on an endorsement of symptoms presumed to be attendant with underlying pathology. Given that masked depression as a construct proposes that these symptoms would be absent, it seems impossible to empirically verify the construct at this time. However, the construct of masked depression appears to be useful clinically, and in fact has been explicated in a slightly different manner through the masculine depression framework, which will be examined next.

**Masculine depression framework.** Another model proposes that rather than masking depression, many men may experience a phenotypic variant, labeled “masculine depression.” This framework, too, begins from the perspective that due to masculine socialization practices that encourage externalization and action and discourage introspection, men who are depressed, and especially those who adhere more strongly to traditional masculine norms, are likely to express externalizing behaviors in response to depressed mood. This model differs from the masked depression model in that it suggests the expression of externalizing behaviors men display that have been labeled “masked depression” are instead a variant form of depression. Essentially, authors working from this framework propose the existence of a different type of depression, typical to more masculine individuals. Models such as Pleck’s gender role strain theory and O’Neil’s

work on gender role conflict suggest that, for many men, masculine socialization requires adherence to restrictive, contradictory, and difficult-to-achieve norms (Pleck, 1981; O'Neil, 2008). Specific patterns of negative effects related to gender-role strain have been studied under the rubric of gender-role conflict (see O'Neil, 2008 for review). These specific patterns include restricted emotional expression, work and family life conflicts, and problems with developing close male social relationships.

In his exhaustive review on gender role conflict using the Gender Role Conflict Scale, O'Neil (2008) highlighted 27 studies that have assessed the relationship between gender role conflict and depression (Blazina & Watkins, 1996; Brewer, 1998; Bursley, 1996; Coonerty-Femiano, Katzman, Femiano, Gemar, & Toner, 2001; Cournoyer & Mahalik, 1995; Shepard, 2002; Fragoso & Kashubeck, 2000; Good & Mintz, 1990; Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996; Good & Wood, 1995; Hayahsi, 1999; Kim, Choi, Ha, & O'Neil, 2006; Jo, 2000; Jones, 1998; Kang, 2001; Kelly, 2000; Magovcevic & Addis, 2005; Mahalik & Cournoyer, 2000; Mertens, 2001; Newman, 1997; Peterson, 1999; Sharpe & Heppner, 1991; Sharpe, Heppner, & Dixon, 1995; Simonsen et al., 2000; Tate, 1998; and Theodore, 1997 as cited in O'Neil, 2008). All but three of these studies (Bursely, 1996, Good et al., 2004; Sharpe et al., 1995) showed a correlation between patterns of gender role conflict and depression, with restrictive emotionality being the most consistent predictor. These studies provided evidence for linkage between gender role conflict and depression across diverse racial, sexual-orientation, and cross-cultural samples of men. Collectively, this research provides substantial evidence that men who restrict their emotions, restrict their affection towards

other men, and who struggle with work and family conflicts are more likely to experience depression.

However, much of this research relied upon correlational designs and measures of traditional depression, which as noted above, may miss many of the facets to men's depression experiences. The fact of a correlation between GRC and depression does not indicate directionality; it could be that adherence to the patterns associated with GRC lead to depression, but it could also be that depressed men are more likely to rely on such norms for other reasons. There may also likely be intervening, contextual variables that mediate or moderate the role of GRC in the development of depression. From an interpersonal perspective, for example, one might expect that emotional restriction (RE) within the context of a marital relationship could lead to a negatively reinforcing cycle of maladaptive communication, eventuating in feelings of isolation and potentiating depressive episodes. From a very different perspective, critics have argued that GRC's correlation with mental health variables, including depression, is less important than personality. Trokar et al. (2003) found that compared to personality, GRC explained very little of the variance in men's mental health variables, and went on to suggest that GRC may be linked to biological disposition more than socialization practices. While this is a contentious point, it presents an area for further clarification in regards to the proposed and observed linkage between GRC and depression.

Branney and White (2008) have suggested that manifestation of specific symptoms, or "enacting depression, may be one way in which individuals enact gender. Given this suggestion, it may be that being prototypically depressed is viewed as "unmasculine," and it is a fear of non-masculinity that leads to a masculine-specific

depression. Emslie and colleagues (Emslie, Ridge, Ziebland, & Hunt, 2006) found that the most common strategy discussed by men recovering from depression was reincorporating values associated with hegemonic masculinity (i.e., reestablishing control and responsibility; being “one of the boys”). On the other hand, a small subset of the participants in this study viewed their depression and recovery as signs of difference from others, emphasizing their sensitivity and intelligence. Branney and White (2008) suggest that some of the symptoms consistent with masculine depression, including interpersonal conflict and substance abuse, may be ways of “doing” depression that enact a particular masculine identity. Emslie et al.’s (2006) work complements this notion, and highlights that different men have different masculinities that are more salient than those associated with hegemonic masculinity, and the masculine-type depression that would seem to accompany this role.

Valkonen and Hanninen’s (2012) research complements the work of Emslie et al (2006) and Branney and White (2008). These authors found that depression was seen, by male interviewees, as a consequence both of realized and unattained hegemonic masculinity. Those who saw their depression as a result of unattained hegemonic masculinity fit into the framework of Pleck’s (1981) discrepancy role strain, in that their lack of attainment of stereotypical masculine roles led to depression. On the other hand, those who had realized hegemonic masculinity often described their depression as resulting from over-reliance on this role, similar to O’Neil’s (2008) work linking gender role conflict with depression. These men represented the largest subset of the study, and were labeled “men of duty, who often experienced depression given their workload and sense of familial responsibility.

This study also revealed two novel styles of masculinity in relationship to depression. One group was labeled “Challenging Hegemonic Masculinity,” and these participants saw masculine norms as barriers to wellness and happiness, viewing their depression as a consequence of their unwillingness to live up to masculine norms. While somewhat similar to the Pleck’s discrepancy role strain in that these participants did not attain the stereotypical masculine norm, these participants differed in that they actively rejected such norms as being worthy of achievement. This subgroup in particular is relevant to the current study, in that taking on the role of SAHF can be seen as a rejection of stereotypically masculine roles. It may be the case, then, that SAHFs who take on the role identify their unwillingness to live up to traditional masculine norms as causative factors for depression. On the other hand, these men may feel empowered through rejecting traditional masculine norms. Similarly, men who are “forced” into the SAHF role, for whatever reason, may be more closely aligned with the non-attainment of hegemonic masculinity, and might view this lack as a contributing factor to their depression. How these depressions might be experienced and expressed remains open for investigation.

*Standardized Measures of Masculine Depression.* Attempts have also been made to develop standardized instruments for measuring masculine depression. Rutz (1999) proposed a “male depressive syndrome” that is congruent with masculine depression. This syndrome differs from prototypical depression, and includes sudden and periodic lowered stress-tolerance, impulsive-aggressive or psychopathic behavior in otherwise non-psychopathic men, and sudden alcohol and/or drug abuse or their equivalents (e.g. workaholism, excessive exercising) in otherwise non-abusive men. Rutz’s work has

resulted in a screening measure, the Gotland Scale of Male Depression, which consists of typical depressive symptoms and these more masculine-predominating symptoms. The scale has shown good reliability (Bech 2001; Zierau, 2002), and is divided into two factors labeled “distress” and “depression” (Zierau, 2002). The distress subscale includes items of being stressed, aggressiveness, irritability, feelings of displeasure, overconsumption of alcohol or related substances, behavior changes, and greater tendency to self-pity. The depression subscale includes items of being burned out, tiredness, difficulty making decisions, sleep problems, hopelessness, and family history of depression or suicide (Moller-Leimkuhler, Heller, & Paulus, 2007). The scale has shown satisfactory convergent validity due to being correlated with the WHO-5, a measure of depression developed by the World Health Organization (Spearman’s  $Rho=0.56$ ;  $p=0.00$ ) (Bech, 1998; Moller-Leimkuhler, Heller, & Paulus, 2007).

Magovcevic and Addis (2008) developed a masculine depression scale, operationalizing the construct as a specific set of responses to negative affect that are influenced by restrictive masculine social roles. This scale is comprised of two factors which measure both prototypical and masculine (e.g. externalizing) symptoms of depression. The measure has been found to have good internal consistency (.96 for Factor 1–Internalizing and .77 for Factor 2–Externalizing symptoms) and support for the two-factor structure has been established (Magovcevic & Addis, 2008). Factor 2 has been found to correlate moderately with traditional depression measures and is strongly correlated with rigid adherence to masculine gender norms.

Overall, research involving the Gotland scale and the MDS suggests that a phenotypic variant consistent with masculine depression does exist. This variation may

not be limited to biological males, but is correlated with measures of traditional masculinity (e.g. Möller-Leimkühler & Yücel, 2010). While the development of these scales has been beneficial in bringing more attention to the unique ways in which men may experience and express depression, they are not without limitations. The GMDS has been critiqued for its limited clinical utility and for psychometric shortcomings (Diamond, 2008; Magovcevic & Addis, 2008), and studies have repeatedly failed to validate its hypothesized *a priori* factor structure (Moller-Leimkuhler et al., 2007; Moller-Leimkuhler & Yucel, 2010; Rice, 2012). Also, the fact that the GMDS has been used to diagnose masculine depression in females (Moller-Leimkuhler & Yucel, 2010) calls into question the theoretical underpinnings of this proposed framework, which suggests males are uniquely exposed to masculine socialization practices resulting in such a syndrome.

The MDS, meanwhile, presents much more rigorous psychometric data, but also has notable limitations. Due to the small sample size in the validation study, the scale is unable to differentiate symptom patterns beyond an externalizing/internalizing binary. There remains a need for scales that have more utility in differentiating the theorized symptoms of a masculine depression.

***Masculine depression framework: Critique.*** There are also problems with the way the masculine depression framework has been studied on the whole. Most of the research has utilized convenience samples of college-attending, Caucasian males, and thus very little is known about the ways masculinity influences the experience and expression of depression in men of color. Another key limitation of the work within the masculine depression framework is that it has primarily examined depression as a final

endpoint, rather than looking at the ways in which masculine role norms may influence the development of pre-syndromal experiences that may lead, eventually, to a full-blown Axis 1 disorder. Kendler's (2006) work has helped illustrate an etiological pathway for depression among men as a group, but work deconstructing the various ways in which *particular* masculine norms influence such development has been lacking.

What has not been measured is how SAHFs might score on such measures of masculine depression. It is likely that there is a wide variability of adherence to masculine norms within this subpopulation, which may thus lead to a wide range of expressions of depression. However, such research has not yet been conducted.

**Gendered responding framework.** One final lens through which depression in men has been studied is the gendered responding framework. This framework has proposed that masculinity may play a role in how men respond not only to depression as a specific disorder, but in how they respond to negative affect more broadly. Addis (2008) developed this framework as a means for integrating the response-styles framework of Nolen-Hoeksema (2012) discussed earlier with research on the social construction and social learning of gender. Gendered responding suggests that gender should influence how individuals respond to negative affect given that emotional experiencing and responding are contexts within which a great deal of gender socialization and learning takes place (Eisenberg, Cumberland, Spinrad, 1988; Fischer, 2000). Addis and colleagues suggest that the specific, discrete emotions expressed in response to negative affect are a function of the context in which the affect is experienced (Barret, 2006; Green & Addis, 2012). It is within a gendered social context that expressions of negative affect may become socially problematic, and thus it is these

gendered contexts which may account for the particular (externalizing) ways in which men respond to negative affect and depression. Authors working from this perspective suggest that because emotion socialization is a gendered process, individual differences in adherence to gender norms will affect how people respond to core negative affect and in turn the likelihood of presenting with prototypical depression (Addis, 2008; Barrett, 2006; Green & Addis, 2012). This suggests that externalizing behaviors such as violence, substance abuse, and risk-taking commonly associated with males (Addis & Mahalik, 2003; O'Neil, 2008) can be understood as gendered responses to negative affect, taking place within a social sphere characterized by the salience of gendered behaviors. Again, this may account for the linkage between adherence to masculine role norms or “hegemonic” masculinity, and externalizing pathologies (Addis and Mahalik, 2003; O'Neil, 2008). In many ways, the gendered responding framework is an extension of the work within the response styles (Nolen-Hoeksema, 2012) and masculine depression frameworks, but with a more clarified understanding of the underlying emotional processes that lead to specific masculine responses and expressions of depression. It differs from the response styles framework in not focusing only on how people respond to depressed mood, taking into account the notion that many men are reluctant to acknowledge such mood states within themselves. It also differs from the masculine depression framework in providing a theory for why such a masculine-form of depression might develop, as elucidated below.

This framework draws on the work of contemporary research in emotion that views different emotions, including depressed mood, not as discrete entities or “kinds” but as phenomena that emerge through a socialized reflective process in response to more

basic core-affect (Barrett, 2006). Barrett (2006) describes core affect as equivalent to a “neurophysiological barometer of the individual’s relation to an environment at a given point in time” (p. 31). Specific emotions, in turn, are thought to arise when conceptual knowledge about emotion is reflected on and applied to the core affect. This knowledge is socially derived, learned, context-specific, and influenced by language (Barrett, 2006). Bringing this perspective into focus in the context of masculinity and depression, then, suggests that what it *means* to a man when his core affect is negatively valenced will be influenced by the gender norms and practices specific to the given social context. To illustrate, one could consider how a man might respond to the negative affect attending grief related to the death of a loved one, loss of a high-powered corporate job, or loss of children in a custody battle. Each of these contexts presents a separate set of gendered expectations that will influence how the underlying negative affect is ultimately understood, reflected upon, and acted upon.

There is a good deal of evidence supporting the contention that recognizing and responding to emotions are processes through which gendered learning takes place. Mothers appear to be more contingent in their responding to their sons’ expression during play, matching their sons’ expressions more than their daughters’ expressions (Malatesta & Haviland, 1982; Tronick & Cohn, 1989), and responding more contingently to their sons’ than their daughters’ smiles (Malatesta & Haviland, 1982). Both mothers and elder siblings mentioned feeling states more frequently to 18-month-old girls than boys, and reported that at 24 months girls referred to more feeling states than boys (Dunn, Bretherton, & Munn, 1987). Fathers, too, have been observed to be more likely to discuss

emotion with daughters (Greif, Alvarez, Ulman, 1981). These observations support the contention that emotional responding is a learned process that is gender-dependent.

Masculine restriction of emotional expression may also be socialized. Eiesenberg, Fabes, Schaller, Carlo, et al. (1991) found that parents' restriction of their sons' expression of negative emotions was positively correlated with those children experiencing personal distress rather than sympathy. Male children whose mothers emphasized control of emotions including sadness and anxiety showed relatively high levels of physiological markers of distress (heart rate and skin conductance) when viewing an empathy-inducing film. At the same time, these same boys reported low distress in response to the film, suggesting that while they were experiencing distress they did not want others to know about it.

Green and Addis (2012) conducted a study with adult participants further investigating both physiological and self-report evidence for the gendered responding framework. Specifically, they exposed men to video stimuli of negative affect and recorded self-report and physiological changes in response to these stimuli. Results suggested that men with greater levels of conformity to masculine norms were more likely to respond with a fearful/avoidant response to images of another man displaying gender-incongruent emotions including tearfulness and sobbing. This study thus provides initial validation for the notion that men, as a result of socialization, may be fearful or avoidant of negative affect, consistent with the gender-responding framework. It is especially noteworthy that these effects were demonstrated at the physiological level, and provides one possible mechanism underlying emotional restriction in men (Mahalik, 2000; O'Neil, 2008; Shepard, 2002). That is, men who adhere to traditional masculine

norms may be inhibiting emotional expression due to fear in the presence of other's negative affect. As the authors note, whether this process is conscious or unconscious remains unclear.

Wong and Rochlen (2005) take a slightly different approach in attempting to understand men's emotional behavior, and specifically critique the notion that emotional restriction is all bad as has often been postulated in the literature on masculinity and depression (Brooks, 1988; Pollack & Levant, 1998). While Addis (2008), Green and Addis (2012) and Jakupcak (2003) have shown that men may be socialized to fear their own emotions, especially negative affect, Wong and Rochlen utilize a process-model of emotional expression and non-expression, as developed by Kennedy-Moore and Watson (1999). This model suggests a pathway through which covert emotional experience is translated into overt emotional expression, and may provide a more nuanced way in which to understand masculine emotional restriction and its consequences, including depression.

The process-model proposes that covert emotional experience undergoes a five-step cognitive evaluative process including pre-reflective reaction; awareness of affective response; labeling and interpretation of response; evaluation of response as acceptable; and perceived social context for expression. This model corresponds with the gendered response framework, in that emotional labeling, evaluation, and perception of acceptability for expression is a socialized process that is heavily gendered, as explicated above. This particular model gives more theoretical shape to how such a process might unfold. Such a shape is useful, in that it may provide more specific ways in which to identify which step a particular man gets "stuck" at, given that men are socialized in

different ways. For example, some men repress their feelings, representing a disruption at step two. Other men cannot identify what they are feeling, representing a disruption at step three. Still others may feel uncomfortable with or even fear their negative emotions (Green and Addis, 2012), representing a disruption at step four.

Beyond providing a model for ways in which gendered responding to negative affect may unfold, Wong and Rochlen critique the idea that emotional restriction, often seen as a function of masculine socialization, is an all-bad process. On the one hand, positive outcomes for emotional expression have been strongly supported in a series of studies indicating that writing about one's feelings following painful emotional experiences leads to psychological and physiological benefits (e.g. Pennebaker, 1997b). On the other hand, the benefits of talking about one's emotions tends to be more situationally determined (Bonnano, 2001), and expression of distressing emotions could negatively impact self-esteem by causing the individual to feel vulnerable (Kennedy-Moore & Watson, 2001). This line of research has implications for studying men's, and stay-at-home fathers', depression. In some cases, emotional restriction, learned through gendered socialization practices, may lead to externalizing behaviors in the presence of negative affect (see O'Neil, 2008, for review). On the other hand, it may be that restriction of private, painful experience may serve an adaptive defensive function for some men, keeping a further spiral into depression at bay.

The work of Green and Addis (2012) has provided initial empirical support for gendered-responding framework, but it remains to be seen how the specific social contexts in which SAHFs are immersed influences their perceived ability to experience and express emotional content in response to negative affect. While some research has

indicated that SAHFs feel stigmatized for taking on this role (Rochlen et al., 2008; Zimmerman, 2000), qualitative research more deeply investigating their experiences and responses to the receptivity of the social surround to their emotional expression would be quite useful. Results of the current study, explicated more fully below, suggest that SAHFs may be turning to more receptive social networks online for expression of negative affect.

**Cultural differences in men's depression.** While the forgoing studies provide detailed analyses of the ways in which masculinity and depression may intersect, there are repeated lacunae, often mentioned in the limitations sections, whereby many groups have been essentially left out, or at the least under-studied. The majority of these studies have examined predominately Caucasian, college-educated males who by and large are subsumed by the dominant (i.e., Caucasian, middle-class) American value system, which deploys the social structures through which masculinity (especially hegemonic masculinity) is defined, learned, and performed. Many authors have called for greater research into the interplay between culture, gender, and psychological functioning (e.g. Wade & Rochlen, 2013; Whorley & Addis, 2006), and literature addressing this interplay will be reviewed below.

Rosenfeld (2012) draws attention to the importance of considering intersectionality in the study of mental health, inasmuch as it appears that disadvantaged status can affect mental health in contradictory ways. Some research indicates that African Americans possess similar or better mental health compared to their White counterparts, in spite of discrimination and economic disadvantages (Breslau, Kendler, Maxwell, Aguilar-Gaxiola, & Kessler, 2005; Breslau, Aguilar-Gaxiola et al., 2005;

McGuire & Miranda, 2008; Rosenfield, Phillips, & White, 2006; Williams, Costa, & Leavell, 2009). On the other hand, research has also shown that African American men may experience greater levels of GRC than their Caucasian counterparts (Norwalk, Vandiver, White, & Englar-Carlson, 2011), which, as we have seen, are associated higher levels of psychopathology (Addis & Mahalik, 2003; O'Neil, 2008). As Rosenfeld (2012) points out, the contradictions related to disadvantaged status and mental health suggests that structural theories of mental health risk cannot fully explain how race, culture, and gender intersect with psychopathology. Intersectional (Browne & Misra, 2003; Jackson, 2005) perspectives argue that in separating class, gender, race, ethnicity, and so on, the full and unique individual experience is lost (Constantine, 2002; Syed, 2010). Instead, combinations of statuses such as gender, race, and class, may have unique effects, rather than additive effects as is suggested by double and triple-jeopardy models (Jackson, 2005; Salazar and Abrams, 2005).

The idea of intersectionality corresponds with Connell's (1990) work on the concept of "masculinities." Hegemonic masculinity, being the model most frequently studied in relationship to mental health concerns (Addis & Mahalik, 2003; O'Neill, 2008), includes character traits of assertiveness, competitiveness, independence, and control (Dec Oster & Heimer, 2006). African American and White men share some fundamental commonalities in their conceptualizations of masculinity (Harris, 1996; Hunter & Sellers, 1998), in that both define ambition, economic viability and responsibility, and an independent sense of self as core masculine characteristics. On the other hand, African American men have shown adherence to less conventional gender roles than White men (Blee, 1995; Kane, 2000; Rowley, Kurtz-Costes, Mistry, &

Feagans, 2007), including more egalitarian family views and greater participation in child rearing. However, these findings are mixed, with some research indicating that African American men endorse traditional masculinity to a stronger extent than Caucasian men (Levant et al., 2003; Levant, Majors, & Kelley, 1998; Levant, Smalley, Aupont, House, Richmond, & Noronha, 2007).

Unique expressions of masculinity, and their relationship to depression and help seeking, have also been disclosed among Mexican-American and Mexican-origin men. Machismo is a construct that has similarities to “hegemonic” masculinity, as described above, and tends to be associated with hypermasculinity, including sexism, alcohol abuse, frequent fighting, and womanizing (Arciniega, 2008). Researchers and authors on Mexican culture have identified machismo variously as being “the masculine force which drives...all masculine behavior” (Andrade, 1992, p. 34), and “Mexican American men’s manifestation of perceived male characteristics, both positive and negative” (Arciniega, 2008, p. 19).

This second definition highlights the notion that adherence to this specifically Mexican-American masculine role may not be all negative, and accords with another term describing prototypical Latino masculine behavior, *caballerismo*. *Caballerismo* includes positive masculine characteristics such as nurturance, protection of the family, wisdom, hard work, and emotional connectedness (Mirande, 1997; Ramos, 1979). This focus on positive masculine norms accords with other prominent authors in the wider men’s studies literature who agree that an exclusive focus on the detrimental aspects of masculinity often obscures some of the more positive aspects and effects of masculinity (Gallagan et al., 2010; Kiselica & Englar-Carlson, 2010).

Research has supported a connection, however, between the more negative aspects of machismo reported above and psychological distress, including depression. In Mexican-American males, higher levels of machismo have been predictive of higher levels of stress and depression (Fragoso & Kashubeck, 2000). This finding suggests that, similar to Caucasian males, adherence to traditionally socialized forms of masculinity (in this case, machismo) may have negative mental health consequences.

