Men's health practices within dual income families

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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PART 1 :
THE RESEARCH APPROACH

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CHAPTER ONE: INTRODUCING THE STUDY

1 Introduction

The topic, men's health practices in dual income families, is worthy of investigation because it highlights the need for a better understanding of how changes to labour markets and family structures have influenced the longstanding division of parental roles and responsibilities. Although child health has primarily been the responsibility of mothers, the increasing trend toward the dual income family has meant mothers are less available for this role than in previous generations. An emerging substitute for maternal health care is that provided by the father. However, little is known about men's willingness, capability and frequency with which they perform the health practices necessary to avert the morbidity and mortality brought on by child illness and injury (Hallberg, 2007; Laws, 2003a). This doctoral thesis uses several means of data collection to obtain descriptions of men's health practices and to gain an understanding of the factors that facilitate, as well as impede men's efforts to promote their child's health. This is a timely study as key researchers of fatherhood report that men are looking to provide a more equitable share of parental responsibilities and direct input into their child's health and wellbeing (Burgess, 1990; Burgess, and Ruxton, 1997; Burghes, et al., 1997)

1.1.1. Types of family structures in Western society

Immediately following the Second World War economic and social reconstruction was geared to support a stable family life. The main feature of the nuclear family was a working father whose income could adequately provide for a wife and children. Mothers were expected to be in the home and community; these were seen as ideal places for rearing the baby boomer generation. However, several forces worked to erode the normality of a biologically related nuclear family. The concept of gender equality encouraged women to seek employment and economic independence and the result was a voluntary postponing of marriage and fertility by young women; ultimately fewer families

were formed. Family structures were also altered by the increasing acceptance of childbirth outside marriage and the increasing ease with which marriages could be dissolved; these factors ushered in a rise in single parent and blended families. Australian families now predominantly consist of two working parents consisting of either two biologically related parents or one biologically related parent and another adult who cohabitates (ABS, 1997, 2000, 2001). The increasing trend toward dual income families, since the 1970s, was also borne out of necessity, with mothers needing to work to compensate for a decline in men's real wages, periods of high male unemployment and an escalation in material wants of families (housing, education, the two car family) (Presser, 2003; Carlsen & Laesen, 1994, Falkenberg L Monachello, 1990; Russell, 1987b).

1.1.2. Role of men and women in the nuclear family

There are two major reasons for the development of clearly defined gender roles in the post war period. Firstly, men identified themselves as the major income earner by creating male only occupations that attracted better wages than women's work and ensuring they received more income than women for the same work. As a consequence, women's wages could only supplement male family income. Secondly, religious beliefs and a lack of reliable contraception contributed to early marriage and large families; parenting responsibilities effectively precluded the vast majority of women from full-time work and a career. A coalescence of these factors served to define men as the breadwinners and women as homemakers and child raisers (Murphy, 2002; Mc Dowell, 2005).

With the introduction of the oral contraceptive (late 1960s) women became more available for work because they possessed a reliable means of timing pregnancies and limiting family size. Mothers were increasingly enticed into the labour force for longer periods by the introduction of state sponsored childcare, equal pay for equal work and legislation upholding equal opportunities to employment (Doiron & Kalb, 2002, Haas et al., 2000). The recent introduction of state sponsored maternity leave has supported longer term employment and career advancement for women. However, although women have been able to devolve some of their parental responsibilities there are few options for devolving sickness care for infants, children and adolescents because child health has long been recognised as a specialised maternal role.

1.1.3 Caring for sick children

From the onset of the industrial revolution men, on mass, became absent from the family for long periods. Men's commitments to highly structured factory work left only the mother at home to care for sick or disabled children (Lupton & Barclay, 1997; Sterns, 1991). Men's labour was often so physically demanding that, even when at home, they had little energy to devote to parenting; as a result fatherhood roles became limited and typified as disciplinarian (Bozett & S Hanson, 1991; Peterson & Steinmetz, 2000). Mothers became increasingly recognised as the prime nexus between the family and providers of health services; commensurate with this emerging role, health services were developed to meet the needs of mothers. Since the early 1950s, organisations seeking to promote the health of women and children developed educational materials to improve the health literacy of mothers and support their acquisition of a wide range of health skills. Contemporary evidence of the primacy of maternal care can be obtained from government health documents (Department of Health and Aging, 2008; Department of Health, 2005) or by performing a simple Google search using the key words 'hospital, mother, child, maternal'; this process reveals that a vast majority of health services use the term 'mother' in their title, thus indicating a stark division of labour for parental health responsibilities.

1.1.4 Dual income families and changing roles

For mothers to maximise their income and workplace opportunities they must devolve a substantial part of their homes duties and parenting responsibilities. Workloads associated with home duties have been reduced by labour saving white goods and pre-prepared meals (Bittman & Rice, 2004). State support for childcare was intended to be a substitute for maternal care during work hours. However, women's workloads have not been fully compensated for by resources available outside the home; consequently working mothers have requested that their spouse or partner perform more family work (Gershuny, 2000). Although men have gradually increased their contributions to family workloads, these increases come from a very low base and men continue to be selective about what it is they contribute to within the home (Bittman, 1997; Bittman & Rice 2004; Budig, 2008). Women who have difficulties combining family workloads with employment workloads and have difficulties in coming to terms with the

discrepancy between the ideal of gender equity and actual equity are likely to experience role strain; this type of strain is associated with health problems (Pocock, 2003; Galinsky, 2000; Haas et al., 2000). Working mothers also experience moral duress caused by concerns over the suspected long term effects of childcare on children's health and development (Paton, 2006). Research has yet to consistently demonstrate that childcare has a neutral or positive effect on a child's wellbeing vis a vis maternal care (Turner-Cobb, 2005). In addition, mothers are most often the parent responsible for locating affordable, accessible and appropriate childcare (Dyck, 1996). The availability of childcare does not necessarily reduce parental workloads as children still have to be prepared for and transported to and from the facility every working day. When a child encounters a health problem precluding them from attending a childcare facility it is normally the mother who stops work to provide the necessary care. From infancy to late childhood the incidence of injury and health problems is substantial. Detailed evidence of the incidence of child health problems and injury is set out in chapters six through to eleven.

In recognition of the unexpected nature of child health problems and the likelihood that they will be called upon to provide care, many women choose part-time employment with flexible hours; this strategy reduces women's earning ability and disadvantages career opportunities as well as reinforcing men's role of breadwinner. For full-time working mothers, there is little option other than to assume caring for the sick child (day and night); this practice leaves most women feeling emotionally and physically exhausted. Increasingly, working mothers are asking their spouse / partner to take on a more equitable role in parenting, including health care. Requests for a more equitable sharing of parental responsibilities have been answered by a modest but upward trend in fathers' contribution (Devreux, 2007; Maume, 2006, Russell & Hwang, 2004; Bittman & Rice, 2002; Bittman, 1992). Even when parenting is equitable, dual income couples report being in crisis because there is little time for the family after commitments to employment have been met (Cousins, 2005; Pocock & Clarke 2005; Pocock 2005; Thornthwaite, 2004; Pocock, 2003; Carlsen & Laesen, 1994). The notion of time poverty and maternal role strain, identified mostly among dual income families (Millward, 2002), emphasises the need for engaging fathers in all

aspects of parenting, including health care, so that they can substitute for maternal care when required (Halrynjo, 2009; Burghes et al., 1997).

1.1.5 Father' care for sick children

There are two reasons why fathers might want to be more involved in promoting child health and providing sickness care. Firstly, there are men who believe in the ideal of gender equity and see practicing child health as a pragmatic means of supporting their working spouse or partner. Secondly, men's increasing involvement in child health has become a personal choice. Key researchers have observed that many men are simply dissatisfied with the relationship they had with their father and as a consequence want to reduce the emotional distance between themselves and their offspring, for their children's sake (Burgess, 1997; Riesch et al., 1996). Men also see manifestations of father love as important as mother love to their child's health and development (Rohner & Veneziano, 2001; Rohner & Britner, 2002). Conversely, men sense that their lives will be enriched by a co-dependent relationship with their child (Lamb & Kelly, 2005; Lamb, 2000);

Although sociologists have emphasised the need for gender roles to change in response to historical events and socioeconomic change (Connell, 1995), barriers exist to men and women assuming roles of the opposite sex; just as women struggled to assume to adopt men's work (Fagan, 2003) men will also struggle to practice health within societal frameworks created to meet the needs of mothers.