Given the mixed results regarding how cultural background, race, ethnicity, social status and gender interact in relation to depression, there is still much to be learned. An intersectional perspective provides a useful prism through which to begin understanding the unique ways in which various groups and individuals experience depressive affect, and how these combinations of background might impact treatment preferences. What is evident is how much more research needs to be focused on these potentially marginalized and certainly under-studied groups of men, in as much as this very marginalization may work to exacerbate depressive experiences. One means for furthering our understanding of how to be helpful with such groups is to explore the wider-angle view considering barriers to treatment for men as a whole. It is to this domain that I now turn.

### **Barriers to Treatment**

This section will explore the literature on barriers to men seeking and receiving treatment for depression. These barriers can be divided into internal barriers, such as personality and intrapsychic variables including adherence to different male role norms or perceived stigma. External barriers including provider's hesitancy to diagnose men with depression, structural, economic, and pragmatic variables have also been identified.

Both internal and external barriers will be examined, noting that the preponderance of the literature examines both of these aspects.

While gender role conflict (GRC), and particularly restrictive emotionality (RE) and restrictive affectionate behavior between men (RABBM), have been linked to resistance to seeking help (Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Jakupcak et al., 2003; Rochlen, Land, & Wong, 2004; Tull, Jakupcak, Paulson, & Gratz, 2007), stigma (i.e. the negative views that society/self holds towards persons who seek professional help for mental health concerns) is also a significant external barrier to help seeking (Hammer et al., 2012; Vogel et al., 2011). Stigma has been shown to fully mediate the relationship between RABBM and willingness to refer a friend or family member to mental health treatment (Vogel, Wester, & Hammer, 2013). These results are consistent with assertions that traditional male gender roles can influence men to feel responsible for “fixing themselves,” and show that this may also influence their decision to refer close friends and family members for help.

Another potential male role norm that negatively impacts help-seeking for depression is toughness (Olaughlin, Duberstein, Veazie, Bell, Rochlen, Fernandez y Garcia, & Kravitz, 2011). Toughness is defined as hiding pain and maintaining independence, and it has been demonstrated that boys are taught from a young age to be tough in order to avoid signaling subordination and loss of autonomy (Addis & Mahalik, 2003; O’Neil, 1981). Men tend to score higher on toughness, and both men and women who score higher on measures of toughness have a greater preference for a “wait and see approach” to treatment (Odds Ratio = 1.14,  $p < .01$ , Olaughlin et al., 2011). It may be,

then, that efforts to redefine help seeking as a tough behavior involving aggressive and decisive action could increase help seeking.

Research has also indicated that men's expectations about counseling are related to gender role conflict (Schaub & Williams, 2007). Schaub and Williams's (2007) research indicates that male clients can be grouped by combinations of GRC and expectations about counseling. The first cluster consisted of participants with average scores on the GRCS and average expectations regarding counseling. Cluster two consisted of men with slightly elevated RABBM, average expectations about their own commitment to therapy and above average expectations about counselor expertise and facilitative conditions. These men may be particularly difficult to engage in therapy due to unmet expectations of their counselor and therapy conditions. Cluster three consisted of men with low expectations for counseling across domains, and average scores on the GRCS. These men are not likely to seek counseling due to their low expectations regarding the enterprise, and their average adherence to masculine role norms. While this linkage between level of GRC and expectations for counseling provides a tentative rubric to understand men's help-seeking, generalizability is limited by the cross-sectional design and reliance on a Caucasian, college-attending population. Of note for this study, no research has specifically examined SAHFs expectations about counseling. There may be unique barriers within this group both regarding counseling expectations and masculine adherence that produce either increased or decreased barriers to seeking counseling.

Another aspect of masculinity that has been hypothesized to be related to avoidance of help seeking behavior is so called "anti-femininity" (Blazina, 2001; O'Neil, 2008, Thompson & Pleck, 1995). This applies to seeking help for depression in several

ways, and constitutes both an internal and external barrier. In a meta-ethnography of men's descriptions of depression and help-seeking attitudes, Hoy (2012) found that the most common theme emerging from 51 studies was men's discomfort with the term "depression." They were much more likely to use terminology such as "stress," "distress," "burnout," or "sadness," and the most common author interpretation of this finding was that men aligned "depression" with feminine qualities or personal weakness (Hoy, 2012). Men's explanations for the causes of their depression (or distress, stress, burnout, etc.) were primarily structural and included financial concerns, poverty, unemployment, and stressful working conditions. These types of structural explanations for their own distress may contribute to men's reluctance to seek therapy, in as much as they may not see how face-to-face discussion (e.g., counseling) could ameliorate such conditions (Hoy, 2012; Matthews et al., 2013). The importance placed on personal autonomy, and viewing help seeking as an admission of weakness, may thus further preclude men from seeking mental health help.

Hoy (2012) points out that the most frequently discussed symptoms in qualitative research on men's help-seeking practices were isolation and loneliness, while these were given the least attention by researchers. Thus, it may be important to develop a greater understanding of how isolation plays into male's experiences of depression, including potentially the isolation they feel from peers based on restrictive male-to-male norms (e.g., the GRCS measures of Restrictive Emotionality and Restrictive Affectionate Behavior Among Men). This isolation or discomfort between men regarding depressive experiences may be especially important, given that open communication regarding such experiences could go some way into reducing stigma surrounding help-seeking (Wester

et al., 2013). Isolation may be especially salient for SAHFs, given their frequent and heightened endorsement of feelings of isolation, which will be covered in a coming section.

Men in these 51 studies (Hoy, 2012) also explicitly discussed barriers to treatment, which fell into four themes. The most common theme was social-stigma, or the perception that family and friends would have negative perceptions of men subsequent to seeking help. Hoy noted that a surprising finding was how frequently men in these studies talked about their anxiety regarding the judgment of other *men*, including fears of exposing their vulnerable self or being ostracized for being perceived as weak, soft, or homosexual (Hoy, 2012). The second most frequently discussed barrier to help-seeking was apprehension related to mental health service providers, with the most common concern being that seeking help would result in being medicated (Hoy, 2012). This fear of being medicated is consistent with the more global masculine norms of self-sufficiency and autonomy, the expectation that a man should be able to handle things “on my own” (Branney and White, 2008). This reveals a gap in the literature on help-seeking, and suggests that studies should include a consideration of what *kind* of help is being considered when assessing men’s barriers to treatment. Notably, none of the studies included a specific focus on SAHFs expectations of therapy, or perceptions of barriers to help seeking. The current study, then, sought to illuminate this area.

### **Facilitative factors**

Given the barriers noted above, it is also useful to recognize that not all men avoid therapy, and factors associated with increased help-seeking have been identified. In the meta-ethnography described above (Hoy, 2012), 14 of the 51 studies reviewed included

descriptions of facilitative factors for help-seeking. The most common of these was having a trusting relationship with someone who encouraged help-seeking, a finding corroborated by research indicating that therapeutic bond is predictive of treatment helpfulness (Cusack et al., 2006). Men who have been in treatment and perceived it as helpful are also much more likely to pursue future help, an important point given that many people diagnosed with depression require more than one episode of mental health care (Cochran & Rabinowitz, 2000; Mann, 2005).

The literature on barriers to help-seeking reveals both important internal and external, structural aspects that impinge on men reaching out for help when depressed. The interwoven nature of gendered role norms, embedded in societal and familial expectations and messages and intersecting with personal variables reveals, again, that adherence to traditionally masculine norms presents a complex wall to overcome en route to receiving help. Given that those men who perceived a genuine connection with their therapists were more likely to refer friends, examining what contributes to this sense of connection would be helpful. It is likely that aspects of the therapeutic alliance such as common task-focus and therapeutic bond would contribute to this connection, as has been shown repeatedly (Horvath, 2011; Muran & Barber, 2011) in the psychotherapy research literature at large. However, in research investigating the alliance, results are rarely disaggregated by gender (Martin, 2007), and men typically make up less than 20% of participants (Bedi & Richards, 2011). At this time, a single study (Bedi & Richards, 2011) has examined treatment alliance specifically for men, indicating that the strongest predictor of alliance for men is the therapist “bringing out the issues,” which includes asking questions, providing suggestions, identifying feelings, and discussing goals. A

single study, however, cannot claim to speak the full truth regarding men's alliance – related beliefs, and thus more targeted research in this area would be useful.

Finally, as noted above, no research has investigated potential barriers or facilitative factors leading to help-seeking among SAHFs. These men may face additional stigma in that reaching out for help could call into question their ability to parent. On the other hand, given that the primary caregiver role may represent an adoption of traditionally feminine traits, these men may have a lower adherence to hegemonic masculinity, which could facilitate greater help-seeking behavior. This study, then, explicitly targeted SAHF's perceptions of barriers to, and facilitating factors to, seeking help for depression.

### **Stay-at-Home Fathers**

The preceding review has examined how masculinity can intersect with depression in unique and varied ways, including the notion that traditional masculine roles may affect the expression of depression, leading to greater externalizing symptoms than those typically associated with depression. One relatively small, but growing, subset of men who may represent a new form of masculinity is the stay-at-home father (SAHF). This section will review the nascent literature on SAHFs, including demographics, reasons for entering the role, and stigma experienced by these individuals. Next, it will examine depression among fathers generally before examining literature related to the well-being of SAHFs.

**Demographics.** One way to begin understanding the role of the SAHF is by examining demographic trends. US Census data indicate that this is an increasingly prevalent role, with the number of SAHFs jumping 64% between 2004 and 2007 (US

Census Bureau, 2007). The most recent census numbers indicate that there are 176,000 SAHFs caring for upwards of 332,000 children in the United States (US Census Bureau, 2012). As indicated in the introduction, however, some authors are skeptical of these numbers, on the grounds that the US Census definition for a SAHF is overly restrictive. As noted in the definitions outlined in chapter one, the US Census defines a SAHF as “a married father with children under 15 years of old who has remained out of the labor force for more than one year primarily so he can care for his family while his wife works outside the home” (US Census, 2008). This definition is fairly conservative, and excludes those primary-caregiver fathers who are gay, single, cohabitating, or divorced. Importantly, it also excludes any father who has *looked* for work in the past year, as well as any father who has worked as little as one week in the past year (Latshaw, 2011). This definition does not seem consistent with current cultural practices nor current economic realities, especially considering the disproportionate job losses among males during the recent recession (Rampell, 2010; Thompson, 2009).

Latshaw (2011) took a two-pronged approach to developing re-estimates of the number of SAHFs in the US. First, she conducted in-depth interviews with 30 fathers who self-identified as the primary caregiver for their family. These results suggested that SAHF tended to identify with that title, and frequently brought in some income during their tenure as primary caregiver (60% of respondents). Reasons for their pursuit of outside employment were varied and complex, but included being able to continue contributing in a traditionally masculine manner, as well as to ease the sense of isolation that came with the SAHF role. Over 80% of these fathers intended to stay in the role on a short-term basis, and planned to re-enter the workforce within 5 years. Given these

qualitative data, Latshaw re-calculated estimates for the number of SAHFs in the US using Census data, but with alternative parameters than those defined by the census (Latshaw, 2011). She developed and examined three different methods. Method 1 included all married fathers with children under age 15, whose wives worked at least 30 hours per week and who themselves worked no more than 20 hours per week. Under these criteria, the number of SAHFs in the US was estimated to be 700,000. Method 2 included married fathers who worked 20 *weeks* or fewer in the previous year, and who have spouses who worked 30 or more weeks in the previous year. Under these conditions, estimates of SAHFs ranged from 460,000 (with children under age 5 as the cut off) to 1,400,000 (with children under 18 as the cutoff). Finally, Method 3 included married fathers with children under age 18 who are not currently at work, unemployed, or “not in the labor force” for any reason and who have wives who are currently employed and at work. Using these criteria, estimates for number of SAHFs in the US ranged from 400,000 to 1,446,000.

In summary, it is evident that the majority of men in this particular sample who identify as SAHFs would be left out of the US Census count due to having applied for jobs, having worked or earned any amount of money while staying home, or who are at home due to being retired or still in school. These estimates are still imperfect, and do not account for gay, divorced, or cohabitating fathers who may be in a SAHF role.

These findings suggest that it may be important to redefine, for population data gathering purposes, who is included as a SAHF, to be more in line with the lived experience of primary caregivers. Indeed, these findings speak to the importance of including both subjective and objective criteria when attempting to understand the

meaning of stay-at-home fatherhood. The imposition of external, objective criteria onto individuals with complex social realities threatens to eliminate individuals who take on that identity but do not meet criteria. Such exclusion weakens and oversimplifies our understanding of these complex social dynamics. Importantly for the current study, it may be that by under-counting the true numbers of SAHFs, those who do take on this role may face stigmatization and pressures to conform to more traditional notions of masculinity. I will now turn to an examination of the reasons SAHFs have given for entering the role, as well as stigma experiences they have faced due to taking on such a role.

**Reasons for entering the role.** Research has consistently indicated that one of the most prevalent reasons given by SAHFs for entering the role was the perception that their female partners had better (i.e., higher salary or better benefits) career prospects (Doucet & Merla, 2007; Merla, 2008; Rochlen et al., 2010; Rochlen, Suizzo et al., 2008; Zimmerman, 2000). This is perhaps not surprising, given that college completion rates for women now exceed those of men (Newburger & Curry, 2000), and census data have also shown that earning potential is directly and positively correlated with amount of education (Cheeseman-Day & Newburger, 2002).

Other reasons given for entering the role have included beliefs that one parent should stay home to rear the children, beliefs that the father was a “better fit” to stay home, lack of adequate or affordable childcare, having a child with special needs, and personal preference or choice (Dunn, Rochlen, & O’Brien, 2011; Doucet & Merla, 2007; Merla, 2008; Rochlen et al., 2010; Rochlen, Suizzo et al., 2008; Zimmerman, 2000). Doucet (2004), in a longitudinal, qualitative study of Canadian SAHFs, also found that

some of these men reported having professional success in other areas, and voiced a readiness for change as influencing their decision to take on the role.

Thus, it would appear that economic factors are the most frequent determinant of men taking on the role of SAHF, followed by personal choice or a sense of “fit” with the role. Research has also begun to examine how men adjust to this role, including experiences of stigma.

**Stigma.** In one of the earliest studies examining SAHFs adjustment to the role, Lamb, Pleck, and Lavine (1987) reported that many stay-at-home fathers found friends and neighbors to be consistently unsupportive of their break from traditional roles. Similarly, Russel (1987) found that only 35% of couples in his study of families with SAHFs reported consistently positive support from extended family members. The stigmatizing trend for SAHFs has apparently continued. Zimmerman (2000) found that stay-at-home fathers reported encountering pressure to “be a man” (p. 345) and “have a real job” (p. 345). Rosenwasser, Gonzales, and Adams (1985) found that men who take on the role of fulltime parent are viewed more negatively than are women who take on this role. In a study of role-perceptions, Wentworth and Chell (2001) reported that SAHFs received the lowest approval ratings, while perceptions of SAHMs were much higher. In this study, women seemed to be more comfortable with the idea of men becoming SAHFs than male respondents were.

It may be that a tension is developing for men, who are expected to be, or have expectations for themselves to be, both primary financial contributors and equal partners in childrearing (Hatter, Vittner, & Williams, 2002). Unfortunately, there may be a double standard at work in this expectation. Deutsch and Saxon (1998) found that men are more

likely to be criticized than women for leaving work to tend to a sick child, and are also more likely to be criticized if they are perceived to have chosen to spend time with their children rather than friends. Riggs (1997), meanwhile, found differential rates of acceptance between mothers who gave up jobs to stay home with young children and fathers who made the same choice. Mothers who made this choice were viewed very positively, while fathers elicited very low approval ratings. In a study examining 73 adults' reactions to imagined vignettes of parents choosing to stay home and care for children, Brescoll and Uhlmann (2005) found that parental dyads with the father serving this caregiving role were significantly less well-liked than dyads in which the mother took this role.

Rochlen and colleagues (Rochlen et al., 2010) conducted the largest and most robust inquiry to date, examining stigma experiences in SAHFs. Of their sample of 203 SAHFs, 93 (44.9%) reported experiencing a negative reaction to their role by another adult. The majority (69.9%) of these respondents indicated that the negative reaction was conveyed by a stay-at-home mother (SAHM). This finding is especially noteworthy, in that SAHMs may represent a potential source of support for SAHFs, given that both likely share activities and physical spaces (e.g., playgrounds, parks). Almost 24% of SAHFs indicated that the negative reactions they experienced were conveyed by multiple men and/or women, while 6.5% reported receiving negative reactions from other non-SAHMs and/or fathers.

The participants in the Rochlen et al (2010) study also expressed their perceptions for the reasons underlying the negative reactions they experienced. The largest portion (36.4%) indicated that gender bias or discrimination was the underlying cause, which

included the idea that their violation of traditional gender norms had led to the negative reaction. The second most common reason given (18.2%) was that of ignorance or unfamiliarity of the SAHF role. Other reasons provided included religious and cultural values/differences, distrust/suspicion/fear of harm, the notion that SAHFs are “encroaching on women’s niche,” and unknown or “other” reasons. Many of the most common stigmatizing experiences took place on playgrounds, which the SAHFs reported left them feeling isolated. This finding is especially relevant given the connection, among men, between isolation and depression noted earlier (Hoy, 2012; Latshaw, 2011). Men who reported stigmatizing experiences also reported lower social support. Research has also examined psychological well-being among SAHFs, though little work has looked specifically at depression. The following sections, then, will explore research related to depression in fathers generally, before looking at research on depression and well-being among SAHFs specifically.

**Depression in fathers.** There has been increasing research attention in the last 20 years examining paternal depression. As noted in the introduction, the transition into parenthood can be psychologically difficult for both men and women (Cox, 20005; Paulson & Bazemore, 2010; Ramchandani, Stein, Evans, O’connor, 2005), and evidence suggests that between 10-24% of fathers may suffer from prenatal and postpartum depression (Paulson & Bazemore, 2010). The occurrence of depression among fathers harms not only the individual sufferer, but his children as well. Longitudinal research has found that paternal depression is predictive of increased psychiatric disorders among the children of these fathers (Ramchandani & Psychogiou, 2009; Ramchandani, Stein, O’Connor, Heron, Murray, & Evans, 2008). Children of depressed fathers have been

found to be at a 66% increased risk of having any psychiatric disorder, and near double the odds of being diagnosed with oppositional defiant or conduct disorder up to age 7. Thus, it is worth learning more about the correlates, predictors, and means of resolving depression among fathers.

Cross-sectional literature has indicated that the most common correlates for depression among fathers are having a partner with depression (Bielawska-Batorowicz and Kossakowska-Petrycka, 2006; Dudley et al., 2001; Gao et al., 2009; Matthey et al., 2003; Pinheiro et al., 2006; Roberts et al., 2006; Zelkowitz & Milet, 1997) and perceived low-social support (Gao et al., 2009; Roberts et al., 2006). Other factors that have been associated with increased depressive symptoms or diagnosis of depression among fathers include paternal unemployment, an unsupportive marital relationship (Ballard & Davies, 1996), immaturity, and unplanned pregnancy (Schumacher et al., 2008). The relationship between paternal unemployment and increased depression is especially notable for our current study, as many SAHFs are unemployed or under-employed (Doucet, 2004, 2006, Latshaw, 2011; Merla, 2008).

Longitudinal research indicates that common risk factors for depression among fathers include low social support or the perception of low social support, low emotional support/perception of low emotional support (Boyce et al., 2007; Castle et al., 2008; Condon et al., 2004; Deater-Deckard et al., 1998; Leathers et al., 1997), and increased negative life events (Boyce et al., 2007; Condon et al., 2004; Deater-Deckard et al., 1998). Based on the fact that many SAHFs endorse experiencing stigmatizing events indicative of low-social support (Rochlen et al., 2010), research into the linkage between social support and depression among SAHFs would be useful.

Much of the research into depression among fathers has relied on traditional measures of depression, which as noted earlier may lead to under-diagnosis (Cochran & Rabinowitz, 2000; Magovcevic & Addis, 2010; Martin et al., 2013). However, some studies (e.g. Madsen & Juhl, 2007) have integrated masculine-depression related measures such as the Gotland Scale (GMDS, Zierau et al., 2002). Madsen and Juhl found that 20.6% of at-risk fathers in their study of depression scored above cut-off points on the GMDS (a measure of masculine depression), but under the cut-off points on the Edinburgh Postpartum Depression Scale (EPDS) (Cox & Holden, 2003), a common measure of postpartum depression in both women and men (Matthey, Barnett, Kavanagh, & Howie, 2001). Thus, in concordance with the body of literature reviewed earlier, providers would be well advised to consider the notion that fathers, like men in general, may present with atypical depression symptoms. Unfortunately, up to this point very little research has examined how depression might manifest, be expressed, and be coped with among SAHFs. There is a small body of literature examining the well-being of SAHFs, which I will now review.

**Depression and well-being in SAHFs.** Research is just beginning to examine the well-being and experience of depression among SAHFs. Some of the research indicates that, in fact, SAHFs are adjusting well to this role. Rochlen and colleagues examined predictors of a variety of measures of well-being among SAHFs (Rochlen et al., 2008), and found that overall, this group was similar or higher than the majority of comparison samples on measures of psychological well-being, relationship satisfaction, and life satisfaction.

Specifically, these authors found that perceived support from significant other

was the variable most strongly related to relationship satisfaction, followed by perceived family member support. In terms of well-being, participant responses indicated that perceived support from friends was the strongest predictor, followed by parental self-efficacy and paternal self-agency. Perceived support from significant other was also the variable most strongly related to life-satisfaction, followed by parental self-agency. In other words, SAHFs who felt supported by their significant others and family members were likely to report higher relationship satisfaction, while those who felt supported by friends, confident in their parenting abilities, and secure in their ability foster independence in their children were more likely to report a sense of well-being. Finally, those SAHFs who felt supported by their significant other and confident in their overall parenting skills were more likely to report general life-satisfaction.

These results clearly support the contention that men considering or currently in the SAHF role should attend to their network of support from family, friends, and community. Examining the literature on stigma, it may be the case that SAHFs are frequently lacking in this sense of community support (Rochlen et al., 2010; Zimmerman, 2000). It is also not uncommon for SAHFs to report a sense of isolation and loneliness, indicative of a weak sense of social support. Stay-at-home fathers report higher levels of loneliness, they tend to be more isolated, and are less likely to participate in community activities than their stay-at-home mother counterparts (Zimmerman, 2000). This may place stay-at-home fathers at a greater risk to negative impacts on psychological well-being than even stay-at-home mothers. While at home parents experience greater social isolation than their partners who work outside the home, this issue seems to be particularly salient for SAHFs

(Rochlen et al., 2008; Whelan, 2002). In one study, working husbands reported a mean score of 1.7 (out of 10) on a “loneliness scale,” while working mothers reported an average score of 2.4. In contrast, SAHMs reported a “loneliness” score of 3.4, while SAHFs endorsed an average score of 4.6 (Zimmerman, 2000).