Descriptions of fathers' efforts to promote the health and wellbeing of their children remain rare in comparison to the number of studies exploring mothers' health practices (Palmer, 2009; Laws 1998; Hewison & Dowswell, 1994; Bailey, 1991). Those researching child health problems make the comment that fathers are commonly absent from family health studies or do not participate in sufficient numbers to require reporting of data (Hallberg, 2007; Ramchandani & McConachie, 2005; Laws, 2004/ 2005; Coley & Morris, 2002; Bailey, 1991; Neill, 2000; Slack-Smith et al., 2000). When researchers are inclusive of fathers they most often report the data for 'parents' only; the author of this thesis has argued that by not disaggregating the data into father / mother responses the gender differences in parenting for child health cannot be determined (Laws, 2003b).

A lack of information on how fathers view their parental responsibilities in matters of child health creates difficulties for health professionals who are expected to be inclusive of fathers in their practice (Stone, 2004; Barclay & Lupton, 1999; Trotter, 1997; Ahmann, 2006). Whilst services should be specifically designed to meet the psychological needs of fathers, as well as mothers, there is little evidence based practice (Ware & Raval, 2007; Fägerskiöld, 2006). It cannot be assumed that fathers parent in the same way as mothers or practice health in the same way (Ahmann, 2006). Without evidence of fathers' health knowledge as well as their actual and potential ability to engage in child health practices, health professionals are limited to expert opinion and speculation on how best to educate and support these men (Coleman et al., 2004; Hughes, 2007; Fegran et al., 2006; Ahmann, 2006).

1.2 Research problem

An explanation for the formulation of the research problem appears in the literature review chapter *Dual income families in crisis* and subsequent chapters; these chapters conclude that published research and literature has not:

i) clearly described the type of health practices men perform for their children;
ii) quantified the frequency of health practices performed by fathers for their children;
iii) adequately explored fathers' experience in caring for a child with a health problem, including the identification of perceived barriers to care.

1.3 Research aim

The research aims to identify:

i) the type of health practices men perform for their children;
ii) the frequency of health practices performed by fathers toward their children;
iii) men's experiences as they carry out or attempt to carry out health practices toward a child with a health problem.

To meet these aims data were drawn from three sources:

i) a systematic document search for evidence of father's health practice (presented in six chapters);
ii) focus group discussions and individual interviews;

iii) a household survey.

1.4 Significance of the study

The significance of the study can be determined by the extent of new information that can be provided to key stake holders, child health professionals as well as mothers and fathers.

- Policy makers require information about fathers' willingness and ability to be available to practice health in order to give guidance to health care organisations on how best to structure child health services for these men (Burgess & Ruxton, 2005; Burghes et al., 1995; Feetham1997).
- Health care organisations need information on men's experiences so that they can identify any barriers to men participating in their child's care (Lewig, 2006).
- Health professionals specialising in child health promotion and sickness care have aimed to be more inclusive of fathers in their practice but they have been frustrated by the lack of evidence. Ergo, contemporary knowledge is needed to give validity to the development of health partnership strategies aimed at including these men (Stone, 2004; Barclay & Lupton, 1999; Trotter, 1997).
- Mothers seeking a more equitable sharing of parental responsibility with their spouse or partner need to be reassured that these men possess the requisite knowledge and skills to practice health, or can be up-skilled as partners in care by health professionals.
- Fathers have a need for their current contributions to child health to be recognised as well as an acceptance of their style of parenting. An assessment of men's health knowledge, repertoire of skills and frequencies of health practices will guide the development of educational packages to better meet their needs (Lumb, 2002; Smith, 2007). Through emphasising the normality of men practicing health toward their children other men will be encouraged to become involved, in what they may have considered to be only women's work.

During the development of this doctoral thesis I published works and presented at academic forums on the topic of fatherhood and health care. There are also linkages between the thesis topic and men's practicing self health. Specifically, the argument has been made for greater involvement of fathers in child health (Laws, 1998; Laws, 2003a). The bourgeoning interest in men's health issues indicates that men are willing and able to make informed choices about their own health (Laws, 2007c; Laws, 2006); from this it has been argued that men's new found health literacy and skills can be applied by fathers to promote their child's health (Laws, 2007a; Laws, 2007b; Laws & Bradley, 2003). Early results from a document search for evidence of fathers' health practices toward their terminally ill child was published; this work led to the conclusion that most men face substantial and multiple barriers to their providing direct care for a child with a life limiting illness (Laws 2004 – *Appendix 8*).

1.5 Structure of the thesis

The thesis is presented in four parts:-

Part one

Chapter 1 – *Introduction*
Chapter 2 – *Dual income families in crisis*: *a literature review*

Part two

Chapter 3 – *Theoretical framework*: *Masculinity*
Chapter 4 – *Theoretical framework*: *Fatherhood*

Part three

Chapter 5 – *Methodology*

- Documentary search for evidence of men's health practices
- Focus group discussion and interviews
- Household survey
    - Questionnaire design
    - Testing of survey sample

Part four

Results: Evidence found in documentary searches
Chapter 6 – *Acute illness*
Chapter 7 – *Chronic illness*
Chapter 8 – *Mental health problems*
Chapter 9 – *Terminal illness*
Chapter 10 – *Injury prevention*
Chapter 11 – *Health promotion*

Results: Qualitative
Chapter 12 – *Focus group discussion and interviews*

Results: Survey
Chapter 13 – *Household survey*
Chapter 14 – *Discussion*
Chapter 15 – *Conclusion*

1.6 Chapter summaries

Chapter 2 ***Dual income families in crisis - a literature review*****:** Reviews of the literature reveal a mismatch between the ideal of labour market equality for women and the reality that too few resources are available to achieve the ideal. Whilst there is evidence of men assuming a greater role in parenting this comes from a very low base leaving women to absorb family and employment workloads; women are dissatisfied and continue to call for a more equitable sharing of parental responsibilities. Men remain constricted in their views of parenting responsibility and time available to personally provide child health care.

Chapter 3 ***Theoretical framework – Masculinity:*** The chapter establishes that gender is not biologically determined but socially constructed. Gender roles are historically contingent and shaped by social and economic forces but appropriate responses lag behind the need for role change. There is no predictive model for shaping male behaviour however; masculinity continues to be characterised by an assertion of power over other groups and is best studied as the relationships between men and others (Connell, 1995).

Chapter 4 ***Theoretical framework – Fatherhood:*** The chapter describes how the industrial revolution changed the relationship between fathers and their family. The diversity of contemporary fatherhood is discussed (single fathers, absent fathers, non resident fathers, cohabitating fathers) with an emphasis on men reclaiming fatherhood in ways that promote the health and wellbeing of children as well as fathers (Burgess, 1997; Lupton & Barclay, 1997).

Chapter 5 ***Methodology:*** The chapter identifies the appropriateness of a mixed method approach in meeting the research aims. A search for documentary evidence of men's health practices is presented as six chapters, each focusing on a discrete category of child health. The focus group discussions and interviews allow for men's voices and experiences to be heard. The household survey collected attitudinal data on gender equity and equitable parenting as well as frequency for actual health practices performed by men.

Chapters 6-11: Each chapter presents the results of a documentary search for evidence of men's health practices undertaken in connection with a childhood health problem (*Acute illness, Chronic illness, Mental health problems, Terminal*

illness, Health promotion and Accident and injury prevention). This work is used to establish the health workloads encountered by parents, their responses to diagnosis and their experiences of support provided by health professionals and health care organisations.