As noted earlier, almost no research has directly addressed depression in SAHFs. In a rare exception, Colombo (2008) examined differences in depression based on MMPI-II data for a sample of 30 SAHFs and 30 employed men in the Upper Midwest. Of the 30 at-home fathers, 29 were White and 1 was Hispanic, while for the 30 breadwinning fathers, 29 were White and 1 was Hispanic. The at-home father group had a mean of 2.2 children in the household, and the breadwinning father group had a mean of 2.3 children in the household. This author examined scores on measures of gender role conflict (GRCS, O’Neil, et al., 1986) and depression via the MMPI-II (Butcher, Graham, Ben-Porath, Tellegen, & Dahlstrom, 2001). Depression was measured by examining scores on the content-scales (Depression, Anxiety, Anger, Low Self-Esteem) of the MMPI-II. While this is an unusual stand-alone means for measuring depression, Colombo (2008) notes that the content scales have been shown to map onto behavioral correlates in a fairly straightforward way (Barthlow, Graham Ben-Porath, & McNulty, 1999).

Results indicated that SAHFs experienced less stereotypically masculine interests and less GRC than traditional breadwinning fathers. One might expect this to lead to lower levels of reported depression, given the positive correlation between increased GRC and increased depression (see O’Neil, 2008, for review). However, results indicated that SAHFs in this sample experienced equivalent rates of depression, anxiety, anger, and

self-esteem as breadwinning fathers.

Other research, however, indicates that the SAHF role is associated with decreased well-being. Staines, Pottick, and Fudge (1986) found that a husband's perception of his adequacy as a breadwinner is a central component of his mental health. Russel (1987) also found that 40% of stay-at-home fathers in his study reported that one major disadvantage of their life-style was a loss of status and self-esteem associated with paid employment. It is also worth noting that the Rochlen team (Rochlen et al. 2008) did not examine depression directly. While one would expect well-being (measured in the study) to be negatively correlated with depression, no such analyses were performed. Additionally, the Colombo study used atypical measures for depression among SAHFs, the MMPI-II content scales, limiting generalizability of the results. Furthermore, both studies may be limited by the nature of selection bias: It is likely that SAHFs with a positive sense of their role may have been more motivated to participate in such studies.

Given these limitations, the prevalence rates for depression among fathers generally, and the fact that very little is known about how depression might manifest and play out within this group, the current study was concerned with directly addressing SAHFs who have experienced depression. Because of the dearth of literature on how SAHFs experience and contend with their depression, and in light of the impacts of paternal depression both on the individual affected and the children under his care (Ramchandani & Psychogiou, 2009; Ramchandani, Stein, O'Connor, Heron, Murray, & Evans, 2008), a more in-depth understanding of how depression plays out in this growing group of men is warranted. Consensual Qualitative Research (Hill et al., 1997; 2005) serves as methodology that can fruitfully unpack how these experiences are lived

through.

### **Consensual Qualitative Research (CQR)**

The phenomenon or area being studied should determine what methods of inquiry are utilized, and the experiential life of people is one area in which qualitative methods are appropriate tools. As noted by Schwandt (2001), “Qualitative inquiry deals with human lived experience. It is the *life-world*, as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study” (p. 84). While there are many approaches to qualitative research, they share certain cardinal features that differentiate them from quantitative approaches. First, the data of qualitative research are primarily verbal as opposed to numeric; this is necessarily the case given that the study of experience requires an intensive exploration with participants resulting in complex discourse (Polkinghorne, 2005). Second, qualitative research seeks to intensively explore the experiences of a few individuals in a more in-depth manner than is typically possible with quantitative methods. As such, qualitative approaches can provide an ideal means for examining individual’s points of view, and rich descriptions of individual’s environments (Denzin & Lincoln, 1994). Third, conclusions in qualitative research are arrived at inductively, emerging from the data, rather than via *a priori* hypotheses. Fourth, qualitative research involves intense or prolonged contact with a field or life-situation (Miles & Huberman, 1994). Finally, qualitative research generally considers the subjectivity of the researcher as an inevitable influence on the mode of data collection and, given the multiple meanings inherent in complex phenomenon, as having an inherent interpretive bias. To that end, qualitative approaches typically seek to make transparent the researcher’s subjectivity, in the interest of bracketing as much as possible such

subjective influence.

The study of stay-at-home father's experiences of depression and help seeking is primarily an investigation of the *lived* experience of these individuals, and the constellation of meanings and identities that inhere in the role. This study sought to explore how this role intersects with the lived-experience of masculinity, and the unfolding of depression within this nexus. In the effort to understand how depression is experienced within the lived world of SAHFs, and how these participants understand their own identities in the context of these experiences, a qualitative approach was most suitable.

One specific format of conducting qualitative research that has been developed is Consensual Qualitative Research (CQR). This model strives to provide a clear and systematic form for conducting qualitative research that attempts to mitigate individual research bias through the consensus process, while still approaching data with the view that conclusions should arise inductively via the narration of participants' lived-experience.

**CQR: Background, theoretical foundation, and rationale.** CQR was introduced by Hill and colleagues in 1997 as a qualitative method that uses multiple researchers, uses a consensus process when analyzing data in the interest of mitigating individual bias, and attempts to establish representative results (Hill et al., 1997). A recent textbook on conducting CQR (Hill, 2012) cited 99 studies that have used this method, ranging across topics including psychotherapy, therapist training, multicultural issues in counseling and training, career development, trauma, medical topics, and same-sex relationships, thus establishing it as a viable and respected approach to qualitative

research.

CQR shares many features with other approaches to qualitative research. Key features of qualitative research that have been identified include the following: words, rather than numbers, as data; researchers use themselves as instruments for analyzing data; researchers seek to describe phenomenon as they are lived, rather than manipulating phenomenon; inductive rather than deductive strategies are used; researchers are interested in understanding the participant's perspective on the phenomenon; contextual factors are acknowledged as important; causes of experience are understood as being non-linear and complex; the scientific process is understood to be an accumulation of tentative ideas rather than facts; and researchers stress the emergence of theory from data rather than applying theoretical frameworks to data (Bogdan & Biklen, 1992; Henwood & Pidgeon, 1992).

While sharing these features, Hill and colleagues suggest that CQR combines the components in a unique way, stressing that "CQR highlights the use of multiple researchers, the process of reaching consensus, and a systematic way of examining the representativeness of results across cases" (519). Additionally, CQR was developed as a means to have a more rigorous, clearly specified qualitative research procedure (Hill et al., 1997).

CQR shares features with other qualitative methods (Elliott, 1989; Giorgi, 1985; Glaser & Strauss, 1967) including interviewing participants, developing core ideas and domains, and continually returning to the data to ensure that results remain faithful to participants' experience (Hill, 2012). CQR differs from other qualitative methods in several ways as well. First, CQR researchers use the same semi-structured interview

protocol across all participants, with variations in use and content of probes.

Additionally, CQR usually uses a fixed number of participants. A major difference is the use of a team in CQR and the consensus process employed within data analysis. This process is in the service of triangulating an approximation of the “truth” or essence of participant’s statements, and as a means for attenuating researcher bias. In CQR, emphasis is placed on understanding participants’ descriptions in a contextual, holistic manner (Hill et al., 1997). CQR attends to the experience as described, rather than taking an interpretive stance. CQR also seeks to disclose the contexts for the phenomenon under investigation such as antecedents, settings, mood, and characteristics of those involved. CQR is also a relatively fixed method, which allows for replication of procedures across different research teams, whereas in other qualitative approaches, researchers vary greatly in the implementation of their method.

The CQR method (Hill et al., 1997, 2005; Hill, 2012) was thus appropriate to this study of SAHFs experiences of depression and help-seeking for a number of reasons. First, there is a paucity of literature examining how SAHFs navigate struggles with their mental health and well-being, and how their sense of masculine identity may or may not be impacted by such experiences. As noted by Hill (2012), CQR is particularly useful for topics that have not been explored previously. Secondly, in-depth and rich descriptions of how this growing minority of caregivers experience depression, help-seeking, and psychotherapy will be helpful in deriving research questions for future studies. Lastly, given its rigorous, standardized, systematic and clearly explicated method, CQR represents an ideal method for conducting a doctoral dissertation study. The specific manner in which CQR was employed is the focus on the next chapter.

### Chapter III Method

#### Participants

**SAHFs.** Twelve SAHFs (9 Caucasian, 2 Hispanic, 1 African American) from across the United States took part in this study, ranging in age from 30 to 51 ( $M = 31.75$ ,  $SD = 7.18$ ). All participants identified themselves as being stay-at-home fathers for children still living in the home, who worked in a paid capacity 10 hours per week or less, and whose partners/spouses were identified as the primary wage-earner, working in a paid capacity 32 hours per week or more. Participants all also identified as having experienced a depressed mood, continuously, for at least two weeks, during their tenure as a SAHF.

Six participants had 1 child currently living in the home, and six participants had 2 children currently living in the home, ranging in age from 6 months to 11 years old ( $M = 5.08$ ,  $SD = 3.66$ ). Participants had been in the role of SAHF from 6 months to 8 years ( $M = 3.25$ ,  $SD = 2.23$ ), and of those that identified (3 participants), began the role as their wife ended maternity leave. Participants and their partners tended to have received a fairly high level of education, with 5 participants having a masters degree, 3 having a bachelors degree, 2 having an associates degree, and 2 having a high school education. Spousal education was similarly advanced, with 4 having a doctorate, 3 having a master's degree, 4 having a bachelor's degree, and 1 having an associates degree. Participants also described level of annual family income: 3 participants had family income between \$30,000-50,000, 5 participants had family income between \$75,000-100,000, and 4 participants had family income greater than \$100,000.

All but two of the participants endorsed having engaged in psychotherapy or counseling at some point in the past. Of the 10 participants who endorsed engaging in psychotherapy or counseling, 5 endorsed engaging in individual therapy only; 2 endorsed engaging in individual, group, and couples therapy; 1 endorsed engaging in individual and couples; 1 endorsed engaging in individual and group; and 1 endorsed engaging in couples therapy only. Participants were asked about how many sessions they had engaged in therapy, with 5 participants leaving the item blank, and 7 responding. Of those who responded, the number ranged between 3 to 65 individual sessions, and between 0 and “over 100” group sessions. The average number of individual sessions attended by those who responded was 19 ( $SD = 25.27$ ). This distribution was bimodal, with 2 outliers having an average of 55 sessions and the rest of the participants who responded having an average of 4.6 sessions.

**Research team.** The interviewer and primary investigator (PI) for this study was a 33-year-old Caucasian male in his third year of study in an APA-approved counseling psychology doctoral program. The research team also included a 27-year-old female in her 2<sup>nd</sup> year of study at the same graduate program as the PI, and a 26-year-old male in his first year of study at a different APA-approved counseling psychology doctoral program. All team members had at least rudimentary training in CQR methods, and had participated in previous CQR studies. The auditor of the study was a 53-year-old female doctoral-level psychologist with significant experience conducting CQR research, who was also a faculty member in the PI’s program. All team members had worked together on separate projects in the past, and had a good professional working alliance.

**Research team biases.** In an attempt to bring to the foreground any biases that may unduly influence the data analysis, and keeping with the precepts of CQR, the three members of the primary research team discussed their expectations and biases regarding the study's focus prior to conducting interviews.

The PI noted that he had been raised in a family with five sisters and no brothers, and that masculinity had been apparent and puzzling from an early age. He noted that he and his wife had discussed how gender norms can have a strong effect even in the context of a relationship that strives for equity. The PI discussed with the other team members his expectation that he may at times be pulled toward advocacy in analyzing the transcripts, and thus asked them to remain vigilant of this potential tendency.

The female team member shared that she grew up in a family with fairly traditional gender roles, in which her father was the primary breadwinner and her mother was a stay-at-home caregiver. She stated that there had been stereotypical expectations for gender roles, especially for the men in her family. Given this background, she noted that she was not sure how she may be biased, but thought she may have to think about perceptions of masculinity that are different from what had been modeled. She described a potential pitfall in terms of coming from an opposite gender role, and a potential propensity to stereotype the participants into traditional gender roles.

The other male team member stated that having no children, he lacked an experiential understanding of parenting. All of the team members agreed with this assertion, in that none have yet been parents. The male team member stated that he connects a lot with the masculinity issues, and reported that while he comes from a gender-role stereotyped, working-class family, he has deviated from expectations

regarding his own career (counseling psychology). He noted that he does not feel as though he was bringing a lot of expectations to the material, but described a potential “practical” bias of wanting to help the PI complete the research in a timely manner. The female team member agreed with this point, and the team thus agreed to monitor each other for expediency-bias.

### **Measures**

**Demographic form.** Prior to the interview, participants were asked to fill out a demographic form asking for basic demographic information, including age, gender, race, relationship status, level of education, annual household income, number of children for whom they are the primary caretaker, number of years in SAHF role, hours per week spent in the SAHF role, hours per week spent working in a paid capacity, therapy history including duration and frequency of sessions, date of termination from most recent treatment, number of sessions in therapy, and reason for seeking therapy. Please see Appendix A for the Demographic Form.

**Interview Protocol.** The interview (see Appendix B) was developed by the PI, and began with a “grand tour” question by asking participants to describe their daily and weekly roles as a SAHF. This question was intended to prime participants’ ideas, feelings, and thoughts related to their identity as a SAHF. Secondly, participants were asked to describe how they came to be in the role of a SAHF; follow-up probes asked about participants’ decision-making process regarding becoming a SAHF, how long they have been in the role, and how long they expect to remain in the role, what they like and dislike about the role, and how their sense of their own masculinity has changed since entering the role. The third question asked how participants feel that others perceive their

role as a SAHF; follow-up probes here inquired about whether they have experienced positive or negative reactions to their role, and if so to elaborate on these experiences. The fourth question asked participants to describe a period during their tenure as a SAHF when they felt significantly depressed, “down in the dumps,” or depleted, for a period of at least two weeks continuously. Sub-questions for this experience included asking participants when this period occurred, what they think may have contributed to this period, what they were feeling and thinking during this period, how this period of depression impacted participants, and how this period impacted participants’ families. Probes following the family-impact question included inquiring how participants’ depression affected relationships with their children, partners, spouses, and friends. Next, participants were asked whether, during the period just described, they considered seeking help. If participants reported seeking help, they were asked to describe what kind of help they sought, and what enabled them to seek help. If participants did not seek help via psychotherapy or counseling, but endorsed seeking other forms of help, participants were asked how this help did or did not help them cope. If participants reported that they did not seek help, they were asked to describe what kept them from doing so. In either event, participants were asked whether and how their status as a SAHF influenced their help-seeking decision. For those who sought psychotherapy or counseling related to their depression during their tenure as an SAHF, the fifth question asked participants to describe their therapy experiences. Sub-questions inquired into the following: (1) duration and frequency of therapy; (2) description of relationship with therapist; (3) what, if anything, did participants find helpful about these experiences; (4) what, if anything, did participants find particularly harmful about these experiences; (5) whether therapy

successfully addressed their concerns; (6) satisfaction with the therapy experience; (7) how this therapy experience affected their likelihood of seeking help in the future; and (8) what they would want other SAHFs to know about psychotherapy or counseling.

Following these questions, participants were given the opportunity to add anything else that they felt the interviewer has not asked about that they felt was important about their perspective on the relationship between their role as SAHF, depression, and treatment. They were also asked to describe why they chose to take part in the study, and how it was to talk about these experiences. They were also given information about contacting the PI should any further thoughts about the interview itself or their recollections of therapy come to mind in the weeks following the interview. While the architects of CQR used to encourage a follow-up interview (Hill et al., 1997), in recent years this practice has not tended to be employed, and when it has, has not tended to produce rich results (Hill et al., 2005; Sarah Knox, personal communication, 2012). For that reason, follow-up interviews were not conducted.

### **Procedures for collecting data.**

**Piloting the protocol.** Our initial intention was to conduct two pilot interviews prior to engaging in interviews with participants, in an effort to refine our interview protocol. Due to difficulties with recruitment, we elected to forgo the piloting process. The interview protocol was subjected to more thorough scrutiny than a typical CQR study, due to being a dissertation project and having input from not only the primary research team, but the dissertation committee as well. All members of the committee were experienced with conducting qualitative research, and thus our confidence in the protocol, even in the absence of a pilot, was secure.

**Recruitment.** Recruitment of participants took place using a variety of means, including snowball sampling through personal contacts, and posting to public groups in online communities such as SAHF groups on Facebook and other internet-based SAHF-related message boards and blogs (after receiving approval by these various sites' moderators). Contacts made via online message boards, blogs, and social media sites related to SAHFs provided all of the study's participants. These sites included athomedad.org, sahd.meetup.com, dadstayshome.com, and several "subreddits" related to SAHFs within the Reddit.com website (/r/daddit ; r/BreakingDad ; /r/SAHP ; /r/Fathersforequality) as well as a blog post written by the PI describing the research on a men's-interest website ([www.goodmenproject.com](http://www.goodmenproject.com)).

Interested individuals were given instructions for contacting William Caperton, M.A. (PI), who then provided via email the materials necessary for potential participants to decide if they would like to be involved, including a letter outlining the process of the research including notification of confidentiality, informed consent forms, demographic forms, and a copy of the interview protocol. Potential participants were able to decide after reviewing these materials if they would like to continue their involvement. Those who were interested in participating were asked to return the forms to the PI, who then contacted the participant to set up a time for the telephone interview. Sixteen potential participants made initial contact with the PI; three of these were interested in participating but did not meet the inclusion criteria, and one of these decided after reading the initial forms that he was not interested in participating.

**Interviewing and transcription.** The PI conducted interviews with each participant via telephone, and these interviews were audiotaped for transcription

purposes. In addition, the interviewer took detailed notes during the interview in the case of technical errors and as a backup for audiotaping. These interviews lasted between 45-75 minutes.

The recordings resulting from these interviews were then transcribed verbatim, with edits made to exclude stutters, silences, and irrelevant encouraging statements or intermediary statements (e.g. “Um”, “ah”). These transcripts were de-identified, and each transcript was assigned a code number for data analysis (described below).

### **Procedures for Data Analysis**

**CQR method.** Data were analyzed using consensual qualitative research (CQR; Hill et al., 2005; Hill, Thompson, & Williams, 1997). As described in the initial article introducing the method, Hill et al. (1997) outlined eight key components in conducting a CQR study: (1) data are gathered using open-ended questions in order to not constrain participants’ responses; (2) words, rather than numbers, are used to describe phenomena; (3) a small number of cases is studied intensively; (4) the context of an entire case is used to understand specific parts of the experience; (5) the process is inductive, and conclusions are built from the data rather than imposing and testing a structure or theory *a priori*; (6) consensus is used among a primary team of three to five researchers, ensuring a variety of opinions and the best possible construction of the data; (7) one or two auditors check the team’s consensus judgments and make sure that the primary team does not overlook important data; (8) the research team continually checks the raw data to make sure that results and conclusions accurately reflect those data (pp. 522-523).

These components are pursued through a process of coding and transforming data which occurs in three stages. First, chunks of text from open-ended interviews are placed

into domains (i.e., topics for clustering data). Next, core-ideas for each domain within an individual case are developed. Core ideas serve as brief summaries that condense the essence of participants' words. Finally, in the cross analysis, domains are examined across cases to develop categories (i.e., common themes) that articulate consistencies within the core ideas (Hill et al., 1997; 2005).

Throughout, this method relies on the process of consensus. Domains, core-ideas, and categories are developed independently, and then brought to the group until consensus on the appropriate placement or wording emerges. This process is expected to reduce the bias that inheres in having one researcher examine data and arrive at interpretations in isolation. Additionally, given that researchers likely will have alternate points of view, it is thought that the full richness of participants' descriptions may emerge through the voicing of various researcher opinions. As Hill and colleagues note (Hill et al., 1997, 2005), this process of coming to consensus requires an equalization of power-relations within the group, and an open acknowledgement of researcher bias.

**Domianing the transcripts.** Once interviews have been transcribed, data analysis may proceed through the process of developing domains, core ideas, and cross-analysis categories. Data analysis begins by developing a list of domains (i.e., topic areas) into which the raw data (participants' words) are placed. Domains may be developed ahead of analysis via a "start list" (Miles & Huberman, 1994), often based on the interview questions. Alternatively, the transcripts can be examined prior to developing domains, in the interest of having the domains emerge inductively from the data themselves. In a more recent review, Hill and colleagues suggest that not using a start list may be preferable in as much as it allows the researchers to examine the data

rather than relying on preconceived ideas of what the data *should* show (2005).

Independent team members, using one to three cases, develop the initial domain list.

These domains are then discussed until consensus is achieved. Once this initial domain list is created, researchers independently read through each remaining case's transcript, placing all of the data into one or more domains. Data that do not fit any domain are placed into an "other" category, which is examined at a later time.

While some CQR researchers use a domain start-list, our approach sought to allow these domains to arise out of the data themselves. To that end, each primary team member domained the first two interviews independently, and met to arrive at consensus on a domain list prior to coding the remaining participant data. Using the preliminary domain list developed via the initial interviews, the primary team domained each participants' interview, revising the domain list as appropriate, and reached consensus regarding the placement of data into domains.

**Developing core ideas.** Data for each domain were then captured via core ideas, which distill the essence of participants' words, edited into a compressed form that retains a sense of clarity, remains close to the participants' perspective, and reduces redundancy.

For the first two or three cases, each team member developed core ideas for each domained transcription until all were familiar and comfortable with the process. Following this point, team members divided the remaining consensus versions and split the task of developing core ideas. Individual members then presented their core ideas to the team, who reviewed these cores for accuracy and faithfulness to participants' descriptions, discussing until consensus was achieved.

**Cross Analysis.** The next stage of CQR involves moving to a higher level of abstraction, in which core ideas within domains are compared across cases (Hill et al., 1997); this step is called the cross analysis. In this phase, team members are seeking to determine whether there are similarities or common themes across the cases, and whether there are patterns within the core ideas that cluster into categories. The team may either review all of the cores for every case in a domain and brainstorm categories together, or work independently prior to coming together to compare categories and reach consensus. Core ideas may be placed into more than one category, if applicable. Similar to domaining, the categories are revised as the analysis continues.

For this project, the team developed categories as a group, and placed every core idea into a category(ies) for comparison across cases. To reduce bias in this step, researchers rotated the responsibility of developing categories. The categories were then reviewed and discussed until consensus was reached. Following this, the categories were then sent to the auditor, to again check the adequacy, clarity, and appropriateness of each category. The research team received this feedback, and evaluated through consensus how to modify the analysis based on auditor suggestions.

One final function of the cross analysis is to examine representativeness of categories by determining their frequency within the entire sample. Using Elliot's (1993) methods, categories are described as: (a) *general* when the category applies to all or all but one of the cases, (b) *typical* when the category applies to more than half (up to the cut off for *general*) of the cases, and (c) *variant* when the category applies to at least two, but no more than half of the cases (Hill et al., 2005).

**Draft of results.** All participants will be sent a draft of the manuscript emerging from this study prior to its submission for publication. They will be asked to ensure that their confidentiality has been retained (See Appendix G).