Chapter 12 ***Focus group discussion and interviews:*** This chapter presents a descriptive analysis of men's health practices and their repertoire of skills. Themes were developed to characterise men's experience of practicing health care, including barriers to caring.

Chapter 13 ***Household survey:*** Presents an analysis of attitudinal data from the questionnaire. Respondents were provided with a set of propositions on the topic of gender equity and equitable sharing of parental responsibilities. Results for the frequency of health practices performed by respondents are presented as tables with comparisons made between men's and women's health practices.

CHAPTER TWO:
Literature review: dual income families in crisis

2.1 Overview

Men do not practice health within a vacuum; the context of this research is the dual income family. There are three arguments advanced in this chapter to indicate that parents in dual income families are in crisis. Firstly, both social and policy research show the declining capacity of a single male wage to meet the material expectations of contemporary family life (Lewis, 2001). An increasing number of parents believe dual incomes to be a financial necessity rather than an optional choice; this phenomenon effectively makes voluntary full-time motherhood a luxury role in contemporary society for most women. The second source of crisis comes from 'doctrinal confusion', a term first used by Hewison and Dowswell (1994). Doctrinal confusion occurs when governments create policies upholding the primacy of maternal family care until such time as labour market demands prompt the development of incentives and penalties intended to increase women's employment participation. The confusion is exacerbated by a shortfall in the supply of affordable childcare. Both the Thatcher and Howard governments are reported in the literature as having developed doctrinal confusion (Hewison & Dowswell, 1994; Hill, 2006; 2004). Thirdly, the benefits of an additional wage are eroded by the cost of childcare. The vast majority of Australian childcare is now supplied for profit and listed on the stock exchange (Sumsion, 2006). Aside from the difficulties associated with locating affordable and trustworthy childcare, mothers face the moral crisis of having to evaluate if such long term institutional care would have a detrimental effect on their child's health and development. At no time is maternal care more needed than when a child is ill and vulnerable. Care of a sick child poses a logistical crisis for the dual income family, most often resulting in the working mother taking time from employment or deciding to work part-time as a means of dealing with these times of need (Lee, 1999).

2.1 Introduction

Each section within this chapter identifies the pressures faced by couples in dual income families, putting them on the edge of crisis as they attempt to balance employment workloads and timeframes with parental responsibilities. The intention is to suggest that day-to-day parental responsibilities for child health, wellbeing and safety may be better balanced if men could also assume these roles. Substituting for maternal health care would also provide respite for working mothers who have multiple roles.

Section 2.2 -'*The trend toward dual income family types'* highlights the growing numbers of dual income families in Australia and countries with similar labour markets. The data provides an indication of the need to provide support for an increasing number of working mothers and dual income couples.

Section 2.3 -'*Can women choose motherhood or are they expected to work*?' explores the perception held by many mothers, that they now feel compelled to work because a single income will no longer support an acceptable standard of living.

Section 2.4 -'*Maternal employment: source of health promotion or self harm?*' provides an analysis of the tensions experienced by women as they seek psychological benefits from employment but assume an employment workload in addition to their traditional family roles (domestic duties, childcare and child rearing).

Section 2.5 -'*Support for working parents: an international comparison'* sets out the differing responses by governments to the needs of working mothers in several countries. The policies of Denmark have been emphasised because this country has done more than most to support dual income families. The doctrinal confusion exhibited by Australian and United Kingdom governments in support for working mothers shows the complex Pilotical and demographic factors influencing women's judgement to engage / not to engage in employment.

Section 2.6 -'*Socioeconomic differences among working mothers'* raises methodological concerns over the study of working mothers, noting that whilst most literature focuses on the time poor and financially constrained working mothers there is a small group of successful professional women who can

successfully devolve their home duties and parenting responsibilities by buying in goods and services.

Section 2.7 -*'Satisfaction with work life balance'* seeks to determine the extent of the difficulties experienced by dual income parents in balancing multiple roles.

Section 2.8 -*'Evaluating claims of time poverty'* seeks to understand the saliency of the concept 'time poverty' in the lives of dual income parents.

Section 2.9 - *'The psychological and physical effects of childcare'* highlights the moral crisis faced by parents as they seek to locate credible evidence that long term out-of-home childcare will not harm their child's health and development (mental and physical).

Section 2.10 - *'Childcare linked to psychological stress of mother and child'*: presents findings from studies that test for an association between elevated cortisol levels (a stress hormone) and negative health outcomes in mothers and children participating in out-of-home childcare.

Section 2.11 - *'Attitudes to working mothers'* provides a summary of social commentary that identifies a lessening of expectation on mothers to be the major provider of parental care, with the exception of mothers of young and vulnerable children.

Section 2.12 - *'What happens when a child gets sick'* sets out the argument that, although dual income couples can devolve their parental responsibilities to out-of-home childcare facilities there are few options for devolving parental responsibilities for care of a sick child or a child with an ongoing health problem. Three factors limit women's full-time employment: i) the unpredictable nature of childhood illness, ii) the primacy of maternal care for ill and vulnerable children and iii) the lack of access to affordable and trustworthy sickness care outside the family. Central to this thesis is the idea that fathers can and do care for sick children, with most children preferring the comfort of at least one parent in times of physical and emotional discomfort. These issues justify the need to identify and describe fathers' health practices within dual income families.

2.2 The trend toward dual income family types

Social policy reform after the Second World War ushered in the 'high water mark' of the male breadwinner role complementing the role of the housewife and caring mother (Gilding, 1991: 21). In Australia the formalisation of 'the family wage' took place in 1907 under arbitration, with the intent that a man's wage would be sufficient to prevent the working-class housewife from entering the workforce (Curthoys, 1984: 328). For the past six decades men have been ostensibly content with the role of improving their working conditions and wages to a point where they can financially support a family and leisure with them (Gershuny, 2000; Sullivan & Gershuny, 2001). However, deregulation of the economy, an increase in casual employment and automation of manufacturing processes have placed a downward pressure on real wages for labouring men and women (Borland, et al., 2002).

> **"Real fulltime earnings increased by 41.4 percent for managers and administrators from 1990 to 2000, but by just 6.9 percent for labourers, and only 4.3 percent for elementary clerical, sales and services workers. In the lowest income occupations, real earnings fell".**
>
> (Hancock, 2002: 124)

In addition, changes to Australia's labour markets resulted in an increased participation rate in employment for women putting pressure on the 'breadwinner' wage and promoting the need for the dual income family (Murphy, 2002).

> **"...the average number of hours that Australians supply to the labour market has not changed markedly between 1974 and 1997. However, there has been a significant redistribution of paid work from men to women, thus creating more dual-earner households."**
>
> (Bittman & Rice, 2002: 25)

The number of families characterised as traditional male breadwinner was 58% in 1981 falling to approximately 30% in recent years (Pocock & Wilson, 2001).

From the 1960s and throughout the 1970s it was increasingly common in Australia for both parents to have employment. Of the five million Australian families, 72% were couple based (spouse or partner) in 1997. There were 444,700 dual income families with children under five years and 1,209,400 families with school aged children (5-14 years). In total there were 1,654,100 dual income families with dependent children (ABS 1997). The dominant type

of family is now 'dual income' accounting for 64% of coupled families with children (ABS, 2001).

In 1987, the proportion of partnered mothers employed full-time was 21% increasing to 30% in 2004 (ABS, 2006). The proportion of partnered mothers employed part-time increased from 30% in 1987 to 36% in 2004. The proportion of employed mothers living with children aged less than 15 years increased from 49% in 1987 to 57% (2.1 million) in 2004. The growth in paid work for working mothers has been mainly in part-time employment.