## **Chapter IV**

### **Results**

The findings from this study of stay-at-home fathers' experiences of depression and help-seeking will be presented below. First, results pertaining to the contexts and roles of these SAHFs will be presented, including reasons for entering the role, tasks in the role, reactions from others to the role, and how participants' sense of masculinity relates to the role. Next, results pertaining to SAHF's experiences of depression in the context of their tenure as SAHFs will be presented, as well as ways in which these participants sought help for depression. For those participants who engaged in therapy while SAHFs, results will be presented regarding the perceived quality of and satisfaction with these experiences, themes of the therapeutic work, helpful and unhelpful features of therapy, as well as willingness to seek therapy in the future. Finally, results pertaining to participants' reasons for and experiences of engaging in the study itself will be presented. A composite case example combining characteristic elements of the above results will be provided, as a means to illustrate these findings in more vivid detail. Categories are labeled with the following frequency descriptors, based on having 12 cases total: General = 11-12 cases, Typical = 7-10 cases, and Variant = 2-6 cases. Results found only in a single case (i.e., "Other" results) will not be included in this manuscript.

#### **Contexts and Roles of SAHF**

As an opening question, participants were asked to describe their role and experience as SAHFs, including reasons for entering the role, tasks performed, confidence in the role, likes and dislikes about the role, and future plans regarding the

role. They also described perceptions of how others have reacted to their role as SAHF. These data were also reflected upon in relation to participants' perceptions of their own masculinity, including how these perceptions have changed since entering the role of SAHF. Findings pertaining to this section are presented in Table 1, below.

**Role as a SAHF.** Participants were asked to describe their role as a SAHF, and results from these descriptions broke down into six sub-domains: Decision process to become a SAHF; Tasks of being a SAHF; Confidence in the role; Likes about the SAHF role; Dislikes about the SAHF role; Sources of support for their role as SAHFs; and Future plans regarding SAHF role.

*Decision process to become a SAHF.* Typically, participants reported that they decided to become a SAHF due to the value and importance they placed on being there for their child's development. One participant stated that he and his wife value building their relationship with their child, and don't think they would be able to do so if their child was in daycare every day. Another participant reflected on becoming a SAHF after losing his job at an investment bank, and described his realization that he valued being there for his child more than the potential income. This participant compared this realization to a death in which he reevaluated his universe and discovered he had been "doing it wrong."

Participants also typically reported that they became SAHFs due to economic or financial concerns. Many of these participants noted that their partners had significantly higher incomes, while others stated that the costs of daycare outstripped the potential gained income that participants could provide. A participant illustrated these intersections, noting that the organization that employed him and his partner had a

daycare that was conveniently located and many of their coworkers sent their children there. This participant “knew” that daycare would be “more expensive than most major surgeries,” and recognized that if they put their child in daycare, they would see him “for an hour and a half a day.” They also realized they would have to pay for extended care and/or babysitting. Given these financial factors, he decided he would quit his job and stay home, thinking, “how hard could it be?”

Participants variantly reported that mental health or medical concerns were instrumental in their decision to become SAHFs. One participant described feeling that extreme pressure to have a high prestige, high income profession, instilled while he was growing up, made him “a wreck when it comes to work,” and stated that his therapist suggested he might be more well suited to being a SAHF.

Finally, participants variantly endorsed the loss or lack of their own fathers as being instrumental in their taking on the role of SAHF. One participant noted that his own father developed cancer shortly before the participant learned his wife was pregnant with their first child. This participant stated that knowledge his own father would never know his son “really did something to (participant),” and that seeing his own father “married to his job” and “not there” convinced participant that he “would not let that happen” to his son.

**Tasks.** Generally, participants described their tasks as a SAHF as caring for their child/ren, including physical, emotional, cognitive, and developmental needs. Participants described feeding, changing diapers, playing, singing and reading, and bathing their children. One participant summarized these childcare tasks stating that he is the “primary caregiver to both of my children, 24 hours a day, 7 days a week, 365 days a year. I wake

them up in the morning, I put them to bed at night. I feed them breakfast, lunch, and dinner, take them to and from school, everything that needs to get done is me.”

Typically, participants also reported that tasks involved caring for the home, including cooking, cleaning and shopping. One participant described himself as “standard caretaker, (who) in the past would have been called a homemaker”, and reported that tasks include preparing meals, doing the dishes, laundry, and “day-to-day things on a household level to help support (his) wife so she does not have to worry about it.”

Caring for their spousal relationship emerged as a variant category. In addition to the description above (“so she doesn’t have to worry about it”), another participant illustrated this task by stating that he does “whatever pops up, (he) warms the bathroom for his wife if (he’s) happy with her and wants to make her happy,” and he makes his wife “pretty much a gourmet lunch.”

A final task that emerged was caring for self, which participants variably endorsed. One participant stated that he went to the gym two days a week and took his daughter to the daycare center there.

***Confidence in role.*** Participants variably endorsed having high confidence, and/or experiencing increasing confidence in their role as SAHFs. One participant saw his parenting as “building people,” and felt he was teaching his kids to be parents by “building a temple in each one of the children.”

On the other hand, participants in equal measure variably endorsed having low confidence in their role as SAHFs. This sense of low confidence was captured by one participant who reported feeling stressed he isn’t trained in early childhood development,

and who had a nagging voice in his head that he's going to do something wrong and that the children will be behind, because he didn't "have those special skills."

*Likes about SAHF role.* Generally, participants reported that one of the aspects they liked most about being a SAHF was being able to spend quality time and develop relationships with their children. Participants noted that they enjoyed spending time with children because "you don't get those years back," and endorsed enjoying seeing developmental milestones such as first steps or words. One participant described enjoying "seeing the excitement through (his child's) eyes" and "experiencing life again," such as when he (participant) pointed at the moon, child said "moon!," and his (participant's) "whole body just felt it."

In a similar vein, participants typically reported that they enjoyed role-modeling and influencing their child's development. One participant described enjoying the fact he has been able to impart his values, morals and ethics to his sons, and has seen the "fruits of his labors" in his sons and their academic/social successes and hard work. Another enjoyed giving his sons the opportunity to see a man performing roles that "society would say are gender-incongruent." which he hoped will get rooted in their psyche so that when older they will know how to do various tasks (laundry, dishes, buying groceries).

Finally, participants variantly reported that an aspect of being a SAHF they liked was having flexibility in their daily lives. Such flexibility included being "free to do what (participant) wants between 8:30 and 2:30," and having the flexibility to maintain the house as problems arise, as opposed, for example, to "not finding a busted water heater until 6pm, after getting home from work."

*Dislikes about SAHF role.* Participants were also asked to describe what, if any, aspects of the role of SAHF they disliked. Results in this section included six variant categories.

Variantly, participants reported disliking childcare tasks associated with being a SAHF. These included things such as waking up early, changing diapers, cooking for and feeding the child, as well as more global descriptions such as “cater(ing) to the child’s needs first” and “general aggravations [sick kids, accidents, injuries, homework] that you don’t find with a regular 9-5 job.”

Participants variantly reported disliking the isolation and loss of connection that came with the role. One participant highlighted this sense of isolation by noting that even though he had friends in the area, he couldn’t “pop into somebody’s office with a 6 month old strapped to (his) chest.” Participants also variantly reported disliking feeling judged by others for taking the role of SAHF. One participant vividly described this category, noting that when he goes out with other dads, they “treat (him) like shit,” think he does nothing all day, or think being a SAHD is a “chick job.” These other dads are professionals with “money to burn” and the participant reported that he feels they do not respect him.

Another aspect of the role participants variantly disliked was a loss of personal income. One participant elaborated by describing what has been lost. He stated that he and his wife were childless with two incomes for 12 years prior to having their first child, and that he had money saved up and was “playing” off of his savings. Playing included going out to lunch, having beers, and buying cannabis. Now, he stated that his wife gives him money but tells him what he can and can’t spend it on.

Variantly, participants also reported disliking the parenting conflicts that have attended their taking on the role of SAHF. At times, this conflict seemed directly related to their role as SAHFs. For example, one participant noted that he believes other people look at him as an “unemployed failure” and think his work could be better outsourced to a “minimum wage nanny.” When his wife is influenced by those thoughts, there is a “ton of marital conflict.”

Finally, participants variantly endorsed disliking the loss of excitement they have felt since becoming SAHFs. One participant stated that he misses the stimulation of a fast-paced job and being a man of action that he doesn’t get from being a stay-at-home father, while another reported he “dislikes that being a SAHF is boring.”

*Sources of support for role as SAHF.* Participants typically reported finding support for their experience as SAHFs in social media or the internet. Several participants noted that they have found support from groups on Facebook including discussions and “problems from frustrated and happy dads”, or through SAHF Facebook pages which have been “great for making (participants) realize there are other people going through the same thing.” One participant summarized this feeling of online support by reporting that his online friends are SAHFs from all over the world, who “have been a saving grace.” He stated that these online friends provide what he had in an office environment, including poking fun at each other, providing each other support, and laughing with each other. This participant stated that talking to friends on social media has been “a liberating experience.”

*Future plans regarding SAHF role.* Participants’ future plans regarding the SAHF role broke into two categories: They either planned to return to work, or were

unsure of their plans. Generally, participants reported that they plan to return to work. Several participants noted that they planned to return to work once their children entered school. Other participants were actively on the job market, or had plans to return to work within a few months. All but one participant voiced, in one way or another, plans to return to work.

Variantly, participants expressed ambivalence or uncertainty about their future plans regarding the SAHF role. One participant noted that he and his partner might home school their child, in which case he (participant) would be the primary teacher. However, he noted they haven't decided yet, in part depending on his employment opportunities

**How others perceive their role as SAHFs.** Participants experienced a mixture of reactions and perceptions of their role as SAHFs, including positive, negative, and other responses.

*Positive perceptions.* Participants typically experienced positive reactions, including from members of the public. For example, one participant recounted how after moving to a new state, he was asked by a coffee shop worker what he did for a living. After he responded that he was a SHAF, a “big grin spread across owners face” and he said “brother, let me shake your hand . . . like he wanted to give me a bear hug.” Other participants noted that they receive generally positive reactions from the public, including that it is “cool” to see a man “step up to the plate” in fatherhood, being a “real man,” and “letting his wife make money.”

Participants variantly reported experiencing positive reactions to their role as SAHFs from members of their families, friends, and mentors. One participant had a graduate school mentor who told him that becoming a SAHF was a “great, great thing,”

and another noted that friends and family have been encouraging and positive, including commenting on how well the participant's child is taken care of and how confident she is.

*Negative perceptions.* On the other hand, participants also typically reported experiencing negative reactions to their role as SAHFs, including from family members, friends, and mentors. The same participant who had one supportive former professor had another professor and mentor tell him that becoming a SAHF was “the stupidest thing (they) had ever heard” and that he would be “committing professional suicide,” as no institution would want to hire him if they learned he was willing to put family above career. This phrase (professional suicide) has “haunted” P since learning he is having another child. Other participants experienced family members as invalidating of their role as SAHF: One participant described his family as “old school”, and reported that they questioned P's decision to be a SAHF by stating, “why don't you want a job, why don't you want to work, why don't you want to put your child in daycare,” and that they stressed the importance of making money to pay for the child.

Participants also variably experienced negative reactions to their role as SAHFs from members of the public. At times, these reactions included unsolicited verbal feedback from strangers, such as one participant who described strangers who would come up to him in public to tell him “this is a woman's job...clearly you aren't masculine because you're wanting to stay home and take care of the baby.”

*Other perceptions of SAHF role.* A third typical reaction reported was that of feeling that others do not understand the role of SAHFs. This sentiment was captured by one participant who reported that being a SAHF is not something that society generally understands, appreciates, or in some cases tolerates. This lack of understanding led this

particular participant to feel that SAHFs have to go above and beyond in their efforts to prove their adequacy as caregivers. Another participant described a lack of understanding from people in his community, noting that “half the [small] town thought I was gay and that I had a husband and these were adopted children” and that “none of my friends understood why I was even considering doing this.”

Finally, participants variably reported that society in general is shifting in terms of gender roles, with greater acceptance of SAHFs. One participant described his sense of a shift over time, describing his sense that the perception of SAHFs changes based on the demographic you are talking to, stating that baby boomers do not approve, gen x is “meh,” and his children think it’s normal.

**Self-perception of masculinity.** Participants were asked how, if at all, their sense of their own masculinity has changed since becoming a SAHF. Participants also spontaneously described their sense of their own masculinity throughout the course of the interviews, providing a fuller picture of how gender identity relates to their role as SAHFs and experiences of depression.

Participants were evenly split in terms of their perceptions of how their masculinity has changed since entering the role of SAHF: Five participants reported an increase in or stable sense of masculinity and gender security since becoming a SAHF, while five participants reported a decrease in masculine security or feelings of emasculation since beginning the role. Two participants reported conflictual perceptions, with both increases and decreases in their sense of masculinity since beginning the SAHF role.

Typically, participants noted increased or stable masculinity since become a SADH. One participant described a shift when realizing he has to be secure in his masculinity to be in “Babies ‘R Us at 9 o’clock on a Tuesday” with only other moms. Another participant noted that he feels like his sense of masculinity has increased since the birth of daughter.

On the other side, participants typically described feeling a decrease in their masculine security, or a sense of emasculation since becoming a SAHF. One participant noted that he wonders if his wife is no longer interested in him sexually/intimacy-wise due to a change in his masculinity. He stated that he is “not a highfalutin, traveling, staying” (in hotels) person, he is “not the same person (he) was” when they were dating, because he is no longer working, which makes him feel emasculated. Several other participants noted that no longer bringing in an income led to feeling emasculated, which was “very humbling”, and, a “bitter pill to swallow” because these participants wanted to be “providers.”

Variantly, participants described their role in such a way that re-cast being a SAHF as definitionally masculine. This sentiment was captured by a participant who described being a dad as very masculine, noting that being able to “reduce (one’s) self to putting on make-up and toe nail polish to make (his) daughter happy *is* masculine.” Another participant summarized his mystification that stay-at-home parenting has ever been considered a feminine role. He reported being unsure of how the human race has survived as long as it has, or how parenting has been a feminine role because “you need all the traits of an alpha male to do this” and “you have to be strong, steadfast, bull

headed, you have to be ready to defend them at an instant. There's just so many things that go on, I just don't know how this is considered a feminine role at all, I really don't."

While considering how their sense of masculinity has or has not changed since becoming a SAHF, participants variably reported that they have never felt stereotypically masculine. Several of these participants discussed having a sense of gender fluidity or flexibility: One noted captured this sentiment by noting that he did not come out of a "macho position" and was okay with not being the primary earner, stating that he does not have "rigid view of masculinity."

Finally, participants variably reported feeling that their sense of masculinity was tied to work. One participant was adamant in this position, stating that he had "stepped on (his) masculinity card by becoming a SAHD," and gave up any masculinity he had.

Table 1. Contextual results

<u>Domain/Category</u>	<u>Frequency</u>
Role as SAHF	
Decision process to become SAHF	
<i>Economic / Financial concerns</i>	Typical
<i>Value / Importance of being there for child's development</i>	Typical
<i>MH / Medical concerns</i>	Variant
<i>P's loss or lack of father influenced decision to become SAHF</i>	Variant
Tasks	
<i>Caring for child (physical/emotional/cognitive/developmental needs)</i>	
General	
<i>Caring for the home (cooking, cleaning, shopping)</i>	
Typical	
<i>Caring for relationship with partner</i>	Variant
<i>Caring for self</i>	Variant
Confidence in role	
<i>High confidence / Experienced increasing confidence as SAHF</i>	Variant
<i>Low confidence as SAHF</i>	Variant
Likes about SAHFhood	
<i>Quality time and relationship building</i>	General
<i>Role-modeling and influencing child's development</i>	Typical
<i>Flexibility in daily life</i>	Variant
Dislikes about SAHFhood	
<i>Childcare tasks</i>	Variant
<i>Isolation / Loss of connection</i>	Variant
<i>Feeling judged by others for being SAHF</i>	Variant
<i>Loss of personal income</i>	Variant
<i>Parenting conflicts</i>	Variant
<i>Loss of excitement</i>	Variant
Sources of support for role as SAHF	
<i>Social media/Internet</i>	Typical
Future Plans regarding SAHF role	
<i>Plans to return to work</i>	General
<i>Unsure / Ambivalent about plans</i>	Variant
How others perceive role of SAHF	
<i>Positively</i>	Typical
<i>From public</i>	Typical
<i>From family/friends/mentors</i>	Variant
<i>Negatively</i>	Typical
<i>From family/friends/mentors</i>	Typical
<i>From public</i>	Variant
<i>Other perceptions of SAHF role</i>	Typical
<i>Others do not understand the role</i>	Typical

<i>Society in general is shifting in gender roles/acceptance of SAHF</i>	Variant
Self-perception of masculinity	
<i>Increase in, or stable sense of, masculinity/gender security since becoming SAHF</i>	Typical
<i>Decrease in masculine security / emasculation since becoming SAHF</i>	Typical
<i>Recasting SAHF role as masculine (“risky”, action-oriented, provider-based)</i>	Variant
<i>Never felt stereotypically masculine</i>	Variant
<i>Masculinity tied to work</i>	Variant

## **Depression and Help-Seeking while SAHFs**

The next section presents results related to participant's experiences of depression and help-seeking during their tenure as SAHFs. This section is broken into four main parts. First, background mental health issues and previous treatment experiences are included as context. Next, descriptions of depression and how participants sought help for depression are provided. For those participants who engaged in therapy while SAHFs, results pertaining to these therapy experiences are also provided.

**Mental health history prior to becoming SAHF.** Some participants provided information on previous mental health issues and diagnoses, as well as treatment experiences. These data are included as contextual information to better understand their experiences of depression and help-seeking during their tenure as SAHFs.

*History of mood / anxiety disorders.* Participants variantly reported having a history of mood and/or anxiety disorders. One participant described two previous "nervous breakdowns," while another reported he had been diagnosed with "clinical depression" since early in his life.

Participants variantly reported that their previous mental health concerns were precipitated by familial distress. In terms of the "nervous breakdowns" previously described, the participant felt these breakdowns were related to work-oriented pressure emanating from his father, and he experienced "30 years of pent up stuff that just broke apart."

*Previous therapy experiences.* Participants typically reported that they had been in therapy prior to becoming a SAHF. These experiences were variantly described in neutral terms, and variantly described as being negative. For the neutral experiences,

participants simply stated they had previously seen therapists, without elaborating on the quality of these contacts. For negative experiences, one participant noted that he has tried “talk therapy of different flavors” but did not feel this got “to the bottom of anything” and he felt no substantial change or relief.

*Previous experience on psychotropic medication.* Finally, participants variably reported having previously been prescribed psychotropic medications. One stated that he has been taking antidepressants for 10-12 years, while another stated that he was “almost hospitalized several times” in the past several years, and is now on anti-anxiety medication.

**Experiences of depression while SAHFs.** Participants were asked to describe their experiences of depression that occurred during their tenure as SAHFs. Results pertaining to these experiences are presented below, including descriptions of depression, perceived causes, how participants coped and/or are coping with their depression, and the effect their depression had on others (see Table 2 below).

*Timing / Duration of depression.* In terms of the timing of depression, participants variably reported that they began to experience depression after an increase in their parental responsibilities, including initiating the SAHF role, after the birth of their first, or after the birth of their second child. Regarding duration, participants variably reported that their depression lasted less than six months.

*Description of depression.* Participants were asked to describe how they experienced depression, which tended to draw out symptomatic descriptions. Generally, participants described having experienced depression as a “pulling inward,” including anhedonia, loss of motivation, social withdrawal, and feelings of resignation. One

participant reported that he felt he was “at 50%” and that his drive and inspiration weren’t there, noting that he felt “detached” and spent time just staring out the window like an “out of body experience.” Another described isolating himself at family gatherings, describing himself as “morose...in the corner...people would be fawning all over my daughter and I would just want to be away.”

Participants typically described depression as involving an increase in negative emotionality including crying, anxiety, desperation, misery, anger, and irritability. One participant described feeling “burnt out, angry, and ready to explode.” Another reported that while depressed, he would “break down at the smallest thing” and get “very emotional.” Yet another reported that he would spend 20 minutes at a time crying with his daughter when he could not comfort her, which increased his feeling “heartbroken.”

Participants also variably described experiencing depression as involving negative cognition related to not working or “contributing.” One participant reported engaging in defeating types of thinking, such as feeling like “a massive failure” (for being a SAHD, as he didn’t chose the role) who couldn’t change his “lot in life.”

Finally, participants variably reported experiencing physical symptoms of depression. Descriptions in this category included one participant’s explanation of “desperation and misery,” as well as physical pain that “sets off bouts of crushing depression . . . one feeds another...in a big ugly cycle.”

***Perceived causes of depression.*** Participants were asked about their perceptions of what had contributed to or caused their depression while SAHFs. Responses to this domain resulted in seven variant categories.

Social isolation was variantly identified as causing depression. One participant reported that being home alone, with no friends nearby contributed to his depression.

Another noted that

when his children were “tiny”, he didn’t know any other parents, and thinks the isolation of being alone at home with two children caused his depression

A similar but more specific form of isolation, the lack of spousal support, connection, and intimacy, was also variantly identified as causing depression. One participant continually returned to his belief that the lack of intimacy in his marriage was the biggest driver of his depression, while others noted that difficulties in communication with their partner drove feelings of depression. This was captured by a participant who noted that while he and his wife have not been having sex, and physical intimacy in general “isn’t really there,” the sex is not “even the biggest issue...we just don’t communicate the same way, and because of that there’s a bunch of tension between us sometimes. I just don’t feel very well liked.”

Another variantly identified cause of depression was participants not being the parent or partner they would like to be. One participant explicitly stated that he felt depressed due to ambivalence about loving his child, which made him hate himself. Another participant explained that he felt like a “failure” for feeling like watching his daughter was difficult, and for not being able to comfort her as well as his wife when she was crying.

Participants also variantly identified loss of employment and independence as causing their depression. One participant described this as a sense of loss and feeling underutilized moving from working in a high responsibility environment to taking care of

a child, which led to feelings of depression. Another noted that having his independence and professional side “stripped away without being able to do anything about it” put him in a cycle of depression.

Stigma related to the SAHF role was also variably identified as causing depression. This was captured by a participant who stated that the public reaction to him as a SAHF (“world telling me I’m a loser”) and “feeling like a loser because I’m choosing the most honorable thing to do, to raise children” combined with his own questioning if he did “anything significant today” led to and increased feelings of depression.

Participants also variably identified biological or genetic factors as contributing to their depression. One participant noted that he has read that as men age they lose testosterone, and he cooks with a lot of soy which he had heard has high levels of estrogen, and feels this may have contributed to depressive symptoms. Another stated that he inherited being an “emotional person” from his mom, and feels this has contributed to depression.

Finally, participants variably reported that high levels of stress contributed to their depression. These included descriptions of days where “everybody’s screaming at you and cutting you off and you go, Ohh, Enough!”

***How participants coped/are coping with depression.*** Participants also described ways in which they have tried to cope with their depression, resulting in one typical and four variant categories.

Typically, participants reported engaging in distractions and activity-based coping. One participant reported he would play video games, go for walks with his

daughter, or “do anything” to keep his mind off his symptoms, while another stated that he developed and adhered to a rigid schedule to “cope and manage the unknown”.

Participants variantly identified social connections as helpful in coping with depression. Much of this social connection was established online through social media: One participant stated that blogging and posting on Facebook gave him a way to talk about his experience that felt helpful.