> **"Mothers worked full-time in 14% of families with a youngest child under 5 years, and 31% worked part-time. In contrast, mothers worked full-time in 35% of families with a youngest child 10–14 years and 36% worked part-time."**
>
> (ABS, 2006: 1)

Ergo, the number of families where the mother is absent from the home because of employment commitments is now substantial. A consequence of the steady increase in mothers working either part-time or full-time (ABS, 2001) meant that by the 1990s, over 40% of children below four years of age used formal childcare in Australia (Ochiltree & Edgar 1995). Australia has similar employment patterns to that of the United Kingdom (UK); in 1991, 43% of UK mothers with children under five were in employment. This represented an increase of 24% on the 1983 figures (Hewison & Dowswell, 1994).

The trend toward dual income families experienced in Australia also occurred across Europe (Carlsen & Laesen, 1994: 53) and in the United States of America (Hochschild, 2001). However, employment patterns have differed between countries.

2.3 Can women choose motherhood or are they expected to work?

Maternal employment was purported in mainstream feminist theory as life choice supported by the concept of gender equity. More recent social analysis suggests the needs of the state to control labour markets, and a growing realisation that dual incomes are an economic necessity appear to have overshadowed the moral suasion of choice and equity (McDowell, 2004; McDowell 2005).

The experiences of Danish women are emphasised in this section because Demark has provided strong policy support for working mothers for over four decades; the

report by Carlsen and Larsen (1994) was a landmark assessment of the effectiveness of such state support. Women's right to participate in paid labour was initially recognised as a 'positive choice' for women and families in Denmark (Carlsen and Larsen, 1994). However, the reduction in men's real wages and an expectation of higher living standards have resulted in a majority of couple based families in Denmark now seeing maternal breadwinning as a financial necessity. After nearly 30 years of state support for working mothers researchers in Denmark have found that working mothers perceive their employment as a negative choice because although women can refuse to go out to work the consequences of them doing so are so unpalatable that they are extremely unlikely to make that choice (Carlsen & Larsen 1994:9). The Danish government, in acknowledging the need for women to devolve their traditional carer role, developed and expanded publicly-funded childcare facilities to reconcile the tensions between work commitments and family obligations. The development of the nursing home sector and primary care programmes for the elderly also served to release women from their role of caring for family elders (Carlsen & Larsen, 1994:32). Despite consistent state support for the release of Danish women from total childcare responsibilities, couples with children under 12 had extremely busy everyday lives leaving working mothers to conclude that 'work takes what time is needed and what remains is left to the family' (Carlsen & Larsen, 1994).

Holt's (1994:53) review of the experience of Danish families, highlights parent preferences for balancing family life and work; although approximately 50% of all couple-based families with dependent children were in full-time work, no family thought both parents working to be ideal. Holt (1994) found that 43% wanted the father to work full-time and the mother to work part-time, with 41% indicating they preferred both mother and father to work part-time. Brannen and Moss (1991) offer a cautionary note to interpreting work preferences, as they observed that women's personal preferences differed over time in relation to three main factors, i) their partner's employment type (part-time/full-time), ii) the actual employment rate amongst mothers and iii) availability of publicly funded childcare. Exemplifying the point, Brannen and Moss (1991) found that in the 1970s, only 47% of Danish mothers expressed a preference for part–time work

with the father in full-time employment (47%) but by 1985 the preference had risen to 83% (Brannen & Moss, 1991: 128).

Studies in other Scandinavian countries, where supportive dual income family policies have been in place for a generation, are reported by Hobson (2004); they also highlight a perceived lack of choice between a domestic life for women and employment. Most recently, Lewis and Campbell (2007) summarised the Scandinavian experience as:

> **"... even in Scandinavia, where (WFB) [*sic.* work for benefit] policies are most developed, it is more accurate to describe them as supporting an adult worker model family (Hobson, 2004)—that is, enabling women to enter the labor market and to leave it "for cause" (i.e., to care)—than as enabling women and men to be able to make a choice to engage in paid and/or unpaid work".**
>
> (Lewis & Campbell, 2007: 8)

The findings from a comparative study of British and French working mothers conducted by Linda Hantrais (1990) concurred with the experiences of Scandinavian women. Although French women purported that the women's rights movement was responsible for convincing them that they should be working, the fact that a single income was not enough to run a household was seen as a key factor in prompting them to work (Hantrais 1990: 148). Social analysts in Australia have researched similar conclusions (Probert, 1997; Rogers, 1996). Additional income is required to balance the cost of raising children and this phenomenon is experienced across all income brackets (Pearson, 2003; Percival & Harding, 2002; Davies & Joshi, 1999). Percival & Harding (2002) estimate the cost of child rearing in Australia to be close to half a million dollars; for the two child family:

> **"The total cost in today's dollars is $448,000 to raise two children from birth to age 20. That's around $322 a week, or 24 per cent of average gross household income of $1324 a week ... parents on average, spend around $50,000 on education and child care, although these costs will rise if the parents choose private schools."**
>
> (Percival & Harding, 2002: 1)

Research undertaken by the author of this thesis (Laws & Fiedler, 2002) supports the findings of Percival and Harding's (2002) with a cost estimate of $35,000 - $50,000 for private school fees. The cost of child rearing represents a substantial pull on parental resources and is an important reason for mothers entering

employment. Conversely, the cost of childcare prohibits women on low incomes from re-entering the workforce after childbirth.

> **"In the UK, the typical cost of a nursery place is more than the average household spends a year on either food or housing."**
> (Viitanen, 2005: 149)

Mothers who may otherwise choose to be at home with their children are compelled to work to cover the cost of rearing children. According to McDowell (2005), responses to this moral crisis have been limited because economists focus on promoting economic growth and stability in labour markets with little attention paid to the moral consequences of having induced individuals to participate / not participate in the labour market.

> **"Little attention has been paid by mainstream economists, or indeed by most geographers, to the attitudes, values and beliefs of the individuals and households whose behaviour has to be changed to encourage their labour market attachment. There is relatively little analysis, too, of the different ways in which men and women are affected by the obligation to engage in waged work while at the same time continuing to care for dependants within their households."**
> (Mc Dowell, 2005: 365)

Having been compelled into the labour force by financial necessity, working mothers receive less income. Instead of a seamless transition from the male breadwinner model to either an individual independent worker model or a dual-earner family model, Australia and UK employment opportunities for working mothers have been largely restricted to lower skilled work with most opportunities for female employment concentrated in the service industries (Duffield, 2002:605). Ergo, working mothers' contribution to household income represents a 'one-and-a-half-earner' income, as the norm, rather than a dual earner family model (Dex, 2003). Lewis (2002) attributes women's part-time work to a patchwork of provisions for childcare. McKie et al., (2001) make the point that creating affordable childcare has meant suppressing the wages of child carers, most of whom are women; the result is women are disadvantaging women.

> **"By promoting low paid jobs for women as paid carers who are predominantly providing care services for other women."**
> (McKie et al., 2001)

And this action merely reinforces the gender template or normality of females providing of almost all childcare.

2.4 Maternal employment: source of health promotion or self harm?

Employment and family policies continue to be based upon a gender template assuming that women are and should continue to be the natural carers for children (Russell et al., 1999). Oakley (1974) was at the vanguard of those quantifying women's workload, estimating that housewives spend on average 77 hours per week doing housework, transporting children and shopping; this figure is exclusive of rest periods. For those women holding down full-time employment the total hours of work ranged from 48-105 hours per week. Working mothers who are not able to successfully negotiate an equitable sharing of parental responsibilities with their spouse / partner are at risk of becoming physically and emotionally exhausted from having to continue with family workloads in addition to employment workloads. Dual income families may face a crisis if the mother experiences a net negative health effect from employment.

A long standing question held by researchers is the measurement of the net health effects from a mother's commitment to employment; the epoch of research on this topic occurred between the 1980s and 1990s. There are two contrasting theories, that of the beneficial health effects of paid work (physical and psychological) and that of the negative health effects brought about by assuming multiple roles and workloads (Arber et al., 1985). A number of studies have identified that women who perform paid work outside the home reap the benefits of improved mental health status compared to those women who continue to be housewives (Macran et al., 1994).

> **"Women who were economically inactive were more likely to evaluate their health as 'less-than good' than women in paid work, after controlling for the presence of a long-standing illness or disability."**
>
> (Macran et al., 1994: 182)

A lack of employment outside the home appears to be a potent contributor to the development of psychological symptoms, for married women of all ages; these symptoms can lead to episodes of mental illness and in particular depression (Staines, 1986:118; Hoffman, 1989: 284). Julian Hafner (1986) argued that an adherence to traditional sex-role-stereotyped attitudes, in the face of increasing social change, leads to unreconciled intra-personal conflict and symptoms of

depression. Traditional sex-role-stereotypes are deeply ingrained in English speaking societies in the form of the male breadwinner and the female nurturer and carer for the family. In the past these roles were seen as complementary and a source of social stability. Where differences did occur, men and women could turn to the church or similar authority to have them resolved. More recently, several social changes have combined to exert substantial pressure on these roles. For women, birth control has regulated the total amount of time spent rearing children. The introduction of affordable labour saving devices and domestic appliances has meant that housework could be considered a part-time job relative to the workload of previous generations (Hafner 1986). Although Hafner acknowledged that sex-role issues were grossly under-represented in clinical and research reports on depression, he counters this by offering analysis of the case histories he has been involved with. Supporting Hafner's theory are a number of studies linking depression to the life style of housewives. Radloff (1980) found that depression among married women increased markedly in the 40-64 year age group but only in those who remained unemployed outside the home. Furthermore, a relationship between sex-role conflict and mental health problems among married women was identified in an empirical study by Krause (1983).

The health gains realised by employment may be eroded by the total workload (paid and unpaid work) assumed by working mothers. Based on British data from a General Household Survey for 1975 and 1976, Arber et al., (1985) conclude that:

> **"Full-time work for young mothers may be detrimental for their health unless there are adequate financial resources to help with the burden of maintaining the multiple roles of housewife, mother and employee, or until the sexual division of labour in home changes."**
>
> (Arber et al., 1985: 375)

Bartley et al., (1992) employed data from the Health and Lifestyles survey, measuring domestic conditions, and separate measures of long-term health status, and short-term physical and psychological health to explore the postulates of a positive health effect of paid employment for women. Bartley et al., (1992) concluded that:

> **"...findings suggest that the association between paid work and better health is rather less apparent for physical than**

> **psychological health, and in women working full-time in professional or managerial occupations."**
>
> (Bartley et al., 1992: 313)

Most recently Klumd and Lampert (2004) undertook a synthesis of 161 measures of the effects of women's employment on wellbeing reported between 1950 and 2000. The variations in the conceptualization and measurement of employment types and health outcomes made it difficult to distinguish social selection effects from social causation effects and consequently limited the inferences that could be drawn from the evidence produced. However, overall the synthesis found no conclusive evidence to show that employment had adverse effects on women and there was no convergence demonstrated between psychological distress, subjective health, cardiovascular risks and disease, and mortality. Some researchers suggest net health gains from employment are minimal (Bartley et al., 1992) whilst others show that economically inactive women 'were more likely to evaluate their health as 'less-than good' than women in paid work' (Macran e al., 1994: 182).

A group of women identified most at risk of negative health effects, and requiring policy support, are low income working women who have a childcare role (Kneipp et al., 2004; Dex, 1999). In addition, longer hours worked by mothers are disruptive to family life (Crouter & Manke, 1994). Michelson's (1990) study of Canadian mothers with young children found that they are spending more hours working and dedicating less time to leisure, personal care and sleep. Consequently, the accumulation of workloads was found to have a negative impact on these women's health (Michelson, 1990). Another group at risk are those returning to employment after childbirth; a concerning proportion of women have psychological problems after childbirth (Brown & Lumley, 1998) and consequently it is important for health workers to assess the readiness of these women to return to work (Saurel-Cubizolles et al., 2000).

A note of caution needs to be made on the interpretation of research findings present thus far. Firstly, Cunningham-Burley et al., (2006), having reviewed the literature conclude:

> **"There are few studies of how women in different family circumstances experience and perceive labour market and workplace effects on themselves, their partners and children, and reconcile these on a daily basis ..."**

(Cunningham-Burley et al., 2006: 388)

Secondly, much of the research investigating the relationship between women's health and work is derived from surveys, including longitudinal data sets. However, this type of research, when subject to critical review has been deemed lacking in 'theoretical underpinning' (Cunningham-Burley et al., 2006). Similarly, Klumb and Lambert's (2003) extensive work on the methodologies lead them to conclude that:

> **"We can only repeat what our predecessors, [Waldron, Weiss, & Hughes (1998) and Warr and Parry (1982a)], wrote 20 years ago: 'there is no justification for further empirical comparisons between the ... wellbeing of women in general who have jobs and those who do not. Research must examine more precise hypotheses."**
>
> (Klumb & Lambert, 2003: 1017)

In recognition of the limitations of this type of survey work Cunningham-Burley et al., (2006) used a qualitative approach to extend the conceptualisation of the social construct of health and illness at the interface between parenting and employment. The thematic analysis from interviews with 30 women in Scotland is revealing and added to this researcher's ability to present coherent questions to the men at interview in this study. Cunningham-Burley et al., (2006) explain the relationship of health – work perceptions of working mothers as they grapple with multiple workloads:

> **"Paid work was also described as being good for health, a relationship supported by quantitative empirical evidence. Work meant that these women had to carry on, despite tiredness or illness: this reinforced the respondents' beliefs that 'not giving into illness' was an appropriate response to illness and a feature of health maintenance."**
>
> (Cunningham-Burley et al., 2006: 402)

Conversely:

> **"For the women in this study, health was described as being in some way compromised by work. Occasionally, this was reported as a direct effect where the nature of the work or workplace had a deleterious effect on health in the manner of the exposure model. More often, however, it was the overload of work and domestic life that was accounted as giving rise to 'feeling shattered' or stressed, suggesting that explanations which only focus on features of paid work will not satisfactorily accommodate the balancing of caring and earning involved in these women's lives and the effects it had on their wellbeing."**
>
> (Cunningham-Burley et al., 2006: 402)

Whilst the role of home making and child-raising is often associated with isolation, monotony and low social status, inferring an association with low self esteem, it cannot be claimed that employment bestows a net gain in health status for working mothers. The multiple roles and workloads of fulfilling obligations to employers and family leave many women feeing physically and emotionally shattered (Oakley, 1974; Barrett & McIntosh, 1994; Kelley, 1995). Employment, as a source of health gains for women (attributed to improvements in life satisfaction, self esteem, social interaction with adults and economic independence) appears to be easily negated by the finding that most women would relinquish their employment if they had access to comparable wealth (Pocock and Wilson, 2001). This decision can be explained by an unpalatable amount of work related anxiety, malaise and conflict experienced by men as well as women (Hunt & Annandale, 1993).

Despite mythological problems the evidence produced by the vast majority of research strongly suggests that working mothers sense threats to their physical and emotional wellbeing. Further, Galinsky et al., (2001) found that women feel more overworked than men, adding to earlier research showing 59% of employed women and 49% of employed men 'felt too rushed' (Glezer & Wolcott, 1999). Unfortunately this literature does extend to making outright claims of a health crisis for women but research commentary and discussion borders on this conclusion. Researchers have sought to explore the notion of 'burn out' and conclude that shared decision making assists in promoting satisfaction with work-life-balance but does not assist with working mothers' temporal experience of burn out from having to combine dual roles (Kushnir & Melamed, 2006; Emslie & Hunt, 2009).

The literature on the health effects of women's employment links well with this study because men's health practices can provide practical support for working mothers by way of shared domestic and parenting responsibilities.

> **"The intensification of paid work patterns exacerbates tension about the inequitable sharing of domestic work, contributing to relationship tensions."**
>
> (Pocock & Wilson, 2001: 26)

If men are blind to the health implications of women with dual workloads, there is a higher risk of relationship crisis within the family. Although the research on

health effects for women does not show a crisis of ill health, there is a crisis for women who have a need to determine the net effect of employment on their everyday lives.