Seeking extramarital relationships was also variantly endorsed as a way participants have tried to cope with depression. One participant stated that when depressed, he tried to reach out to his wife during the day via text, but she couldn't talk or text at work, so he began talking to women at online dating sites.

Participants variantly identified expressing emotions as being helpful in coping with depression. One reported that keeping things in and exploding is “no good.” and stated that while he is scared, introverted and quiet, talking is something he “needs to do.”

Finally, participants variantly reported using substances, including alcohol and cannabis, as a way to cope with depression. Cannabis use was described by several participants as a way of “self-medicating.” One participant reported he smoked because of “the monotony” and described smoking pot as “the only thing that keeps me going” and stated that it helped him “come to terms with (his) lot in life,” and “stay to (him)self.”

*Effect of depression on others.* While participants described their own symptoms and experiences of depression, they also reflected on the impacts their depression had on others.

Generally, participants reported that their depression had a negative effect on family members. Participants reported taking their children out of the house less frequently than they would otherwise due to depression, being unable to focus on multiple children at once, and in general engaging less with their children. One participant noted, for instance, that his depression “affects his family more than (he) would like to acknowledge, if (he) is in a crappy mood everyone is in a crappy mood.” Participants also described family members being increasingly worried about their emotional state, which often increased participant’s own feelings of guilt.

Variantly, participants reported that their depression had no effect, or were unsure of the effect their depression had on others. Participants in this category noted they were unsure if their depression affected anyone outside of their family because they were avoiding friends, while others stated they simply were unsure.

Table 2: Experience of Depression

<u>Domain/Category</u>		
<u>Frequency</u>		
MH history prior to becoming SAHF		
	<i>History of mood / anxiety disorders</i>	Variant
	<i>Previous MH concerns precipitated by family distress</i>	Variant
	<i>Previous therapy experiences</i>	Typical
	<i>Neutral previous experience</i>	Variant
	<i>Negative previous experience</i>	Variant
	<i>Previous experience on psychotropic medication</i>	Variant
Experience of depression while a SAHF		
	Timing / Duration of the depression	
	Timing	
	<i>After increase in parental responsibility (child birth, SAHD initiation, 2<sup>nd</sup> child birth)</i>	Variant
	Duration	
	<i>Less than 6 months</i>	Variant
	Description of depression	
	<i>“Pulling Inward” (Anhedonia / Withdrawal / Loss of motivation / Resignation)</i>	General
	<i>Increased negative emotionality (crying, anxiety, desperation, misery, anger, irritability)</i>	Typical
	<i>Negative cognitions related to not working / “contributing”</i>	Variant
	<i>Physical symptoms</i>	Variant
	Perceived causes	
	<i>Social isolation</i>	Variant
	<i>Lack of spousal support / connection/intimacy</i>	Variant
	<i>Not being the parent / partner P would like</i>	Variant
	<i>Loss of employment and independence</i>	Variant
	<i>Stigma of the SAHF role</i>	Variant
	<i>Biological / Genetic causes</i>	Variant
	<i>High levels of stress</i>	Variant
	How coped / coping with depression	
	<i>Distractions and activity-based coping</i>	Typical
	<i>Social connection</i>	Variant
	<i>Seeking extramarital relationships</i>	Variant
	<i>Expressing emotions</i>	Variant
	<i>Substance use</i>	Variant
	Effect of depression on others	
	<i>Negative effect on family members</i>	General
	<i>No effect / Unsure of effect on others</i>	Variant

**Help-seeking related to depression while a SAHF.** Participants were asked to discuss if and how they sought help for depression during their tenure as SAHFs. This section resulted in five domains, including motivating factors, help-seeking via professionals, help-seeking via non-professionals, facilitating factors, and barriers to help seeking (see Table 3 below).

***Motivating factors.*** Typically, participants reported being motivated to seek help as a way to protect their families from the effects of participant's mental health. One participant summarized this category well by stating that if he didn't have kids he would have "taken the honored male way out of sucking it up and dealing with it (depression)," but having kids motivated him to seek help, as he wants to be the best he can for wife and kids. Another noted that he didn't want his daughter to be around someone that's depressed, but rather wanted her to be around someone that's positive and who can help her grow into a better person.

Participants also typically reported that emotional and relational distress motivated them to seek help. Emotional distress included descriptions of feeling "something's off," feeling that "it's (unclear referent) just been so forced for a long time," and noting that "whether or not that's a masculinity issue... (I) shouldn't be sitting here crying, all day long." Participants also stated that relational issues of isolation and a desire to explore "things about (their) upbringing" motivated help-seeking.

***Help-seeking via a professional.*** Participants described the type of help they sought, including from professionals. Under this domain, participants typically reported seeking help from a talk therapist (counselor/psychologist). One participant stated that he sought a counselor through his insurance to address specific issue, and then was referred

to a trauma specialist. Another noted that while he has not yet followed through, he was in the process of contemplating working with a therapist “just so I could have somebody in a room that would listen to me without talking” and “let me get some of the general stress off my back without prescribing anything”.

Variantly, participants reported seeking help from a medical doctor (family physician/psychiatrist). One participant stated that he called his HMO and asked for therapy, and was offered 6 medical and 10 therapy appointments. He stated that so far he had gone to medical appointments, and had “pretty much been only talking about the medicine...we haven’t been doing therapy, in any case.”

*Help-seeking via a non-professional.* Participants also described avenues for help seeking via non-professionals. Variantly, participants reported that they sought help for their depression via social media sites. One participant, who used Facebook as a means for attenuating his depression, noted that comments from people he hadn’t heard from in “forever” included “you’re not alone, you’re not alone in this, you’re not alone with feeling depressed, in regards to your kid, you’re not alone in not loving her.” These comments and support made this participant feel better.

In addition to online support, participants variantly reported seeking help from friends or local support groups. One participant reported he was referred to a general new father support group by his midwife and other fathers, while another stated that, not having money to go to psychiatrist/therapist, the “only thing (he) could do was go to (his) social group,” a depression support group.

*Facilitating factors.* While participants previously described the factors that initially motivated them to seek help (see above), they also described facilitating factors,

that is, factors that enabled them to follow through on their initial motivation. These factors broke down into three variant categories.

Participants variantly reported that having a flexible, non-stereotypical sense of masculinity facilitated their help-seeking. One participant noted that he views himself as someone who does not have a “rigid” sense of masculinity and is someone who talks about feelings so he “didn’t have a big threshold” to going to counseling.

Participants also variantly reported that having insurance facilitated their help-seeking. This was a straightforward category in that participants stated explicitly that having insurance enabled them, financially, to seek therapy.

Finally, participants variantly reported that previous counseling and/or exposure to the mental health field had lowered their inhibitions or sense of stigma related to help seeking. Several participants noted that being in previous counseling had lowered any inhibitions they had regarding seeking help.

***Barriers to help-seeking.*** While participants were able to identify facilitating factors, they also reported barriers to their help-seeking efforts. This domain broke into three variant categories.

Participants variantly reported negative thoughts regarding treatment, which served as a barrier to their seeking professional help. One participant stated that his experience with therapy and medication when he was younger “turned (him) off to the whole thing . . . [he] wanted to be able to fix (his) problems on (his) own.”

Similar to how insurance was perceived as facilitating help-seeking, participants variantly identified the lack of insurance and finances as a barrier to help-seeking. Several participants noted flatly that the lack of insurance precluded their seeking help

due to potential costs they would incur, while others reported that they had discontinued with prior therapists due to insurance running out or owing too much money to continue seeking help.

Finally, participants variantly identified childcare or family-life challenges as barriers to help-seeking. One participant noted that taking care of the kids and his wife “superseded my contacting someone to speak about this (depression),” and he was not sure what to do with his children while he was at a therapy appointment.

Table 3: Help-Seeking

Domain/Category  
Frequency

Help-seeking related to depression when a SAHF

Motivating factors

*Help seeking seen as way to protect family from P’s MH*

Typical

*Emotional / Relational distress*

Typical

Help seeking via a professional

*Talk therapist (counselor / psychologist)*

Typical

*Medical doctor (Family doctor; Psychiatrist)*

Variant

Help seeking via a non-professional

*Social media support*

Variant

*Friends / Local support group*

Variant

Facilitating factors

*P’s Flexible / Non-stereotypic masculinity*

Variant

*Having insurance*

Variant

*Previous counseling / exposure to MH field lowered inhibitions / stigma*

Variant

Barriers to help-seeking

*Negative thoughts regarding treatment*

Variant

*Lack of insurance / Finances*

Variant

*Childcare / Family life challenges*

Variant

**Therapy experience while a SAHF.** Participants were asked if they had engaged in therapy for depression during their tenure as SAHFs: In the current sample, 9 participants had and 3 participants had not. Thus, for the following results, frequency ratings for categories will be altered as follows: General = 8-9 cases, Typical = 5-7 cases, and Variant = 2-4 cases. Categories with fewer than two cases (“Other”) will not be included in these results. Participants who had participated in therapy during their tenure as SAHFs described the logistics of these meetings, the quality of their relationship with their therapists, themes of the therapeutic work, perceived progress and satisfaction with therapy, helpful and unhelpful aspects of their therapy, attitudes towards future help-seeking, and what they would want other SAHFs to know regarding therapy (See Table 4, below).

***Demographics/Logistics.*** Participants reported on the length and frequency of their therapy during their tenure as SAHFs. Regarding length of treatment, participants typically reported being in treatment for less than one year, and variantly reported being in therapy for more than one year. Regarding frequency of therapy appointments, participants typically reported having appointments less than once per week, and variantly reported having appointments at least once weekly.

***Relationship with current or most recent therapist.*** Participants were asked to describe the relationship they had with their current or most recent therapist. Typically, participants described these therapeutic relationships as being good, “professional,” and “open.” These participants described their therapists as asking “the right questions...get[ting] me going and it’s very helpful,” and feeling “really free” to talk

about “some hard things.” Therapists were also described as being warm, inviting, supporting and professional, which inculcated a sense of having a good relationship.

***Themes of therapy work.*** Themes of therapy work broke down into two variant categories, including parenting/SAHF themes, and marital themes. Participants variantly reported that their therapy work focused on issues related to parenting or being a SAHF. For one participant, this included his self-critical internal dialogue related to not working, which was connected to family-of-origin expectations and pressure.

Participants also variantly reported that their therapy focused on marital themes. One participant described a fairly frank appraisal given to him by his therapist, who stated “yeah, of course you’re depressed, your wife doesn’t sleep with you and you don’t have sex, I mean, sorry.” This participant noted that the therapist then helped to consider options the participant might have, including focusing on the positive things he has or getting out of the marriage.

***Perceived progress/satisfaction in therapy (for all therapy while a SAHF).***

Typically, participants reported mixed progress and ambivalence about their satisfaction with the therapy they experienced while SAHFs. One participant summarized this feeling of ambivalence by noting that his “irrational” side continues to feel entrenched in anxiety and self-hate, while his rational side feels he has accomplished a lot in therapy, including being invited to read material from his blog in front of a large audience. Others noted they could “take it or leave it,” or reported that while therapy “wasn’t a waste of money,” the copay was more than they were willing to pay, considering the benefit they saw.

Variantly, participants felt they made good progress and were generally satisfied with their therapy. One participant reported feeling very satisfied, and was grateful he

“found good help in time.” This satisfaction included the feeling that therapy was “doing more than I thought it would,” and was having a “tangible...positive impact on other parts of my life” more than just resolving the presenting issue.

Participants also variantly reported feeling dissatisfied, and having made no progress in their therapy. One participant voiced his dissatisfaction with the lack of perceived intervention on his therapist’s part. He stated that he did not feel he had been given any analysis, strategies, techniques or interpretation, and reported that while he felt his therapist got a lot of information and brought up a lot of issues, they did not “do anything with it.” Summarizing his sense of satisfaction, this participant stated that he “could get this (e.g. therapy) from my waitress.”

*Helpful features of therapy (for all therapy while a SAHF).* Participants identified one typical and one variant helpful feature of their therapy. Typically, participants reported that it was helpful when their therapists’ techniques appeared to match their presenting concerns. This was most clearly identified by a participant who engaged in EMDR. He reported that therapy (EMDR) was “resolving” his issues instead of “talking” and stated that this has made him less reactive. This participant described his understanding of EMDR, stating he was “resolving specific neural networks that have been formed in trauma” and rather than reacting like “a little kid acted, I can now choose my reaction a bit more freely as an adult.” Another participant, who described his depression as being comorbid with chronic pain issues, reported that the most helpful feature of his therapy was having a therapist who was a specialist in pain and understands the cycle of physical and mental pain.

Variantly, participants reported that it was helpful to have an open, non-judgmental space in which to voice their concerns. Participants described finding it helpful talking to someone not in their social circle or connected to their wife, and being able to talk openly and feeling heard without being judged. One participant specified that this was helpful given his perceptions of the burden his needs place on his wife, noting that therapy gave him an outlet where he can “go bitch to somebody else” as his wife has “a lot of stress on her shoulders” [finances, prior bankruptcy] and he feels that in comparison, his concerns are “nothing, I shouldn’t be worrying her with this.”

*Unhelpful features of therapy (for all therapy while a SAHF).* Participants also described unhelpful features of their therapy, which broke out into three variant categories. Variantly, participants described logistics of therapy as unhelpful, including office locations, mode of service delivery, and frequency of meetings. One participant reported often having phone sessions instead of in-person, and found these unhelpful as he is not a “phone person” and will fall asleep. Additionally, these sessions felt unhelpful as going out of the house to his therapist’s office gave him a sense of freedom, because he was away from his daughter a bit.

Participants also variantly reported that having an unresolved rupture or disagreement with their therapist was unhelpful. For one participant, this included unprofessional comments made by his therapist regarding the participant’s wife’s weight. Another had a disagreement about discontinuing his use of cannabis. In both cases, these disagreements led to discontinuation of therapy and were described as being an unhelpful aspect of treatment.

Finally, participants variantly reported that the lack of specificity in either technique or area of focus was unhelpful. For these participants, therapy at times felt like an unproductive conversation, “just talking back and forth”, or “talking to somebody in an elevator.” These participants felt their therapists were not able to provide an adequate explanatory framework for their approach, which led to doubts about their ability to be helpful.

*Attitudes towards future help seeking.* Participants were asked how their therapy experiences during their tenure as SAHFs affected their likelihood of seeking help in the future. Generally, participants reported a willingness to seek future help. For some, this willingness was more of an expectation that they may be in therapy and on meds for the rest of their life, including one participant who accepted that as “a fact.” Others noted that while they currently do not feel they will need therapy long term, they would return “if necessary” because of having had good experiences, knowing there “are good ones (therapists) out there.”

On the other hand, participants variantly reported fears that future therapy would not be helpful. One participant, reflecting on his poor therapy experience, stated that “if this is what therapists are like, then who needs them?”

*Message to other SAHFs regarding therapy.* Participants were also asked what they would want other SAHFs to know regarding psychotherapy or counseling. Typically, participants had positive views and would encourage other SAHFs to consider seeking therapy as needed. One participant wanted other SAHFs to know that it is a lonely job, with difficulties and stigma associated with the role, and they need someone (a therapist) to talk to other than their partner. Finally, another placed the possible need

for therapy in a larger societal context, and wanted other SAHFs to know that we are “in a new paradigm...defining new roles of what a parent...man...woman...culture and society are made up of. And psychotherapy is there to help us analyze it, and...slow down our thought process,” and help...”navigate these changes.”

Table 4: Therapy experiences while SAHF

<u>Domain/Category</u>	
<u>Frequency</u>	
Therapy experience while SAHF	
Demographics/Logistics	
Length of current/most recent PT	
<i>Less than 1 year</i>	Typical
<i>More than 1 year</i>	Variant
Frequency of current/most recent PT	
<i>Less than once/week</i>	Typical
<i>At least once weekly</i>	Variant
Relationship with current or most recent therapist	
<i>Good rx</i>	Typical
Themes of therapy work	
<i>Parenting/SAHF themes</i>	Variant
<i>Marital themes</i>	Variant
Perceived progress/satisfaction in therapy (For all tx engaged in while SAHF)	
<i>Mixed progress / ambivalent re: satisfaction</i>	Typical
<i>Good progress / satisfied</i>	Variant
<i>No progress / dissatisfied</i>	Variant
Helpful features of therapy (for all therapy while a SAHF)	
<i>Techniques that matched P's concerns</i>	Typical
<i>Objective, non-judgmental space</i>	Variant
Unhelpful features of therapy (for all therapy while a SAHF)	
<i>Logistics (office location, phone vs in person, freq. of meetings)</i>	Variant
<i>Unresolved rupture/disagreement</i>	Variant
<i>Lack of specificity (in focus, technique)</i>	Variant
Attitudes toward future help-seeking.	
<i>Willingness to seek future help</i>	General
<i>P fears future therapy will not be helpful</i>	Variant
Message to other SAHFs regarding therapy	
<i>Encourage therapy</i>	Typical

**Closing Results: Reasons for participation and experience of interview**

This final section of results will cover closing questions related to participants' reasons for participation, as well as their experience of the interview process (See Table 5, below). The category frequencies for these results are based on the full sample (N = 12; General = 11-12, Typical =7-10, Variant=2-6).

**Why participate.** Near the close of the interview, participants were asked for their reasons for choosing to participate in this study. Typically, they reported that they participated out of a desire to advocate for or to help other SAHFs. One participant noted that he wanted to change the way that SAHFs are viewed because “right now it’s not good.” while another stated that it is a passion for him to dispel myths and erroneous ideas about SAHFs.

Variantly, participants reported that they value education and research, which motivated them to take part in the study. Several participants either were in, or were planning to attend, graduate school, and thus saw their participation as being “from one student to another.” As one participant stated, he knows that when he is working on his thesis, he will need to find people as willing as he was to participate.

Finally, participants variantly reported that they participated because it “felt good to share.” For one, participating gave him someone to talk to, and “it was either this or play on the computer or get lost in Facebook.”

**How participants learned about the study.** Participants were asked how they learned about the study. They variantly reported that they learned about the study via social media groups on Facebook, including “Dadbloggers,” and other non-specified groups.

**Experience of interview.** As a final question, participants were asked about their experience of being interviewed. Participants variantly described having a positive interview experience. One suggested that he would vet the interviewer to other members of SAHF Facebook groups, and let them know the interviewer is “cool” and they should talk to him. Another reported that “it’s good to know that somebody wants to actually listen to what people like (him) have to say. It almost just feels like a little bit of a weight off my shoulders. To just get it out and have diarrhea of the mouth for an hour. You know to talk to somebody else on the other end. I think it’s a little cathartic to just get it out a little bit.”

On the other hand, participants also variantly reported that the interview was challenging. One participant stated that he was worried about letting the interviewer down with his responses, though he “knows that is ridiculous”.

Table 5: Closing results

<u>Domain/Category</u>	<u>Frequency</u>
Why participate	
<i>Advocate for or desire to help SAHFs</i>	Typical
<i>Values education and research</i>	Variant
<i>Felt good to share</i>	Variant
How learned about project	
<i>Via a social media group</i>	Variant
Experience of interview	
<i>Positive interview experience</i>	Variant
<i>Challenging interview experience</i>	Variant

**Illustrative example**

As a means to illustrate and integrate these results in a more vivid manner, a composite case study will be presented below. This case is based on typical and general results, and combines elements from all of the participants in order to preserve anonymity.

Mike was 32 years old and had been staying home with his 5-year old child for the past 4 years. Mike and his partner decided that he would stay home for two reasons: First, Mike's income as a theater stage-hand would barely offset the costs of daycare. Second, Mike and his partner highly valued being present for their child's development, especially given Mike's experience of not having a father when he was growing up.

The value of "being-there" for his child's development was demonstrated when Mike described aspects of the SAHF role that he particularly enjoyed, those small moments during the day when the two of them connected on a deeper level, such as the first time his child pointed at the sky and used the word "Moon," and having his child say "dada" while out in public. While some of the day-to-day tasks were less enjoyable, Mike found online communities of other SAHFs to joke about dirty diapers and diminished sex lives.

Mike often received compliments from strangers for "stepping up to the plate" as a father. Family and mentors were less supportive, however, including one former mentor who told him he would be "committing professional suicide" by becoming a SAHF. Family members questioned his decision as well, claiming that he was simply trying to avoid working. Mike nevertheless felt that "taking one for the team" by staying home was the best way he could provide for his family, and gave him a stable sense of his

masculinity. On the other hand, he noted that no longer earning an income was “very humbling,” and he wondered whether his transition to a less stereotypically masculine role (as a SAHF) had diminished his sexual appeal for his wife.

Mike became depressed shortly after becoming a SAHF, during which time he stopped seeing friends, stopped calling family members, and felt resigned that “this is my lot in life.” He cried more frequently, often argued with his partner, and felt “burnt out, angry, and ready to explode.”

He also missed the feeling of connection he found at work, and sensed greater distance and isolation from his partner now that he was taking on this new role. Mike missed the financial independence that came with being employed, as well, which compounded his depression. Additionally, he felt more depressed when he was unable to comfort his child. This perceived lack of ability to parent as he hoped left him feeling that he was letting his partner down, which in turn exacerbated his depression.

In order to cope with his depression, Mike distracted himself by playing video games, taking his child for walks, and socializing both on and offline. He sensed that his depression was negatively affecting his family, and he regretted not taking his child out of the house more and having conflict with his wife. Mike decided to seek therapy to help his family, rather than simply himself. Though initially reluctant because of the difficulty of finding time for therapy amid his childcare duties, he eventually connected with a psychologist.

Mike reported that his psychologist was helpful in asking questions and enabling him to talk about difficult things, including his own sense of failure as a husband and parent. Their work focused on his self-critical internal dialogue related to not working,

which was connected to family-of-origin expectations and pressures. They also addressed Mike's communication skills, ways to practice intimacy, and options for negotiation between Mike and his partner.

Mike reported ambivalence regarding his satisfaction with therapy, and remained unsure if the copay was worth it, considering the limited benefits he saw. The most helpful thing was having a therapist who had good experience working with men and fathers, and who guided him to resources for SAHFs. Despite his ambivalence, Mike expressed a positive view of seeking therapy in the future. He also strongly encouraged other SAHFs to seek help. He wanted other SAHFs to know that it can be a lonely job, with difficulties and stigma associated with the role, and that talking to a therapist can help them improve as fathers.

## Chapter Five – Discussion

This study sought to explore how stay-at-home fathers (SAHFs) experienced depression, how they sought help for depression, and how they experienced psychotherapy for depression during their tenure as SAHFs. The discussion below will examine how the results of this study fit with and add to the larger literature on depression and help-seeking.

Overall, SAHFs who have experienced depression during their tenure as SAHFs focused on relational distress, isolation, loss of independence, and social stigma as causes of their depression. They appeared to retain a high value on providing for their families, both in the decision to take on the role of SAHF and in deciding to ultimately seek help for depression. The idea of seeking help as a means to protect and provide for their families appeared congruent with their descriptions of masculinity, which recast the SAHF role as being definitionally masculine. Finally, this growing but still somewhat marginalized group of men appeared to be building social networks both on- and offline to support their sense of identity and as a means for coping with the unique stressors they face. Results will be discussed in more detail below, focusing on general and typical findings.