2.5 *Support for working parents: an international comparison*

Women are only able to achieve gender equity in the labour market if they are provided with affordable and accessible childcare. In this section it will be argued Australian women who want to be in full-time employment and pursue a career are in crisis because of lack of state support. The following accounts of the development of policies across several countries is intended to demonstrate that there are complex Pilotical and demographic factors influencing women's judgement to engage in full-time employment.

2.5.1 Denmark

Denmark has done more than any other country to secure a smooth transition from women's traditional role of wife and mother into that of full-time employee. The sharpest increase in the labour force participation rate for Danish mothers occurred from 1960 (Carlsen & Laesen, 1994:36). This phenomenon was linked to a dramatic increase in the number of places available in state funded childcare. The change to the life style of young Danish women has been substantial. In 1966 the majority of Danish women (66%) were classified as housewives caring for children less than six years of age, and by 1991 this had fallen to only 4%. Half of all mothers with children under six years were employed full-time with 90% working an average of 34 hours per week (Carlsen & Laesen, 1994: 32). Between 95% and 98% of Danish fathers were employed full-time working an average 41 hours per week (Carlsen & Laesen Jorgen, 1994: 53). By the mid 1990s Denmark had achieved the absolute highest labour force participation rate for women in the whole of the western European community. These figures indicate that a large proportion of Danish couple based families were in full-time employment supported by fully state funded childcare. However, even when the Danish state provides the best support, most parents are dissatisfied with their employment outcomes because there are non-monetary costs to the family (Carlsen & Laesen, 1994; Park et al., 2007; Klumb & Lambert, 2003).

2.5.2 United Kingdom

In contrast to the Danish experience the UK is marked by a debate as to why part-time employment should be such a predominant feature of the working lives of mothers. In the UK, between 1971 and 1986, the number of part-time jobs increased by 49% while full-time employment for women decreased by 12% (Brannen & Moss, 1991: 28). By 1986 working mothers accounted for only 18% of all full-time employment and 50% of part-time employment. This meant that mothers of the under-fives in the UK had the second lowest full-time employment rate in the European Community (Hewison & Dowswell, 1994: 3).

Supply side economists could argue that women exhibit a preference for fulfilling their traditional maternal roles and simply use employment to supplement the family's income rather than have career expectations. However Dex (1988), in a study of women's attitudes towards work, found that where women gained more experience in the workplace their preference for traditional roles diminished. Dex (1988) concluded that:

> **"…it is clear that a woman's decision to work fewer hours is heavily constrained most notably by the presence of children and child-care this raises."**
>
> (Dex. 1988)

The implication of this finding is that a greater proportion of women would have taken full-time employment had the government provided publicly funded childcare (Dex, 1999).

The comprehensive work by Hewison and Dowswell (1994) supports longstanding claims that employment practices in the UK are not at all sympathetic to the needs of mothers. There have been several reasons put forward as part explanation as to why successive British governments have failed to respond to the needs of working mothers. Firstly, mainstream Pilotical doctrines and the popular press promote the family as the cornerstone of society and as such encourage women to stay at home and raise children. Secondly, the British government, in an effort to contain fiscal spending and inflation has made it clear that it is a choice of women to work or not to work, therefore it is their business to arrange childcare; the hope was that the private sector would respond to their needs. Thirdly, government attempts to strike a balance between the needs of the economy, the family and support for working mothers, has often

resulted in doctrinal confusion and this has hampered the development of appropriate legislation. For example, during the Second World War, 62,700 childcare places were created in order to release women into the workforce and support the war effort (Hewison & Dowswell, 1994). Immediately following the war the government urged women with young children to stay at home. Consequently, the number of childcare places dwindled to only 29,000 by 1986. In effect this policy supplied childcare places for only one in every 100 children aged less than five years. Moss (1990) concluded that this type of funding provided more of a social work resource for those families in financial difficulty rather than a right for women to be in full-time employment (Moss, 1990). Although there have been some minor UK policies aimed at increasing the number of working mothers in the workforce, such as tax incentives designed to induce employers to create workplace nurseries, the recession of the early 1990s deferred any major initiatives in this area. Hewison and Dowswell's (1994:5) account of a speech made by Margaret Thatcher, as reported in the Guardian (19.7.90) further illustrates the notion of ongoing doctrinal confusion. Regarding the provision of publicly funded childcare Mrs Thatcher stated:

> **"It was for business to attract women back to work by offering child care facilities, flexible working conditions, career breaks and home working opportunities."**

Mrs Thatcher nevertheless admitted that:

> **"... no matter how hard any woman planned to combine work and family, it was impossible to do everything oneself."**

And went on to propose the following solution:

> **"You have to seek reliable help - a relative, or what my mother would have called a treasure."**
>
> (Hewison & Dowswell, 1994: 7)

More recently, Lewis (2003) a key family policy analysit in the Britain stated:

> **"The UK has long been near the bottom of the EU 'childcare league'. Attitudes of policymakers towards employment for the mothers of young children were ambivalent up to and including the Thatcher years, and the problem of 'reconciling' work and family was historically deemed to be a private decision."**
>
> (Lewis, 2003:219)

Hewison and Dowswell (1994), in the midst of the Thatcher years, explain that market forces were unlikely to improve matters for working mothers and their childcare needs as "custom and practice, organisational structures and social

values all exert powerful pressures in favour of the status quo." (Hewison & Dowswell, 1994: 5).

In France the subject of state support for working mothers is open to debate whereas the British government's policy in the mid-1980s was based not on an explicit policy of objection to working mothers but more on a policy of wait and see how the market responds to families' needs (Brannen & Moss, 1991: 31) (Hantrais, 1990: 183). Hantrais's (1990) exploration of labour markets for French and British women leads her to conclude that:

> **"French women are more successful than their British counterparts in gaining access to higher education and pursuing continuous full-time employment and careers, while achieving similar patterns of family building."**
>
> (Hantrias, 1990: 148)

In contemporary Britain, the potential demand for childcare is suppressed by a large deficit in supply. In 2003 the Day-care Trust released data showing that for every five children under the age of eight years, there was only one childcare place available (Hall, 2003: 11). Policy initiatives devised to engage all women in the UK in the labour market have failed. Recent data (Duffield, 2002) shows an employment rate of 21.8% for mothers with children aged 5-10 and only 16.0% for those with children aged 11-15 years. An explanation for this phenomenon is discussed in the upcoming section on the "socio economic differences among working mothers" (Duffield, 2002).

The Blair government introduced new and improved laws for working parents in the UK in April 2003. This substantial package, The Work and Families Bill, extended the period of paid and unpaid maternity leave, introducing for the first time paid leave for fathers and adopters. Parents of young and disabled children were also given rights and support when requesting flexible working arrangements. The effects of these legislative changes are still being evaluated; most recent studies show that two weeks of paternity pay at a flat rate of £106 per week (approx $220 Aust.) merely supports fathers being present immediately after birth. A steep inverse (negative) relationship continues to exist between increased weekly earnings by fathers and propensity to take leave. Secondly, financial constraints remain the biggest incentive to prompt mothers to return to paid work (Smeaton & Marsh, 2006).

2.5.3 Australia

There has been a strong tendency, since World War II for Australian women to participate in the labour force. From 1947 to 1991 there was a steady increase in the number of working mothers from 24.9% to 52% respectively (Bittman, 1992: 1-3). Australian mothers have a preference for part-time employment that is similar to that of their counterparts in the United Kingdom. In 1983 23.8% of mothers were employed part-time, increasing to 37.4% by 2002 (Gray et al., 2003). There has been an increase in the number of Australian women working outside the home, rising from 45% in 1980 to 54% in 2000 (Pocock, 2001). There has also been an increase in the number of coupled mothers working full-time. In 1983 there were 18.3% employed full-time compared with 25.5 % in 2002 (Gray et al., 2003).

In Australia, work and family policies have varied in focus dependent on ideology of incumbent governments. The Labor governments, in power between 1972-1975 and 1983-1996, created substantial equity gains for women, which has been attributed to the party's close relationship with the trade union movement (Brennan, 2007). However, a lack of detail and transparency of any plans to legislate for paid maternity / paternity leave suggested the Labor party was reluctant to fully match the ideal of gender equality with the reality of women's labour force participation. The election of the Howard government in 1996 began a policy domain characterised by family values rather than gender equity. The Howard government used the taxation system as the primary mode of effecting family policy. The main features were the Family Tax Benefit (FTB) scheme and the Child Care Benefit (CCB) scheme. The FTB and the CCB were income tested. Thus the FTB reduced when dual incomes and secondary earners' income increased. This created a crisis for mothers who wanted to improve their income because they lost FTB. Hill (2006) concluded that:

> **"The structure of the FTB makes it financially irrational for many households to increase the secondary earner's participation in the labour market".**
>
> (Hill 2006)

The 2004 Budget Overview made it clear that the family-tax package (income tax cuts, family payments, government superannuation co-contribution) would give maximum financial benefits to dual income families where the 'primary earner'

(read male) contributed 80% of the household income (Hill, 2004) Married mothers who retained the right to choose not to work at all would be eligible for the maximum FTB (Hill, 2006).

Brennan (2007) argues that the general thrust of the Howard government was to discourage labour force participation of mothers of young children, suggesting a return to the traditional gender division of labour for women:

> **"…with the important exception of sole parents who experience social penalties if they are not employed."**
>
> (Brennan, 2007)

Brennan (2007) points to policies whereby the Howard government:

> **"...increased family benefits but imposed substantial penalties on second earners; it has funded a generous non-means-tested Maternity Payment, while refusing to introduce paid maternity leave; it has expanded the provision of publicly subsidized child care for profit while undermining the Australian system of nonprofit, community-based care. "**
>
> (Brennan, 2007: 19)

The Howard government oversaw a substantial expansion in private sector supplied childcare, particularly long day care and out-of-school hours care. However, the almost full corporatisation of childcare raised deep concerns about the impact of private-sector dominance when the public sector was underwriting the multimillion dollar profits. Since 2002, the growth of for-profit services has continued at a rate eight times greater than that of not-for-profit services (Department of Family and Community Services, 2005). By 2001, 67% of childcare services were for-profit (Australian Institute of Health and Welfare, 2003). By 2004, fewer than 30% of children in childcare attended not-for-profit services (Department of Family and Community Services, 2005). The consequence of the private sector dominance has been that childcare is prohibitively expensive for many families. A UK study found that:

> **"A little over one-third of mothers said that their return to work depended on the successful search for suitable childcare while one-fifth claimed that the cost of childcare prohibited return."**
>
> (Smeaton & Marsh, 2005: 34)

The general thrust of the Howard government was to discourage labour force participation of mothers at times when there were labour shortages in the economy.

Morgan and Zippel (2003) examined policies in support of paid parental leave for young children in Australia and a wide range of European countries, concluding that although the discourse contained in policies is 'gender neutral' the content of the policy documents strongly suggests that advocates of the policies share a strong belief in the merits of maternal care over any other form of care (Morgan & Zippel, 2003: 64). Secondly, options to care for children are rarely taken by men because they have not been accompanied by wider attitudinal change in the social and economic areas of men's lives; men are not yet fully appreciated as competent and willing carers for young children. A recent government report by Bittman et al., (2004) characterises Australian men's uptake of family friendly policies as low.

> **"In 1999, only 18% of fathers used flexible hours to balance work and family, and 73% did not use a single family-friendly provision. A mere 2% of men indicated that they had switched to part-time work for child care reasons. More than two-thirds of fathers with preschool-age children said that their partner was the usual carer of these children."**
>
> (Bittman et al., 2004: executive summary)

Thirdly, policies may seem generous, but the longer women take from work the fewer the opportunities for career advancement, wage growth and protection against the risk of unemployment (Morgan & Zippel, 2003: 70).

Even if Australia were to follow the policy patterning used in Britain to improve Work Family Balance (WFB) it is unlikely that state support will translate into working parents moving toward greater gender equity in the family and workplace. This statement is supported by recent analysis showing a continued crisis in equity in Britain.

> **"…while the nature of the policy mix that has developed in the UK - including services, leaves, and working hours - has held out considerable promise for achieving WFB policies that promote gender equality, in practice there is little evidence of movement in the direction of enabling men and women to choose a different pattern of paid and unpaid work".**
>
> (Lewis & Campbell, 2007: 23)

And whilst some groups of fathers' desire for more time with their children was noted in the policy documents, there has been no substantive support for addressing the long hours fathers work and a rather inflexible approach to maternity and paternity leaves for men (Lewis & Campbell, 2007).

Many, if not most Australian dual income families, and those in other countries are coping with a crisis brought on by a lack of family based policies that have not been guided by research evidence. Consequently, working mothers and their spouse / partner are being placed in an untenable situation of needing to work but being unable to secure the support and necessary resources to devolved their parental responsibility to the state (childcare) or rely on a coherent system of workplace arrangements that are family friendly and offer the necessary flexibility (Lewig et al., 2006; Gray et al., 2002; Gray et al., 2003). An overarching analysis of social policy in Australia, Canada, Great Britain and the United States by O'Connor et al., (1999) revealed a differential range in childcare, dependent on the user's ability to pay. And an emphasis on the free market supply of childcare effectively rewards those already privileged in the labour market, by wages, conditions and opportunity associated with full-time employment. Those couples with weaker employment circumstances, burdened by family care responsibilities and less able to pay for care are set to form an underclass of dual income families (McDowell, 2005).

2.6 Socioeconomic differences among working mothers

Not all working mothers are disadvantaged by their dual roles. There are typically professional women, employed full-time and living as a couple who have the means to purchase care for their children or elderly relatives as well as to buy commodities that are substitutes for routine household tasks (pre-prepared food, affordable family restaurants, laundry services, house cleaners) (Anderson, 2001).

Smeaton and Marsh (2006) reported on survey data, collected by telephone interviews with a nationally representative sample of 2,504 mothers (17 months after the birth of their child). Smeaton and Marsh (2006) found that personal characteristics of women were less important 'job' and 'employer' related factors:

> **"Mothers in higher-level jobs providing flexible opportunities, often in unionised workplaces, and treated well by their employers, were the most likely to return to work after maternity leave."**
>
> (Smeaton and Marsh, 2006: 3)

Mothers with higher prior earnings, employed in higher-skilled occupations, were more likely to receive maternity pay. By contrast, mothers who have a spouse/

partners receiving higher-than-average earnings were more likely to remain at home.

Above all else, financial constraints are the biggest single factor in determining a mother's return to work. A crisis of care may occur for many mothers who do not find paid maternity leave adequate for their needs and have a spouse / partner on a low income and / or a house mortgage which 'pushes mothers back to work' (Smeaton & Marsh, 2005). Some women reconcile financial and caring needs by returning to part-time work. Working part-time whilst their children are young often means accepting less income and diversion from a projected career pathway. These factors are likely to cause a great deal of stress, particularly for relatively well educated women holding a professional qualification (Barnett & Gareis, 2003).

Women in low income families face a moral crisis over decisions to meet government incentives to engage in contractual labour such as work-for-welfare as well as childcare obligations. Lewis (2002) and Mc Dowell (2005) argue that a commitment to the responsibilities and duties owed to others may outweigh the individualistic commitment to maximize income when people are making decisions about how to divide and fulfil their caring obligations. Such a commitment is largely unrecognized in welfare-to-work. Thus, people's/women's willingness to enter waged work if the financial incentives are improved may be over-estimated policies and as such the policy may present many women with a crisis of care.