### **Context and Roles of SAHFs**

**Role as SAHF.** Results indicated that SAHFs took on the role for two primary reasons: financial reasons and the value placed on being there for their children's development. The financial aspect is consistent with research from several countries (US, Canada, Belgium) that has indicated one of the most prevalent reasons given by SAHFs

for entering the role is the father's perception that this female partner had better (i.e., higher salary or better benefits) career prospects (Doucet & Merla, 2007; Merla, 2008; Rochlen et al., 2010; Rochlen, Suizzo et al., 2008; Zimmerman, 2000). Our participants also valued being present for their child's development. In previous research (Dunn, Rochlen, & O'Brien, 2011; Doucet & Merla, 2007; Merla, 2008; Rochlen et al., 2010; Rochlen, Suizzo et al., 2008; Zimmerman, 2000), this finding has also been reported, but at a much lower rate than financial reasons. One possibility for this difference may be that as SAHFs have become a larger portion of the overall population (Latshaw, 2011), a concurrent trend has evolved in which some men, our participants included, seem to characterize their own sense of masculinity as being "providers" for their family. The assertion of values-driven behavior (e.g., being present for children's development) is in some ways more agentic than "falling" into the role due to financial considerations. It may be, then, that an overall narrative of choosing the role of SAHF for altruistic reasons is more consonant with an evolving sense of masculinity that prioritizes self-sacrifice or being a provider. Several authors in the masculinity literature at large have highlighted some of these more positive aspects of masculinity that emphasize nurturance, protection of the family, and connectedness (Gallagan et al., 2010; Kiselica & Englar-Carlson, 2010). It appears that our participants may share this less "stereotypical" masculine viewpoint.

The participants in this study described their tasks as SAHFs particularly in terms of the child and home-care tasks that occupied the bulk of their day-to-day activities. These included tasks such as cooking meals, feeding, reading to and playing with their children, assisting with homework, taking children to school, bathing their children, and

tending to the home itself (e.g., cleaning). While few studies have examined in-depth the tasks of SAHFs, these findings are consistent with the literature on tasks for stay-at-home parents generally (Harrington et al., 2012). It appears, then, that child and home-care tasks are the most germane aspects of the day-to-day role of SAHFs, similar to their SAHM counterparts. This would be expected, given the demands of childcare that attend staying home as a parent.

Our sample expressed several opinions regarding their confidence in taking on the role of SAHF, though none was endorsed by a majority of the sample. On the one hand, several participants described high or increasing confidence since beginning the role, and noted how experience had disproved earlier worries that they may not be up to the task. These results are consistent with previous research (Rochlen et al., 2008), which found that SAHFs rate themselves as high as non-SAHFs and mothers on measures of parenting self-efficacy. Furthermore, the Rochlen study showed that men who were confident in their parenting skills and who felt supported by their partners reported higher overall life satisfaction. Our results also indicated, however, that several of our SAHFs did not feel confident in their role, and worried about “making mistakes” that would be detrimental to their child’s well-being, ultimately exacerbating their own depression. For men who decide to enter this role, then, it may be important to find ways to prepare for and build skills within the typical task-set of a SAHF. A sense of familiarity with the skills relevant to stay-at-home-parenting (e.g. childcare and house-care tasks) would likely improve the sense of parental self-efficacy, which may be protective against dissatisfaction with life, and perhaps ultimately, depression.

Social cognitive theory (Bandura, 2001) and social cognitive career theory (SCCT) (Lent, Brown, & Hackett, 1994) provide further elaboration on potential ways to increase self-efficacy among SAHFs. Bandura (2001) noted there are four primary factors affecting self-efficacy: experience, modeling, social persuasion, and physiological factors (e.g. rest, patience). As noted above, several of our participants appeared to have an increase in self-efficacy as they gained experience and mastery in tasks of child-care. Given the relative lack of SAHF role-models in the culture at large, another avenue to improve self-efficacy could be to highlight SAHFs doing well, such as through advertising or public-service announcement campaigns. Indeed, at least one of our participants seemed aware of this potential benefit, in noting that he would like to see Brad Pitt on the cover of a magazine specifically talking about his fathering role.

SCCT (Lent et al., 1994; Lent & Brown, 2013) also provides information on potential adaptive behaviors for SAHFs to consider while transitioning into and establishing competence in the SAHF role. Some of these behaviors include adjusting to work requirements, managing work stress and dissatisfaction, engaging in self-advocacy, and engaging in organizational citizenship behaviors, such as mentoring others. SCCT predicts that the more these behaviors are enacted, the greater a person's sense of self-efficacy and overall career satisfaction; in this case, the career being SAHFatherhood. It appeared that many of our participants were engaged in advocacy and mentoring, and seems likely that encouraging other SAHFs to consider adapting these behaviors would prove beneficial to their sense of well-being, and potentially help to mitigate depression.

Our participants were able to identify several things they enjoyed about the role, which tended to focus on relational aspects. Participants enjoyed spending quality time

with, and building more robust relationships with, their children, and being able to be a strong role-model and influence upon their children. The relational orientation and ability to positively influence their children's development is consonant with research that has suggested a positive source of meaning and identity for many men involves responsibility and accountability beyond the self, including family and community (Hammond & Mattis, 2005), and is concordant with potential new definitions of masculinity that include an emphasis on care, connection with children, and intimacy (Silverstein, 1996). It also makes sense that our participants would enjoy the relational aspects of their role, given the strong influence that being present for their child's development had on their taking on the role.

While our participants described enjoying spending time with and bonding with their children, they also identified a range of features they disliked about the SAHF role, though none emerged in more than a few participants. First, there appeared to be a theme uniting several of the dislikes, having to do with loss. Participants disliked the loss of excitement, loss of personal income, and loss of social connection that came with the role of SAHF. The loss of social connection, or isolation, attending the role of stay-at-home-parent has been identified by several previous studies (Deusen, & Mazar, 2012; Latshaw, 2011; O'Brien 2012; Zimmerman, 2000). It is worth noting that these descriptions accord with participants' most frequently depicted depressive symptoms; thus, it is difficult to unpack whether they disliked that taking on the role of SAHF included a sense of loss, or if depression led to anhedonia and social isolation, which our participants then narratively connected to their role, rather than to their depression. Either way, it appeared that a sense of loss attended the assumption of the SAHF role. Another aspect of the role

participants disliked were the tasks of child-care. These tasks tended to be contrasted with the “typical” tasks of a 9-5 job (e.g. going to an office or worksite and engaging with other workers, complex problems), and may reflect a discomfort with fully taking on the traditionally feminine roles that go along with being a stay-at-home parent. That is, it is possible that our participants were interested in positively influencing their children, and in developing close bonds with their children, but were less enthralled with the aspects of the role which appear more service-oriented. Based on the value these participants placed on “being there” for their children, and the enjoyment they took in role-modeling and influencing their children’s development, it may be useful to consider developing pre-parenting programming that illuminates the ways in which these routine childcare tasks are elements of care directly tied to the values SAHFs hold.

While some of our participants did note feelings of isolation and social disconnection, most were highly invested in seeking support via social media websites and internet message boards. In particular, almost all of the participants indicated they were members of SAHF-specific social media sites, where they could discuss their concerns, struggles, and experiences in a way that replaced for some the collegiality found in a workplace environment. There appear to be a growing number of SAHF-specific websites, with greater organization both in centralized ([Athomedadnetwork.com](http://Athomedadnetwork.com)) and localized (city-specific meet up groups/Facebook pages) manners. These sorts of organizations appear to be extremely helpful for SAHFs generally, and perhaps especially for those experiencing distress and depression.

Developing a sense of community is likely helpful for SAHFs experiencing depression for a number of reasons. In the first place, many of our participants described

loss of connection and isolation as having caused their depression; having a sense of affiliation with like-minded individuals experiencing some of the same difficulties likely ameliorates this sense of isolation. At the same time, it may be that participating in such groups by giving feedback and opinions could also increase a sense of self-efficacy and resonate with the value our participants seem to hold around providing and contributing. An empirical question, which our study did not address, but which these findings suggest may be useful, is determining what elements of social media participation appear to have protective effects for individuals, including SAHFs, experiencing depression.

In regards to the future of their role, our participants almost universally planned to return to work outside the home. Many of the participants were planning to return to work once their children were in school full time, while others were actively looking for work at the time of participation in the study.

The desire to return to work among our sample of SAHFs contrasts with previous research: In a 2012 study, Harrington and colleagues (Harrington et al., 2012) found that SAHFs were content in their role with no active plans to return to the job market. On the other hand, an Irish study of SAHFs was consonant with our results, in that all participants expressed a desire to return to work (O'Brien, 2012). While not specifically assessed in the present study, perhaps overall family financial status played a role in SAHFs decisions regarding return to work, given the importance placed on this factor in initiating the role. That is, it may be that once children enter school, the high costs of daycare no longer cancel out any earning the father may be able to contribute.

**How others perceive SAHF role.** Participants described both positive and negative reactions to their role as SAHFs, arising from family members, friends, and

mentors, as well as from members of the public. While this mixture occurred across both close and more distant relationships, participants more frequently identified positive reactions from members of the general public, and more frequently described negative reactions from family, friends, and mentors. Stay-at-home parents of both genders have both endorsed the perception that society does not respect their role, and that their work is perceived as uninteresting (Zimmerman, 2000). The finding that our participants typically experienced negative reactions to their role is concordant with previous research indicating that men in the SAHF role are looked upon less favorably than women who take on the role (Rossenwasser, Gonzales, & Adams, 1985) and experience stigma (Rochlen et al., 2010). In the largest study to date of stigma experiences among SAHFs (Rochlen et al., 2010), the majority of respondents (69.9%) who experienced a negative reaction to their role described this reaction as coming from a stay-at-home mother. This finding was not replicated in our study, as our participants did not describe negative reactions from stay-at-home mothers. However, several of our participants noted a dearth of resources for SAHFs as compared to SAHMs, and they described discomfort in situations where they may be the only SAHF with other SAHMs.

The fact that our participants described experiencing negative reactions more frequently from family members, friends, or mentors than from members of the public is intriguing. There could be multiple reasons for this relative increased frequency of negative reactions from friends and family, including, perhaps, greater comfort among family with disclosing honest and potentially painful opinions. It is also quite possible that reactions from people in the close personal surround have greater impact and thus are more available for recall when giving self-narratives. On the other hand, it could be that

members of the public who chose to make positive comments see themselves as advocates for changing gender roles, and perhaps advocates are more likely to speak up than possible detractors or traditionalists. The reasons for this discrepancy were not examined in this particular study; what is notable, however, is that participants seemed to experience more negative reactions from the people from whom they most likely needed support in order to feel confident in their role. Our participants noted that stigma, high levels of stress, and social isolation were all contributing factors to their depression; the perception of stigma from family members, friends, and mentors for our participants may have inculcated a sense of greater isolation and exacerbated the level of stress attending parenting, perhaps contributing to eventual depressive episodes.

On the other hand, previous research has not reported the positive reactions our participants experienced, especially from members of the public. This finding is likely reflective of the changing norms around masculinity and parenting roles, and our participants highlighted their perceptions of these changing norms, describing a “paradigm shift” and noting that the reactions to their role as a SAHF seem to differ depending on the age of the person with whom they are interacting (i.e., older individuals tended to be more suspect of the role, and younger individuals seemed to perceive the role as “normal.”). It could be, then, that as norms around masculinity and parenting continue to shift, future SAHFs may be exposed to less negative and more positive perceptions from members of the community at large, which could attenuate feelings of stigma and isolation that can eventuate in, or exacerbate ongoing, depression.

One final common description of others’ reactions to the role was our participants’ perceptions that people do not understand the role of SAHFs. It appeared

that our participants particularly felt that other people underestimate or undervalue the work that goes into being a SAHF, and for some, this lack of understanding led to a feeling of needing to go “above and beyond” in their efforts to prove their adequacy as care-givers. It seems quite possible that the felt-need to go “above and beyond” could be experienced as additional stress, which as noted earlier, was one of the described causes of depression among our participants. This lack of understanding may also contribute to feelings of isolation, which has the potential to exacerbate depression. Previous research has found that loneliness and low social support predict poorer outcome of untreated depression (van Beljouw, Verhaak, Cuijpers, van Marwijk, & Penninx, 2010). Returning to the social cognitive and SCCT literature (Bandura, 2001; Lent et al., 1994), these negative and lack of understanding comments from members in our participants’ social surround likely negatively impacted self-efficacy. This literature suggests that social persuasion, or the presence of supports and positive reactions of important others, plays a key role in improving self-efficacy (Lent & Brown, 2013). It may be helpful in counseling, then, to help SAHF clients identify areas of growing competence and reinforce these specific behaviors, building mastery over time in the context of a supportive therapeutic atmosphere. Similarly, helping SAHFs to reconceptualize their vocation *as* a career choice may prove useful in gaining buy-in for counseling. Future research could benefit from explicitly examining the SAHF process from a social cognitive career theory perspective.

**Self-perception of masculinity.** Participants were evenly split with regard to how they felt their own sense of their masculinity had changed since beginning the role of SAHF. Five of our participants reported an increase in, or stable sense of, their own

masculinity since entering the role, while five reported feelings of emasculation or a decreased sense of masculine security. Another two participants experienced ambivalence, reporting both increased and decreased feelings of gender security since beginning the role.

To our knowledge, this is one of the first studies that has explicitly asked participants to reflect on the evolution of their sense of masculinity since taking on the role of SAHF. Two previous studies (Colombo, 2008; Rochlen et al., 2008) have compared measures of traditional masculinity (CMNI) and gender role conflict (GCRS) between SAHFs and men who were working, and found that the SAHFs rated themselves lower on both scales. Our participants who noted an increased sense of masculinity did not necessarily map their descriptions of masculinity onto traditional notions such as winning, dominance, emotional suppression, and anti-femininity (Blazina, 2001; O'Neil, 2008, Thompson & Pleck, 1995). Instead, they felt that becoming increasingly comfortable with their role was a signal that they were also more stable and secure in their sense of themselves as men. For others, taking on additional caretaking roles was seen as a new type of provider-ship, which increased a sense of masculine responsibility.

On the other hand, several respondents reported feeling a decreased sense of their own masculinity. These participants lamented the loss of their ability to provide financially, which led to feeling emasculated, and frequently impaired the level of intimacy they felt able to have with partners. Some worried that their partners no longer found them sexually appealing due to their taking on this care-giving role or for no longer having the markers of traditional masculinity (e.g., high-powered job, making money,

traveling). Others felt emasculated in groups of male acquaintances and friends, who were still in the workforce.

Perhaps most interesting was the finding that a few of our participants re-cast their role as a SAHF in terms congruent with traditional masculinity, as captured by a participant who noted that being able to “reduce” himself to putting on make-up with his daughter *is* masculine. This “reduction” can be seen as a form of self-sacrifice or emotional stoicism, which accords with traditional descriptions of masculinity (O’Neil, 2008; Smiler, 2006). Another participant expressed a belief that stay-at-home parenting has “always” been a masculine role, in that one needs to have the traits of “an alpha male” (bull headed, strong, steadfast) to be successful. This recasting of stay-at-home parenting as being not only masculine but “alpha” male accords with Brannon’s (1976) descriptions of masculinity (e.g. “Big Sturdy Oak”). Furthermore, the participants’ recasting of the role of stay-at-home parenting as being definitionally masculine can be seen as an enactment of the masculine norm of taking control and independence (Dec Oster & Heimer, 2006). For these participants, it may be that one way in which they preserve and assert their masculinity is through defining for themselves what it means to be masculine.

Summarizing, then, these SAHFs entered the role for both financial and child-valuing reasons, both of which are tied to the notion of “providing” for their families. Thus, “providing” may be extended beyond breadwinning to include a maximization of both familial financial resources, as well as the emotional/social investment in offspring. The home care and childcare tasks described by our participants mirror those that have been described by SAHMs, while confidence in their ability to execute these tasks was

mixed. It may be, then, that building SAHFs sense of self-efficacy in the typical tasks of stay-at-home parenting will be important going forward. Finally, SAHFs, in responding to both a sense of isolation and a desire for places to increase sense of self-efficacy, turned to on- and off-line social networks for social support.

### **Depression and Help-Seeking while a SAHF**

Another question this study sought to explore was the ways in which SAHFs experience depression, and how they navigated seeking help for depression. This question was stimulated in part by the literature, which has shown a correlation between aspects of traditional masculinity and depression, and well as unique symptom patterns for men who experience depression (e.g. “Masculine” or “Masked” depression) (Cochran & Rabinowitz, 2000; O’Neil 2008; Pollack, 2005). Furthermore, given the lack of research with SAHFs, we were interested in the ways they have sought help for their depression.

**Mental health history prior to becoming SAHF.** Though not an explicit part of our interview protocol, some participants provided information on their mental health history, including previous treatment experiences. A few of our participants described previous episodes of depression and/or anxiety disorders. This should not be surprising, as depression is often chronic, with even mild symptoms predicting future episodes and functional impairment (Klein, Schwartz, Rose, Leader, 2000). These previous depressive episodes were most frequently described as being precipitated by family distress and loss, whether loss of a job or of a relationship. As will be discussed, these themes of family distress and loss continued to be salient in participants’ perceptions of causes of depression. It may be that those willing/interested in taking on the SAHF role, who may

place a high value on family relationships, are particularly sensitive to perturbations in their families, which then contribute to depressive episodes.

**Descriptions of depression while a SAHF.** Our participants described their experience with depression during their tenure as SAHFs. Symptomatic descriptions generally accorded with DSM-V depictions, with the two most prevalent themes being “pulling inward” and increased negative emotionality. The “pulling inward” theme included anhedonia, loss of motivation, social isolation, and feelings of resignation, while negative emotionality included crying, misery, desperation, anger and irritability. In some ways, these two major themes reflect the division of depressive symptoms measured on scales of masculine depression, such as the GMDS (Rutz, 1999) and the MDS (Magovcevic & Addis, 2008). These two scales measure both prototypical, internalizing symptoms of depression (e.g., feeling burned out, tired, or hopeless; having difficulty making decisions; experiencing sleep problems) as well as less typical and/or externalizing symptoms (e.g., aggression, irritability, overconsumption of alcohol or related substances) that are thought to be correlated with masculine presentations of depression. In particular, the descriptions of desperation, anger, and misery given by our participants and collected under the negative emotionality theme may be reflective of these more externalizing, typically masculine symptoms. Even though our participants endorsed having increased negative emotional experiences (e.g. crying, irritability), they more frequently described withdrawal or “pulling inward” experiences. It may be that a sense of isolation and helplessness attending taking on the SAHF role (e.g. due to financial constraints) led these participants to further social withdrawal in order to avoid possible negative perceptions and comments from others, as described above. This cycle

of withdrawal and avoidance may have eventuated in a sense of resignation, and perhaps exacerbated a sense that participants were not “contributing” or being the parent they wanted to be, again further worsening a self-critical internal monologue.

Our study found limited evidence that would support the Masked Depression construct (Cochran & Rabinowitz, 2000). As noted previously, this is a difficult, if not impossible, construct to validate presently, as it presumes that externalizing behaviors such as problematic anger, substance abuse, and antisocial personality disorder are in fact masking a latent depressive disorder. A few of our participants described problematic reliance on substances, which they occasionally connected to their descriptions of depression, suggesting they were self-medicating. However, it is difficult to say whether these behaviors truly represent a symptom of an underlying prototypical depression or are instead a response to the depression descriptions that were more heavily endorsed (pulling inward and negative emotionality).

**Perceived causes.** There was little consensus among our participants on their perceptions of what had caused their depression, which may reflect the multiplicity of pathways to depression (Kendler et al, 2006), but which also likely speaks to the limitations of self-awareness when it comes to explaining complex biopsychosocial phenomenon such as depression. Our results suggested that SAHFs perceived social isolation, lack of spousal support, not being the parent or partner they would like, loss of employment and independence, stigma related to the SAHF role, biological and genetic factors, and high levels of stress as contributing to their depression. As noted in the literature review, Kendler and colleagues’ (Kendler et al., 2006) developmental model of depression in men suggested three primary pathways to depression. The first path,

internalizing symptoms, was comprised of genetic risk factors, neuroticism, low self-esteem, early-onset anxiety, and past history of major depression. A second pathway, labeled externalizing symptoms, comprised genetic risk factors, conduct disorder, and substance misuse. The final pathway, adversity and interpersonal difficulty, comprised predictor variables of low parental warmth, childhood sexual abuse and parental loss, low education, lifetime trauma, low social support, history of divorce, past history of major depression, marital problems, and stressful life events.

Using these three pathways as a comparison point, it is evident that our participants provided little in the way of their perceptions of how distal events may have contributed to depression (e.g. low parental warmth, childhood sexual abuse, early-onset anxiety), and were more focused on proximal events (e.g., low social support, marital problems, stressful life events) as captured primarily in the third pathway provided by Kendler (Kendler et al., 2006). It is also notable that the Kendler study found that childhood parental loss appeared to have more diverse and potent impacts for men as compared to women. Our participants variantly noted, in fact, that the loss of their own fathers was an impetus for entering the role, and it is possible that such loss not only motivated them to take up the role but also influenced their developing depression. The reasons why this might be remain obscure, though psychoanalytic gender models may provide one avenue of understanding. Traditional psychoanalytic theory has argued that in order to establish a normal and healthy sense of masculinity, the young boy needs to disidentify with his mother and counteridentify (e.g., find a male role-model, guiding the boy away from all things “feminine”) with his father (Greenson, 1968). In a situation where the young male child has lost his father, the child may begin to feel guilt over his

perceived role in driving the father away, or may begin to punish himself as a way to punish the internalized father image. Such early loss may also predispose an individual to be fearful of future losses, with depressive symptoms serving as a means for securing interpersonal reassurance and attachment. While interesting theoretically, more research would need to be conducted to determine the relationship between early parental, and perhaps especially father-loss, with the development of depression among SAHFs.

What was clearer from our results is that feelings of interpersonal isolation were perceived as contributing to our participants' depression. This result is concordant with literature examining depression in fathers generally, which suggests social isolation is a major contributor to depression (Boyce, Condon, Barton, Corkindale, 2007; Condon, Boyce, & Corkindale, 2004; Deater-Deckard, Pickering, Dunn, & Golding, 1998; Leathers, Kelly, & Richman, 1997), and literature that suggests social isolation is one of the most frequently described symptoms of depression among men generally (Hoy, 2012). It is useful to point out that SAHMs have also identified social isolation as a feature of taking on their role, and have connected this sense of isolation to descriptions of depression; however, research thus far has indicated that SAHFs tend to endorse isolation at greater rates and describe such isolation as distressing more frequently than their SAHM counterparts (Whelan, 2002; Rochlen et. al., 2008, Zimmerman, 2000). The identification of isolation as contributing to their depression reinforces the idea presented by our participants suggesting that connecting via online social communities was an important way they sought support, both for their role as SAHFs and as a means to cope with depression.

It is also interesting to note that our participants did not primarily explain the cause of their depression in structural terms (e.g., financial concerns, poverty, unemployment, stressful working conditions), as has been the case in previous research (Hoy, 2012; Matthews et al., 2013). While these factors were occasionally mentioned (e.g., loss of employment and independence, high levels of stress), relational factors such as social and spousal isolation, and parenting difficulties and disappointments were more prominent. As these participants have moved out of the work-world, it may be that relational issues have become more salient and thus more of a focus for their sense of depression. On the other hand, men who are willing to take on the role of SAHF may be more attuned and sensitive to interpersonal concerns based on underlying personality characteristics; future research could investigate such a hypothesis. It is also interesting to note that previous research has found that social isolation is frequently described as a *symptom* of depression by men (Hoy, 2012), but less frequently as a cause of depression. For our participants, social isolation appeared to function as both cause and effect of depression, at least to some degree.

Finally, it is worth looking at our participants' views on what caused their depression in light of Pleck's role strain theory, as well as Valkonen and Hanninen's (2012) grounded theory work examining depression in men. Our participants' views on what led to their depression fit with Pleck's discrepancy role strain model, as they suggested that their failure to achieve traditional markers of masculine success (high-powered job, independent self-sufficiency) led to social isolation, loss of spousal support and connection, and ultimately stigma from members of the public, which reinforced negative self-evaluations and contributed to depression. These descriptions also fit well

with Valkonen and Hanninen's (2012) description of a subgroup of depressed men they labeled "Challenging Hegemonic Masculinity." This group was described as seeing masculine norms as barriers to wellness and happiness, and viewing their depression as a consequence of their unwillingness to live up to masculine norms. It appeared that our participants did not neatly fall into either the discrepancy role strain or "challenging hegemonic masculinity" models, but expressed a mixture of the two, and indeed seemed to attempt to re-establish a sense of masculine role as a reaction to the sense of having lost some masculine currency through taking on the role of SAHF. This process was especially apparent, as noted earlier, in their recasting the role of SAHF as being *definitively* masculine. It could be, then, that similar to the "Real-Men, Real Depression" campaign (Rochlen & Hoyer, 2005), efforts to characterize the SAHF role as one congruent with generative, positive aspects of masculinity could attenuate feelings of loss and isolation that may contribute to depression among this population.

**Coping.** The most frequently endorsed coping strategies employed by our participants were distraction and activity-based coping. These strategies included approaches as varied as playing video-games, going for a walk to distract from negative cognitions, and writing. Such approaches seem to be consistent with attentional re-deployment (Tamres et al., 2002), and the prevalence with which these more active coping methods were endorsed is consistent with the observation that men tend to employ more active, if more restricted, coping styles than women, who tend to rely more on rumination (Nolen-Hoeksema, 1990, 2012). In some ways, these active, distraction-based coping strategies were likely beneficial in the short term; however, previous research has also shown that an over-reliance on distraction, a form of avoidance, can exacerbate

depression (Spinhoven, Drost, de Rooij, van Hemert, & Pennix, 2014), and previous research on men's descriptions of depression has shown that such avoidant strategies only provide short-term relief and can lead to worsened mood (Greenfeld et al., 2009). It would appear, then, that similar to men in general (Nolen-Hoeksema, 1990, 2012), our participants tended to rely on active, distraction-oriented coping methods, which, while helpful in the short term, may have reinforced interpersonal and cognitive patterns that kept depression in place.

**Effect of depression on others.** Participants discussed the effect their depression had on others in their social surround, most commonly by noting the negative effects their depression had on other family members. Such effects included their not being as available for their children or partner as they would like, and a feeling that their negative mood-states had a contagion effect. Interestingly, as will be discussed below, this sense of their depression having a negative effect on family members was a prime motivator for seeking help. This perception of increased burden on family members further exacerbated participants' own depressive symptoms, in a negative feedback loop. This result is consistent with previously reported accounts of men's depression (Greenfeld et al., 2009), wherein men described depressive symptoms being aggravated by environmental factors and their own negative reactions to these environmental factors. In the case of our study, the "environmental factors" included relational discord subsequent or concurrent with depression, and self-perceptions of deficient parenting. Also similar to other research (Greenfeld et al., 2009), the attempt to conceal increased suffering from family members, due to the perceived negative effects that their depression was having on family members, in reality exacerbated the situation. It would appear, then, that SAHFs may be

acutely aware of the potential negative ripple effects their depression has on family members, which can in turn be a prime point of leverage for moving these men to consider seeking help.

**Help-seeking for depression while a SAHF.** Our participants described ways they sought help for depression, including motivating factors, type of help sought, facilitating factors, and barriers to their seeking help. These results will be discussed below.

As noted above, our results suggest that one of the primary motivating factors for seeking help among our participants was the desire to protect their families from perceived possible harm or neglect related to participants' depression. This appears to be a novel finding in the literature, and differs from previous findings on motivating factors for help-seeking among depressed men. In the first place, it is worth noting that little research has investigated motivations for help-seeking among men. Where this research has been conducted, a consistent finding has been that the encouragement of a trusted partner (e.g. friend, partner) helps to lower men's inhibitions about seeking help (Good, Dell, & Mintz, 1989; Greenfield et al., 2009; Mahalik, Good, & Englar-Carlson, 2003; Vogel, Wade, & Haake, 2006). Our results suggest that the mere presence of a valued other (e.g. child, partner) was sufficient in motivating these men to seek help; any direct intervention by the other was not required.. The motivation provided by the presence of a valued other was especially well summarized by the participant who noted that, were it not for having a child, he would have "taken the honored male way out of sucking it up and dealing with it (depression)." The presence of children, and potentially, the increased sense of responsibility for their well-being, given the context of our participants' greater

role in day-to-day childcare, seemed to bring a new sense of responsibility for self-care in the service of being the best fathers they could be. It seems likely, then, that efforts to position the idea of seeking help within narratives highlighting a sense of responsibility and improved ability to father may improve efforts to recruit SAHFs into treatment for depression. Our participants also reported that emotional and/or relational distress motivated them to seek help. It appears likely that these two findings (relational distress and protecting families from potential harm) are inter-related, and suggests that SAHFs appear particularly motivated to seek help due to relational concerns.

Our results also provided novel information on what sort of help SAHFs may tend to seek for depression. Participants most often reported seeking help from professional therapists. A subset of our participants were specifically not interested in medication, which in part drove their decision to seek talk-therapy, while others were referred by their insurance. The finding that several participants were disinterested in medication accords with previous research indicating that a frequent barrier to help-seeking among men is concern over being medicated (Hoy, 2012). Additionally, it makes sense that there appeared to be a preference for talk therapy over medical help-seeking, given the psychosocial factors that participants seemed to more frequently identify as the source of their distress.

In summary, our participants' descriptions of depression generally accorded with traditional (e.g. DSM-V) depictions, highlighting a sense of withdrawal and isolation, in addition to increased negative emotionality. Feelings of isolation and helplessness attending taking on the role of SAHF may have led to further social isolation in an effort to avoid potential negative perceptions and feedback, in turn exacerbating a sense of low

self-efficacy and the feeling that participants were not “contributing” in being the parent they wanted to be. While there was little consensus on what may have caused their depression, participants tended to highlight feelings of loss (of connection, excitement, independence). This result is concordant with previous literature that has highlighted the role of isolation in contributing to fathers’ depression, and research that has shown men cite frequently cite isolation as a symptom of depression. Our results bring these previous data together, in that participants described social isolation as both a cause *and* effect of their depression, at least to some degree. It appears evident, then, that a sense of isolation is salient for SAHFs in describing depression, which is notable in that this is not a symptom of a major depressive episode in the DSM-V. Similar to men in general, these SAHFs tended to use active and distraction-oriented coping methods, which, while helpful in the short turn, may have reinforced cognitive and interpersonal patterns that kept depression in place. Our participants appeared acutely aware of the ways their depression may have negative effects on family members, which became one of the primary motivators for their help-seeking. They had a preference for talk therapy with professional therapists, consistent with their self-understandings of the causes of their depression, which tended to emphasize psychosocial aspects.

### **Therapy Experiences while a SAHF**

Nine of our participants engaged in therapy for depression during their tenure as SAHFs. These results provide novel information regarding how SAHFs experience psychotherapy for depression.

Participants tended to have been in therapy less than one year, and usually had therapy sessions less than once weekly. Two outliers had an average of 55 individual

sessions, while the remaining seven had an average of 4.6 sessions. While this number (4.6) is greater than the modal number of therapy sessions in the public at large (e.g. 1 session), it is less than the mean (e.g. 8.5 sessions) (Gibbons, Rothbard, Farris, Stirman, Thompson, Scott, Heintz, Gallop, & Crits-Cristoph, 2011).

Our participants described having good relationships with their therapists, which they characterized using terms such as “professional” and “open.” As has been repeatedly shown, aspects of the therapeutic alliance, such as common task focus and therapeutic bond, likely contributed to this perception of a positive relationship (Horvath, 2011; Muran & Barber, 2011). Indeed, a shared therapeutic focus appeared to contribute to positive relational perceptions, as the most frequently endorsed positive aspect of treatment was therapists using techniques that matched participants’ concerns. While each participant brought unique issues to the therapy room, there was a shared sense of being helped most when their therapists were able to attune and modify their techniques to match these specific concerns. Participants tended to recognize their therapists’ ability to match their concerns through feedback or interventions that therapists provided: One participant noted that his therapist is “tough in consistently pointing out negative self statements...which I need,” while another noted that he came to greater self-understanding through his therapist providing “strategies and feedback” specific to his concerns. To our knowledge, only one study (Bedi & Richards, 2011) has examined treatment alliance specifically for men, finding that the strongest predictor of alliance for men is the therapist “bringing out the issues,” which includes asking questions, providing suggestions, identifying feelings, and discussing goals. It may be then, that similar to men in general, SAHFs feel most helped by therapists who take an active stance, help the

client identify goals and feelings, as well as provide more suggestions and feedback than may be typical. This result is consistent with the psychotherapy research literature at large, which suggests that outcome can be improved by adapting interventions to particular clients' needs (Castonguay & Beutler, 2006; Norcross & Wampold, 2011).

Our participants reported ambivalence regarding their progress in, and satisfaction with, therapy. This ambivalence was expressed in several ways, such as describing a split between the "rational" part that feels helped and the "irrational" part that continues to feel mired in anxiety and self-hate. Others described their ambivalence in more stereotypically masculine terms, noting that they could "take it or leave it" (psychotherapy), in a sense reasserting self-control and dominance norms. The reassertion of self-control through expressing ambivalence about therapy would mesh well with previous descriptions of men's recovery from depression, which have included re-establishing a sense of hegemonic masculinity (Emslie, Ridge, Ziebland, & Hunt, 2006), and is particularly interesting considering that a number of our participants felt a loss of masculinity associated with the SAHF role. It could be, then, that part of their effort to recover from depression involved downplaying the role of therapy, in order to increase a sense of personal agency and recover ownership of traditional masculine role norms. On the other hand, it is also possible that this ambivalence reflects the sometimes limited gains that have been associated with both pharmacological and psychosocial treatments for depression (Paykel, 2008). One final consideration is worth noting, in relation to Pollack's (2005) conceptualization of male depression and suggestions for psychotherapy. Pollack (2005) has described early relational disruption in which young males are forced to "disidentify" with the mother (e.g., avoiding all activities and

behaviors thought to be feminine, such as crying when hurt, expressing feelings) and repudiate all things feminine as “normative male-gender-linked trauma” (p. 205), which may cause males to develop an exaggerated sense of mastery and control, concealing an inner core of shame and depletion. This, in turn, is thought to create what has been described above as “masked depression” (Cochran & Rabinowitz, 2000; Pollock, 1998). Pollack (2005) has thus suggested that it is important to support male patients’ need to believe that the therapy and the therapist are unimportant, and suggests a self-psychological approach in which, rather than directly confronting a male client’s defenses, the therapist attempts to replicate the early holding environment and provide a stable, idealizing self-object experience. The curative effect is thought to derive from providing the client with reflective, empathic, and idealizing responses that attenuate earlier relational damages. While difficult to ascertain at the level of inquiry of the current study, our participants’ ambivalence regarding therapy could be seen through this psychoanalytic developmental framework, and it may be that the repudiation of a sense of being helped by therapy is actually a practical effort to re-establish a sense of mastery and self-idealization. At present, however, this suggestion remains theoretical.

Despite our participants typically reporting ambivalence regarding their satisfaction with and progress made in therapy, they nearly universally expressed a willingness to seek help in the future, and reported that they would recommend other SAHFs also consider seeking therapy. The willingness to seek future therapy in the face of ambivalence regarding satisfaction may be mediated by the quality of the therapy relationships described; this suggestion would fit with previous research, which has found that therapeutic bond is the most robust predictor of perceptions of treatment helpfulness

and future help-seeking (Cusack, Deane, Wilson, Ciarocchi, 2006). The fact that these SAHFs reported they would encourage other SAHFs to consider therapy is also useful to consider in light of previous research on men's descriptions of help seeking. Hoy (2012) found that the most commonly described facilitative factor in help-seeking across 52 studies investigating men and depression was having a trusting relationship with someone who encouraged help seeking. Given that our participants seem to rely on communities of fellow SAHFs for a sense of connection and solidarity, it is likely that relationships amongst these in-person and online groups of SAHFs could lead to greater willingness to engage in therapy. Willingness to engage in future therapy may especially be likely if trusted individuals or leaders within such communities provide narratives of their own helpful experiences in therapy.

In sum, our results suggest that SAHFs experiencing depression may benefit from engaging in therapy focused on interpersonal concerns (e.g. loss of social connection, "excitement"), and from working with therapists who are able to attune to the particular needs of their client and deliver therapy that is perceived as being coherent and consistent to those specific needs. It also appears that, though they may not outwardly express a sense of progress and satisfaction, if the preceding factors are in place, SAHFs are likely both to consider seeking help as needed in the future, and to refer other SAHFs to do so as well.

### **Closing Results**

Participants were primarily motivated to participate in this research out of a desire to advocate for or help other SAHFs. It appeared that the urge to have their story heard was intended to be altruistic, again perhaps reflective of the provider/protector role

associated as a positive aspect of masculinity. These participants appeared hopeful that the provision of their experience and personal wisdom could help protect other SAHFs from negative perceptions and stigma experiences, and provide support for the idea of seeking help when needed.

### **Limitations**

First, our participants and their partners had fairly high levels of education and income, and were primarily Caucasian and heterosexual, and thus may not reflect the experiences of those with less education, lower income, or those from other racial/ethnic groups or sexual identities. Additionally, our participants' children ranged in age from early infancy to teenage years; much of the research on depression in fathers has focused on the transition to fatherhood, and it is likely that the difficulties facing a new parent are different from those facing an experienced parent of teens. Another limitation is in the distribution of our participant's therapy experiences; of the nine participants who engaged in therapy during their tenure as SAHFs, two outliers had an average of 55 individual sessions, while the remaining seven had an average of 4.6 sessions. Therapy experiences with such a wide range of session numbers may not be comparable. Given that this was a dissertation project, the primary investigator took responsibility for conducting all of the interviews, which may have affected data collection, especially considering that the PI was a male interviewing other males, in part, about their masculinity. Finally, our study relied on snowball sampling and online recruitment, and we attracted most of our participants from online SAHF groups. This recruitment strategy may have tapped into men who already are in an "advocate" role, and thus may not reflect the experiences of all SAHFs seeking help for depression. It would be useful to

gain info on experience of SAHFs who are not plugged into these online communities, especially given the role these communities appear to play in coping with both the stresses of being a SAHF and with depression experiences in particular.

### **Implications for Practice**

This research suggests several practical implications. Our participants clearly value being in the role of SAHF, especially in as much as they are able to deepen relationships with their children in service of role-modeling and influencing their children's development. Efforts should be taken to reinforce the positive role that this group plays in contributing to their children's development, especially given the potential negative impacts of bias towards men taking on this role. This investment in providing for their children's well-being has possible negative repercussions, however, especially when a sense of social and spousal isolation leads to a cycle of further withdrawal and eventual depression, which our participants acknowledged had negative effects on their family members, further deepening their negative self-evaluations. Thus, it appears that developing robust social networks outside of the work-world is important for SAHFs, and these can be developed both in person and on-line. Our research implies that many SAHFs benefit from the sense of community they find in online communities of like-minded fathers, and these positive effects could be enhanced by further development of localized, in-person meetings and groups. Mental health practitioners with an interest in issues of masculinity, fathering, and parenting in general should thus consider developing both psychoeducation opportunities, support groups, and therapy groups for SAHFs in their communities. One potential avenue for such groups would be prenatal fathering skills-groups, aimed at exposure to the tasks associated with SAHFathering (changing

diapers, swaddling, soothing the baby). Such groups would likely improve SAHFs' sense of self-efficacy through enactive attainment (e.g. experience), modeling, and positive reinforcement (Bandura, 2001). Programs such as "Basic Training For Dads" ([www.menexcel.com](http://www.menexcel.com)) provide frameworks for developing such groups.

Our participants re-cast the role of stay-at-home parent as being definitionally masculine, and were motivated to seek help in order to "protect" their families from perceived harm subsequent to their depression. It seems, then, that marketing and public health efforts aimed at positioning help-seeking as a fundamentally masculine trait, associated with the provider/protector role, and as a means for improving parental self-efficacy, may improve efforts to recruit SAHFs into therapy. Efforts such as the "Real Men, Real Depression" campaign (Rochlen et al., 2005) could provide useful starting points for such efforts. These efforts would be best served by using real stories of SAHFs, explaining both the joys and trials of their role, and highlighting positive help-seeking experiences. Authentic stories from peers, framing help-seeking as one way in which they "took charge" of both their own well-being, but importantly, in service to the larger value of caring and providing for their families (e.g. generative fathering), would likely have a strong impact on other SAHFs considering seeking help. Dissemination of such marketing materials could take place via the nodes of connection already being developed organically by groups of SAHFs, including *athomdadnetwork*, *Reddit*, *Facebook*, and *meetup*.

Our results also suggested that prior exposure to therapy in and of itself, whether positive or negative, was adequate to lower SAHFs' inhibitions about seeking help. It may be useful to consider integrating brief, prevention-oriented therapy or psychoeducation

into prenatal programs for fathers, especially when those fathers are considering becoming SAHFs. It seems likely that even such brief exposure may facilitate future help-seeking if and when these fathers experience depression. One aspect of such programming that would likely be helpful would be informing fathers about the various ways in which men in general, and SAHFs in particular, have described experiencing depression, especially drawing attention to the propensity to further withdraw socially and to experience a greater range and frequency of “negative” emotions. It would also be useful to provide education on the full range of treatment options for depression, including evidence for psychotherapy, given our participants’ concerns about being medicated. It also appears it would be prudent to screen fathers for depression using both traditional (e.g. EPDS, PHQ-9, BDI-II) and masculine specific (MDS) scales both prior to the birth of their children, and following their transition into the role of SAHF. Such screenings may be fruitfully integrated into pediatrician visits, given that it appears far less likely, based on the value of “being there” and providing for their children, that SAHFs would skip care for their own child than they might care for themselves.

Additionally, there is some evidence that men are more likely to experience a spike in depression 3-6 months post-partum (Paulson & Brazemore, 2010), and should thus be monitored in this critical window in particular. There is emerging evidence that online delivery systems for therapies targeting postpartum depression in women have been effective, and these methods should be expanded to working with SAHFs. Two studies have examined the efficacy of an online behavioral activation (O'Mahen, Woodford, McGinley, Warren, Richards, Lynch, & Taylor, 2013) and combined behavioral activation and cognitive behavioral treatment (Danaher, Milgrom, Seeley,

Stuart, Schembri, Tyler, & Lewinsohn, 2013). Both studies showed significant reductions in depressive symptoms over a relatively short period of time (6-12 weeks), and would likely be beneficial for SAHFs as well.

Several implications also emerge for therapists who work with SAHFs experiencing depression. Interpersonal issues, including a sense of social isolation and relationship distress, will likely be salient themes, and therapists working with SAHFs should assess for these concerns during early meetings. Therapists may want to balance providing an open, empathic space for SAHFs to address their concerns, with providing a concrete rationale for how their treatment modality matches the specific concerns brought to bear by their client. These are likely to be beneficial tactics in therapy generally, but appear particularly salient for SAHFs. Therapists would also benefit from assessing and reinforcing SAHFs' engagement with social networks outside of their families. Knowledge of local and national SAHF groups may be useful for therapists to have at hand, and providing such information may help consolidate the therapeutic alliance. Clients' greater involvement in SAHF groups may be particularly helpful for addressing issues related to stigma. It could also be important to frame seeking social support not just in terms of the personal benefits that may accrue, but through providing research that higher level of social support is predictive of better overall family functioning (e.g. Dimitropoulos, Carter, Schachter, & Woodside, 2008; Rochlen et al., 2009). This information would likely resonate, given the importance SAHFs place on seeking help in order to attenuate possible negative familial consequences.

Given that all of our participants were planning on returning to work, it would thus be useful to learn more about career-related implications for men who chose to take

on the SAHF role. For those in therapy, it may be helpful to prepare for the transition back into work, as these role transitions have been identified as particularly sensitive periods for exacerbating depression. For therapists working with SAHFs who identify career concerns, it may be useful to situate discussions of fathering as a career, exploring the ways in which pursuit of this role is another form of being a provider. Social Cognitive Career Theory (Lent & Brown, 2013) provides a useful framework for helping SAHFs consider their options and efficacy in navigating a return to work, and providers may consider using such a framework in working with SAHFs.

Given that role-transitions appear to be particularly critical periods in the development of depression for SAHFs, as noted above, it may be beneficial to include psychoeducation for both parents (in dual-partner households) regarding warning signs of depression in the months leading up to, and following, the birth of a child, and any other significant role transitions such as moving into a full-time caregiver role. Our recommendation here echoes Rochlen and colleagues' work (Rochlen et al., 2008) in the suggestion that clinicians working with couples or men considering becoming SAHFs may want to engage these parties in discussion of their gender beliefs and how these beliefs may affect their transition into the role. Our research further implies that partners should be encouraged to monitor each other's mood and behavior over the initial months in the new role. Again, as noted above, pediatricians and family physicians should consider regularly monitoring new fathers' mental health, especially in the 3-6 months post-partum. Providers might also consider developing short pamphlets highlighting information about male depression, and the full range of treatment options beyond just medication.

Therapists may also consider exploring the experiences SAHFs had of their own fathers. Many of our participants were motivated to become SAHFs based on the loss or absence of their own fathers, and also at times struggled with how their fathers may or may not accept their taking on the primary provider role. For SAHFs experiencing depression, exploration of their value of “being-there” for their children, especially in light of potential loss of their own fathers, may be a leverage point for recalibrating away from distraction and avoidance-based coping and towards pursuit of the value of “being there” for their children more fully.

Finally, family or couples therapy approaches should certainly be considered a first-line approach to treatment for SAHFs experiencing depression, given the primacy of relational distress and isolation in narratives of SAHFs’ depression experiences, and given the importance placed on seeking help in order to be better providers and parents. Therapists using these approaches may consider involving wider family networks beyond the partner/child systems, given the sense of negative familial evaluations many of our participants described, and the potential that internalization of these negative messages may exacerbate depressive cognition.

### **Implications for Research**

While our research provides a rich perspective on how SAHFs experience depression, help-seeking, and therapy, the findings also suggest areas for future research. We did not disaggregate SAHFs who chose to take on the role from those who felt more compelled by external factors (e.g., job loss) in moving into the role. Future research would benefit from examining and comparing these groups, especially in terms of differences in contributing factors to depression and perceptions of helpful aspects of

therapy. There may be significant differences in adjustment experiences between these two groups, and a more refined understanding of these differences would help illuminate prevention and intervention approaches. Similarly, as noted in the Limitations, our participants' children had a fairly wide age range, and we did not disaggregate "new" fathers from those with more experience. Given that these parents likely have different stressors at different developmental periods (both in terms of their children and their development as fathers), future research would benefit from looking at more homogenous groups in terms of years-of-parental experience and/or age of child.

It would also be beneficial to conduct further research examining the protective role of online social support versus in-person social support for SAHFs. Given the important role online SAHF groups appeared to play for our participants, and the more limited options for in-person SAHF groups that may exist due to demographics (e.g., relatively few SAHFs in some parts of the country), a greater understanding of the specific aspects of online social support that appear to help SAHFs is warranted.

Our study did not find partner mental health concerns being discussed by our participants as contributing to their own depression. This is a marked difference from previous correlational research that has indicated spousal depression as a primary factor in predicting depression in fathers (Bielawska-Batorowicz and Kossakowska-Petrycka, 2006; Dudley et al., 2001; Gao et al., 2009; Matthey et al., 2003; Pinheiro et al., 2006; Roberts et al., 2006; Zelkowitz & Milet, 1997); thus, future researchers should consider developing protocols more specifically examining the role of partner mental health in SAHFs' own sense of well-being.

SAHF groups, both online and in-person, were a significant source of support for these participants, and future research would benefit from learning more about what aspects of these groups are most helpful. Our participants were advocates for SAHFs in general, and much could be learned from conducting focus groups with already established SAHF organizations to learn about their successes and challenges, and to understand what additional resources they may need. In addition to focus groups, given the advocate position that many of our participants took, and the importance of having a sense of contributing, one further avenue for research that may yield important benefits could be participatory action research. Projects focused on investigating barriers to help-seeking among SAHFs from within their own communities may be beneficial, as could projects examining how societal aspects such as maternity/paternity leave affect the development and course of depression among groups of SAHFs.

Researchers should also consider learning more about providers' comfort with and knowledge of working with SAHFs, especially given the importance this group seems to place on having providers with experience in their concerns. There is some evidence that mental health and medical providers are less likely to diagnose men in general with depression due to gender bias (Potts, Burnam, & Wells, 1991), and thus learning more about the expectations and stereotypes that clinicians carry about SAHFs in particular may help illuminate diagnostic proclivities and treatment implications.

Further empirical work examining measures of masculine-type depression in SAHFs is also warranted. One avenue for such research could include using masculine depression scales, including the GMDS and MDS, to compare SAHFs with working fathers and with non-parenting men. It would be interesting to determine if there are

unique symptom profiles within each of these groups, and if so, how treatment might be modified to target said differences.

Finally, given the somewhat limited experience our participants had in therapy, it would be useful to conduct further research examining therapy experiences among SAHFs who have satisfactorily completed treatment for depression. Specifically, learning more about what these SAHFs have taken away from positive therapy experiences could help tailor primary and secondary prevention programs. It would also be useful to learn how these therapy experiences have or have not affected participants' sense of self-efficacy as SAHFs, beyond reduction of depressive symptoms.

### **Conclusion**

In summary, the findings from this study indicate that SAHFs who have experienced depression during their tenure as SAHFs note relational distress, social isolation, loss of independence, and social stigma as contributing to their depression. These SAHFs placed a high value on providing for their families, in the form of sacrificing aspects of themselves in order to care for the family at large, including, at times, altering stereotypical masculine scripts (e.g., "suck it up") in the service of protecting or improving their family's well-being. This alteration of stereotypical masculine scripts was perhaps most clearly illustrated by our participants' re-casting of the SAHF role as being definitionally masculine, and through their descriptions of being motivated to seek help for depression after realizing the potential negative aspects their depression was having on family members, in order to protect their families. There appears to be a growing, SAHF-driven development of social support networks, which our participants tended to rely on to cope both with the isolation of being in their role,

and as a means to attenuate and distract from depressive symptoms. While it is unclear how satisfying such online connections may be in the long term, at present they appear to be significant sources of support for this growing minority of parents. Even when our participants experienced ambivalence regarding their therapy, they appeared motivated to return as needed, and strongly endorsed therapy as a viable means for addressing depression. As this population continues to grow in both numbers and cultural prominence, it will be important to continue learning about their specific experiences and difficulties, and future research is thus encouraged.

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**Appendix A**  
**Demographic Form**

Code Number (to be completed by researcher): \_\_\_\_\_

First Name: \_\_\_\_\_

Age: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Relationship Status:

\_\_\_\_\_ Married

\_\_\_\_\_ Partnered/Cohabiting (Living together, but unmarried)

Total # of children in the family currently living in the home: \_\_\_\_\_

Age(s) and sex of children currently living in the home: \_\_\_\_\_

Highest level of education completed:

You: \_\_\_\_\_

Partner/Spouse: \_\_\_\_\_

Annual Household Income (US Dollars):

\_\_\_\_\_ 0-30,000

\_\_\_\_\_ 30,000-50,000

\_\_\_\_\_ 50,000-75,000

\_\_\_\_\_ 75,000-100,000

\_\_\_\_\_ >100,000

Are you the primary caregiver for your children: \_\_\_\_\_ Yes \_\_\_\_\_ No

Number of years you have been a stay-at-home father: \_\_\_\_\_

How many hours per week (on average) do you spend in the primary role as caregiver for children per week:

\_\_\_\_\_ Less than or equal to 10

\_\_\_\_\_ Greater than 10

How many hours per week (on average) do you work in a paid capacity:

\_\_\_\_\_ Less than or equal to 10

\_\_\_\_\_ Greater than 10

Have you ever been in psychotherapy/counseling: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please indicate the primary focus of your treatment:

Treatment history:

- Types of treatment (mark all that apply):
  - \_\_\_\_\_ Individual
  - \_\_\_\_\_ Group
  - \_\_\_\_\_ Couples
  - \_\_\_\_\_ Other
  - If other, please specify:

For each course of treatment you completed, please indicate the following:

- How long you were in treatment: \_\_\_\_\_
- Frequency of sessions: \_\_\_\_\_
- Total number of sessions \_\_\_\_\_
- When you discontinued: \_\_\_\_\_
- Why you discontinued:

## Appendix B Interview Protocol

Thank you for your willingness to participate in this research investigating stay-at-home-fathers' (SAHF) experiences with depression, help-seeking, and masculinity. This interview will ask you to describe a) your thoughts and feelings related to your role as a SAHF; b) how this role intersects with your beliefs, thoughts, and feelings about masculinity; and c) a time when you experienced a significant period of depressed mood during your time as a SAHF. Next, it will ask you to describe how, if at all, you have sought help for these depressive experiences, including psychotherapy or counseling. If you have sought psychotherapy or counseling, the interview will conclude by asking you what you have found helpful and harmful in any therapy or counseling sought. If you have not sought psychotherapy or counseling, the interview will conclude by asking about other ways you sought help or coped with these depressive experiences.

Just as a reminder, participants must self-identify as stay-at-home fathers for children still living in the home, and their partner or spouse must be the primary wage-earner. Participants must not work in a paid capacity for more than 10 hours per week, and must have partners/spouses who work outside the home for 32 hours per week or more. Participants also need to have experienced a depressed mood, continuously, for at least two weeks during their time as a SAHF.

All information will be kept confidential by assigning each participant a code number and deleting any identifiers.

1. Please describe your daily/weekly role as a SAHF, including activities you perform in this role.
2. How did you come to be a SAHF?
  - a. Please tell me about your decision process.
  - b. How long have you been in the role?
  - c. How long do you expect to stay in the role?
  - d. What have you liked most about this role?
  - e. What have you liked least about this role?
  - f. How, if at all, has your sense of your own masculinity changed since becoming a SAHF?
3. How do you feel that others perceive your role as SAHF?
  - a. What, if any, positive reactions have you received to your role as a SAHF?
  - b. What, if any, negative reactions have you received to your role as a SAHF?
4. Tell me about a period during your time as a SAHF when you felt significantly depressed, depleted, or "down in the dumps" for at least two weeks continuously.
  - a. When did it occur?
  - b. What are your thoughts about what might have contributed to, or stimulated, this difficult time?

- c. What do you recall feeling? Thinking?
  - d. How did it affect you?
  - e. How did it affect others in your life?
  - f. During that period, did you seek help?
    - i. If so, what kind of help?
    - ii. What enabled you to seek this help?
    - iii. If this help was not via psychotherapy or counseling, please describe how this help did, or did not, help you cope during this depressed time.
  - g. If you did not seek help, what kept you from doing so?
    - i. What would have facilitated your seeking help?
    - ii. How did you cope with your depression?
  - h. How, if at all, did your status as SAHF influence your decision to consider seeking help?
  - i. How, if at all, did your own sense of your masculinity influence your decision to consider seeking help?
5. (Omit for those who did not seek psychotherapy or counseling)  
If you sought psychotherapy or counseling during the time when you felt depressed, please tell me about that experience.
- a. How long were you in therapy?
  - b. How often did you see your therapist?
  - c. How would you describe the relationship you had with your therapist?
  - d. What, if anything, was particularly helpful in the therapy?
  - e. What, if anything, was particularly harmful (or not helpful) in the therapy?
  - f. Do you consider the therapy to have successfully addressed the concerns that brought you there?
  - g. How satisfied were you with your therapy experience?
  - h. How has this therapy experience affected the likelihood of your seeking therapy in the future?
  - i. What would you want other SAHFs to know about psychotherapy or counseling?
6. Is there anything else you would like to add about your experiences with depression and help-seeking that we have not addressed?
7. Why did you choose to take part in this study?
8. How was it for you to talk about these experiences?

**Appendix C**  
**Participant Contact Information Form**

For the purposes of being able to contact you regarding participation in this study, please fill out the following information.

Name: \_\_\_\_\_ Phone  
number: \_\_\_\_\_

Mailing Address:

\_\_\_\_\_

Email Address:

\_\_\_\_\_

Best times to schedule interview: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Appendix D**

### **Letter to Potential Participants**

Dear <Name of Participant>:

My name is William Caperton, and I am a third-year counseling psychology doctoral student at Marquette University. I am currently seeking volunteers to participate in my doctoral dissertation research examining stay-at-home fathers' experiences of depression and psychotherapy.

Stay-at-home fathers are a rapidly expanding and under-studied group, and I am hoping that you will be able to give about an hour of your time to share some of your experiences in this area. The study has been reviewed and approved by Marquette University's Institutional Review Board. Participation in this study involves an audiorecorded telephone interview, which will take about 45 to 60 minutes.

The focus of the interview will be on your experiences with depression, your experiences seeking help for depression, and (if you sought therapy for the depression) your thoughts regarding helpful and harmful practices for stay-at-home fathers in therapy. It will also ask you to reflect on ways you think your own sense of masculinity has changed since becoming a stay-at-home father, and ways in which your own masculinity influenced your help-seeking decisions. Recordings, as well as the resulting transcripts and data, will be assigned a code number. After transcription, recordings will be erased.

Participants must self-identify as stay-at-home fathers for children still living in the home, and their partner or spouse must be the primary wage-earner. Participants must not work in a paid capacity for more than 10 hours per week, and must have partners/spouses who work outside the home for 32 hours per week or more. Participants also need to have experienced a depressed mood, continuously, for at least two weeks during their time as a SAHF.

I recognize there is a slight chance that talking about your experiences of depression may be uncomfortable, and I am grateful for your willingness to do so. Participation in this project is strictly voluntary, and you may withdraw your consent at any time without penalty. The purpose of this research is not to evaluate you or your experience; instead, my goal is to understand how stay-at-home fathers experience, contend with, and move through periods of depression. Thus, I am grateful for the experience and expertise you will share should you participate in this study.

If you choose to participate, please complete and return the enclosed/attached Consent and Demographic forms as soon as possible (using the provided envelope). I will then contact you to set up a time for an initial interview. I have also included the interview protocol so that you may make fully informed consent. Please take a look at these questions prior to your first interview so that you have had a chance to think about your

responses. If you do not meet the criteria for participation, I would be grateful if you would pass this information along to a colleague who might be interested in participating.

Your comments and questions regarding this study are welcomed, so please feel free to contact me. I look forward to your response.

Appreciatively,

William Caperton, MA  
Doctoral Student  
Department of Counselor Education and Counseling Psychology  
College of Education  
Marquette University  
Milwaukee, WI 53201  
Phone: 612.889.2661  
[william.caperton@marquette.edu](mailto:william.caperton@marquette.edu)

Sarah Knox, PhD  
Dissertation Advisor  
Director of Training, Counseling Psychology Doctoral Program  
Department of Counselor Education and Counseling Psychology  
College of Education, Schroeder Complex 168 H  
Marquette University  
Milwaukee, WI 53201-1881  
414/288-5942  
414/288-6100 (fax)  
[sarah.knox@marquette.edu](mailto:sarah.knox@marquette.edu)

**Appendix E**  
MARQUETTE UNIVERSITY  
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS  
**PARTICIPANT COPY**

Stay-At-Home Fathers: Navigating Depression  
William Caperton, MA  
Counselor Education and Counseling Psychology, College of Education, Marquette  
University

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

**PURPOSE:** The purpose of this research study is to gain an understanding of the ways in which stay-at-home fathers (SAHF) experience and seek help for depression, as well as their perceptions and reflections on psychotherapy experiences related to their depression. You will be one of approximately 16 participants in this research study.

**PROCEDURES:** The study involves one audio recorded phone interview, lasting approximately 45-60 minutes. The interview will involve a discussion of your experience of depression while in the role of stay-at-home father, and discussion of your help-seeking and therapy experiences (see enclosed interview protocol). You will also be asked to complete a brief demographic form. The recording will later be transcribed and erased after completion of the study. For confidentiality purposes, code numbers will be used, your name will not be recorded, and any identifiers will be removed.

**DURATION:** I understand that my participation will consist of one recorded telephone interview totaling 45-60 minutes.

**RISKS:** I understand that the risks associated with participation in this study are minimal, but may include the possibility of triggering certain emotions when describing my thoughts and feelings about my depression, help-seeking, therapy experiences, and experiences as a SAHF. I understand that I may discontinue my participation at any time, without penalty, if I become too uncomfortable.

**BENEFITS:** I understand that there may be no direct benefits associated with participation in this study other than the opportunity to share my experiences, but indirect benefits may include helping to improve our understanding of stay-at-home fathers' experiences of depression, in addition to helpful and harmful practices in psychotherapy for these concerns.

**CONFIDENTIALITY:** I understand that all information I reveal in this study will be kept confidential. All of my data will be assigned a code number rather than using my name or other information that could identify me as an individual. When the results of the study are published, I will not be identified by name. I understand that the data will be destroyed by shredding paper documents and deleting electronic files two years after the completion of the study. My data will be kept in a locked cabinet in a locked room, to which no one outside the research team will have access. There is no anticipated use of my data in the future.

Recordings made of my interview will be erased after completion of the project. The researchers' records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

**VOLUNTARY NATURE OF PARTICIPATION:** I understand that participating in this study is completely voluntary and that I may withdraw from the study and stop participating at any time without penalty or loss of benefits to which I am otherwise entitled. To withdraw from the research, all I need to do is inform a member of the research team. At that point, all of my data will be destroyed. I understand that I may also receive a copy of the study results (i.e., a draft of the manuscript) in which no identifying information will be used.

**CONTACT INFORMATION:** If I have any questions about this research project, I can contact William Caperton, MA, at 612.889.2661 or [william.caperton@marquette.edu](mailto:william.caperton@marquette.edu). If I have questions or concerns about my rights as a research participant, I can contact Marquette University's Office of Research Compliance at (414) 288-1479.

**I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.**

\_\_\_\_\_  
(Printed Name of Participant)

\_\_\_\_\_  
(Signature of Participant)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Printed Name of Individual Obtaining Consent)

\_\_\_\_\_  
(Signature of Individual Obtaining Consent)

\_\_\_\_\_  
Date

**Appendix F**  
MARQUETTE UNIVERSITY  
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS  
**RESEARCHER COPY**

Stay-At-Home Fathers: Navigating Depression  
William Caperton, MA  
Counselor Education and Counseling Psychology, College of Education, Marquette  
University

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

**PURPOSE:** The purpose of this research study is to gain an understanding of the ways in which stay-at-home fathers (SAHF) experience and seek help for depression, as well as their perceptions and reflections on psychotherapy experiences related to their depression. You will be one of approximately 16 participants in this research study.

**PROCEDURES:** The study involves one audio recorded phone interview, lasting approximately 45-60 minutes. The interview will involve a discussion of your experience of depression while in the role of stay-at-home father, and discussion of your help-seeking and therapy experiences (see enclosed interview protocol). You will also be asked to complete a brief demographic form. The recording will later be transcribed and erased after completion of the study. For confidentiality purposes, code numbers will be used, your name will not be recorded, and any identifiers will be removed.

**DURATION:** I understand that my participation will consist of one recorded telephone interview totaling 45-60 minutes.

**RISKS:** I understand that the risks associated with participation in this study are minimal, but may include the possibility of triggering certain emotions when describing my thoughts and feelings about my depression, help-seeking, therapy experiences, and experiences as a SAHF. I understand that I may discontinue my participation at any time, without penalty, if I become too uncomfortable.

**BENEFITS:** I understand that there may be no direct benefits associated with participation in this study other than the opportunity to share my experiences, but indirect benefits may include helping to improve our understanding of stay-at-home fathers' experiences of depression, in addition to helpful and harmful practices in psychotherapy for these concerns.

**CONFIDENTIALITY:** I understand that all information I reveal in this study will be kept confidential. All of my data will be assigned a code number rather than using my name or other information that could identify me as an individual. When the results of the study are published, I will not be identified by name. I understand that the data will be destroyed by shredding paper documents and deleting electronic files two years after the completion of the study. My data will be kept in a locked cabinet in a locked room, to which no one outside the research team will have access. There is no anticipated use of my data in the future.

Recordings made of my interview will be erased after completion of the project. The researchers' records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

**VOLUNTARY NATURE OF PARTICIPATION:** I understand that participating in this study is completely voluntary and that I may withdraw from the study and stop participating at any time without penalty or loss of benefits to which I am otherwise entitled. To withdraw from the research, all I need to do is inform a member of the research team. At that point, all of my data will be destroyed. I understand that I may also receive a copy of the study results (i.e., a draft of the manuscript) in which no identifying information will be used.

**CONTACT INFORMATION:** If I have any questions about this research project, I can contact William Caperton, MA, at 612.889.2661 or [william.caperton@marquette.edu](mailto:william.caperton@marquette.edu). If I have questions or concerns about my rights as a research participant, I can contact Marquette University's Office of Research Compliance at (414) 288-1479.

**I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.**

\_\_\_\_\_  
(Printed Name of Participant)

\_\_\_\_\_  
(Signature of Participant)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Printed Name of Individual Obtaining Consent)

\_\_\_\_\_  
(Signature of Individual Obtaining Consent)

\_\_\_\_\_  
Date

**Appendix G**  
**Letter for Participants to provide feedback on draft of MS**

<MU LETTERHEAD>

Dear <Name>:

We deeply appreciate your willingness to comment on your experiences of depression and help-seeking. Your investment of time in this project contributes meaningfully to the research.

Enclosed you will find a draft of the results of this study, developed from the interviews of all participants. Please read it and make any comments you feel are appropriate. We are particularly interested in the degree to which these collective results match your individual experiences. We also wish to provide you the opportunity to make sure that your confidentiality has been maintained. Please note any comments on the attached form. You may keep the draft, but please return the completed form in the enclosed envelope as soon as possible, ideally within two weeks.

Thank you again for your participation in this research. Your contribution has been informative and valuable. If you have any questions, feel free to be in touch.

Sincerely,

William Caperton, MA [researcher to contact for participation]  
Department of Counselor Education and Counseling Psychology  
College of Education  
Marquette University  
Milwaukee, WI 53201  
612 889 2661  
414 288-6100 [fax]  
William.caperton@marquette.edu

## Appendix H - Email Recruitment Letter

Stay-at-home fathers are a rapidly expanding and under-studied group, and I am hoping that you will be able to give about an hour of your time to share some of your experiences in this area. A team of researchers at Marquette University is seeking volunteers to participate in a study of stay-at-home fathers' experiences of depression and help-seeking. The study has been reviewed and approved by the Marquette University Institutional Review Board.

Participants must self-identify as stay-at-home fathers for children still living in the home, and their partner or spouse must be the primary wage-earner. Participants must not work in a paid capacity for more than 10 hours per week, and must have partners/spouses who work outside the home for 32 hours per week or more. Finally, participants also need to have experienced a depressed mood, continuously, for at least two weeks during their time as a SAHF. Participation in this study involves completing one audio recorded telephone interview, lasting 45-60 minutes.

The focus of the interview will be on your experiences with depression, your experiences seeking help for depression, and (if you sought therapy for the depression) your thoughts regarding helpful and harmful practices for stay-at-home fathers in therapy. It will also ask you to reflect on ways you think your own sense of masculinity has changed since becoming a stay-at-home father, and ways in which your own masculinity influenced your help-seeking decisions. To ensure confidentiality, recordings, as well as the resulting transcripts and data, will be assigned a code number, and all identifiers will be deleted. After completion of the project, recordings will be erased.

We recognize that there is a slight chance that talking about your experiences may be uncomfortable, and we are grateful for your willingness to do so. Of course, you are under no obligation to participate in this project, and you may withdraw your consent at any time without penalty. Let us assure you, as well, that our purpose is in no way to evaluate you, your parenting practices, or your therapy; instead, our goal is to understand more about the unique experiences stay-at-home fathers have contending with depression.

If you would like to participate, please email William Caperton, MA, at the address below. He will then send you the Consent and Demographic forms for you to complete and return (please sign and return the Researcher Consent form; you may keep the Participant Consent form) as soon as possible. He will also send you the interview protocol so that you can make fully informed consent. Upon receipt of the Consent and Demographic forms, he will contact you to arrange for the interview. We encourage you to look over the protocol questions prior to your interview so that you have a chance to think about your responses. If you do not meet the criteria for participation, we would be grateful if you would share information about this study with others who might be interested in participating.

Appreciatively,

<p>William Caperton, MA          Doctoral Candidate          Counselor Education and Counseling          Psychology          Marquette University  <a href="mailto:William.caperton@marquette.edu">William.caperton@marquette.edu</a>          612.889.2661</p>	<p>Sarah Knox, PhD, Dissertation Advisor          Director of Training, Counseling Psychology Doctoral          Program          Department of Counselor Education and Counseling          Psychology          College of Education, Schroeder Complex 168 H          Marquette University          Milwaukee, WI 53201-1881          414/288-5942  <a href="mailto:sarah.knox@marquette.edu">sarah.knox@marquette.edu</a></p>
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