The crisis for women in low income and dysfunctional families is that they cannot escape part-time work and the subsequent poverty trap because they are tied to traditional roles. There is longstanding evidence (Edwards, 1998) to show that social workers prefer mothers to stay at home to provide childcare than for fathers to provide childcare so that the mother can work; the inference being that in some social circumstances the children may be at risk in the care of fathers (Munro, 1998).

> **"Edwards's study demonstrates the gulf between rhetoric and reality: the workers she interviewed consistently spoke of the importance of engaging men, but in their practice gave covert messages that child care is a woman's job and failed to engage with the men they did encounter."**

(Taylor, 1999: 211)

The structure of social work practice continues to reinforce traditional models of gendered role segregation within problem families (Taylor, 1999). Further to this, there is a tendency in social work education, to conflate mothers as functional parents and disregard the potential contributions of non-abusive fathers (Trotter, 1997; Risley-Curtiss, 2003). These findings explain how women with family problems are constrained from full-time employment by childcare responsibilities and as a consequence may face financial crisis brought on by low incomes attached to part-time and low skilled work (Duffield, 2002:605).

Many contemporary women who have employment opportunities perceive that their life may be difficult or develop into crisis should they give birth early in their career. Rather than adopt a working mother life style, exposing them to the expense, inconvenience and moral anguish associated with possible long term effects of childcare, many contemporary women choose to delay having children. Current teenage fertility is the lowest since 1921 and the total fertility rate for Australian women has halved in the last 50 years (Australian Institute of Family Studies, 2008). Similar strategies are used by women in the UK.

> **"Contemporary women are delaying their first childbirth until their late twenties; the mean age of first birth in Britain is now 28 (Office of National Statistics, 1996)."**
>
> (Moffitt, 2002: 727)

Importantly, more than a quarter of men and women have fewer children than they would ideally like to have (Gray et al., 2003). It may also be that better educated women seek to reap the rewards of that social investment in the labour market and in so doing decide to postpone their fertility by contraception (Wood & Newton, 2006). Women less educated have fewer early-life employment opportunities and prospects of financial rewards from labour market participation and as such may decide on non-monetary social rewards such as planned motherhood. There are now more childless women in the workforce and more women who have fewer children. Evans and Kelly (2004) examined long term trends in Australian women's workforce engagement from 1984 to 2002 to model key influences. The strongest factor predicting employment was an association between fertility control and education.

> **"...the strong rise in women's educational attainments and the large decline in fertility both exert substantial influences elevating women's workforce participation and hours worked."**
>
> (Evans & Kelly, 2002: 1)

Importantly, Evans and Kelly (2004) concluded there was no evidence to suggest a link between government policy initiatives and timing of women's changing fertility and educational profile; time effects have occurred in other countries. The reunification of East and West Germany in 1990 resulted in revision of social and economic policy. A critical issue was the changing social position of women from the former German Democratic Republic (GDR). The East German state had been paying for 80% of the cost of children but after reunification working mothers saw a one-third reduction in their income, mainly due to the disappearance of child-related benefits alone. As a consequence, East German women have decided to forgo marriage and childbearing in order to prioritize their careers resulting in a 60% drop in the birth rate (Lee et al., 2007).

> **"The association between fertility and women's labor force activity reflects the incompatibility between caring for children and participating in economically productive work that typifies industrialized societies"**
>
> (Brewster & Rindfuss, 2000: 271)

Women who choose to become working mothers have been the focus of researchers seeking to determine satisfaction with work – life balance.

2.7 Satisfaction with work – life balance

Parents in dual income families aim to balance the benefits of employment and time spent at work against time spent in their relationship, with their children, extended family and friends. Outside the time spent performing household duties, free time to be with the family is a precious and precarious commodity. A paucity of free family time is a key factor in eroding family cohesion, bringing many marital relationships to a crisis point.

To improve the accuracy of measuring the effects of labour market changes and work-life balance (WLB) many contemporary researchers advocate the use of a secondary analysis of historical data (Bittman & Rice, 2002; Sullivan & Gershuny, 2001) and the need for changes to research methods (Goodin et al., 2005). Sullivan and Gershuny (2001) drew upon comparative cross-time data

archived by the Institute for Social and Economic Research at Essex University to determine trends in work-life balance with data comprised: "… successive time-use diary surveys from a range of industrialized countries collected from the 1960s to the 1990s" (Sullivan & Guershuny, 2001:331)

Sullivan and Gershuny (2001) found, for a range of industrialised countries, a 'relative stability' in the balance between family, work and leisure across several decades. However, there is evidence to show that some families in the United States, where labour markets differ from that of Europe and Australia, have had a reduction in leisure time concomitant with an increase in working hours. Jacobs and Gerson (2004) revealed that over a third of American professional males and one sixth of professional females worked over 50 hours per week.

> **"Americans as a whole are working more than ever ... The main culprit is a shift in cultural values, with individual workers preferring to pursue personal goals at work - to the detriment of families, communities and children"**
>
> (Jacobs & Gerson, 2004: 1)

Bittman and Rice (2002) investigated time use surveys conducted in 1974, 1987, 1992 and 1997 to unravel the effects of increasing diversity in hours spent in paid employment by Australian parents. Bitmann and Rice (2002) determined, from raw data, that "…households are supplying more working hours to the labour market than ever before" and "there were more dual income families than ever before". In traditional families (male breadwinner, wife and children) an average of 50 hours a week was allocated to the labour market and 70 hours on unpaid work (totalling 120 hours). For dual income families, where the spouse / partner works part-time, 70 hours was spent in paid labour and approximately 60 hours in unpaid work (totalling 130 hours) (Bitmann & Rice, 2002).

In earlier work, Bittman (1992) had observed that the hours spent by men in employment fluctuated in accordance with employment and unemployment trends. The average time men devoted to paid work was 50 hours a week in 1974 falling to 44 hours a week in 1987 (Bittman 1992: 27). More recent figures show a return to longer working hours with Australia and the United States now having a similar proportion of men (20%) working more that 50 hours per week (Pocock, 2001). In the mid 1990s, fathers of under-fives in Britain worked the longest hours in Europe with more than a third working 50 hours per week (Hewison &

Dowswell, 1994: 3). In contrast to the Australia, United Kingdom and USA trend, less than 10% of men in Sweden, Luxembourg and the Netherlands work over 50 hours per week (Pocock, 2001). The Life Course Study, when conducted by the Australian Institute of Family Studies, produced data showing that 66% of men and 23% of women worked more than 41 hours per week; within this group 50% of men and 46% of women "felt that work interfered with home life" (Glezer & Wolcott, 2001).

Although Pocock & Wilson, (2001) contend that the impact of increased labour participation and a trend to longer working hours in Australia is difficult to determine with great certainty:

> **"The academic literature on the specific effects of long hours on family life is leaner. Australian material is especially scant"**
>
> (Pocock & Wilson, 2001: 3)

The hours worked by Australian men and women, particularly in dual income families, is seen as problematic in terms of achieving a work-life balance. Pocock and Wilson's (2001) review of existing literature leads them to conclude that:

> **"After leading the world on working time reduction in the 19th century, Australia's pattern of hours now most closely resembles that of the US and sits amongst those with the longest average working hours in the industrialised world. What is more, many want to work fewer hours, and find that their hours are not only longer, but more pressured, more demanding"**
>
> (Pocock & Wilson, 2001: 27)

And despite the Pilotical hype about family friendly workplaces Pobert (1997) found that:

> **" ....more than a quarter of employees believe their ability to balance work and family demands has declined, and half of those who are working longer and who also have dependent children or relatives are less satisfied about this balance."**
>
> (Probert, 1997, A11)

The extent to which Australian workplaces actually provide for family friendly working conditions is poorly understood. Gray and Tudball (2002) claim to have conducted:

> **"The first large-scale analysis of the extent to which employees within organisations in Australia have differential access to a range of family-friendly work practices."**
>
> (Gray & Tudball 2002: 50)

This analysis was based on the recent data available to researchers, produced as late as 1995. Gray and Tudball (2002) conclude:

> **"Employees with the lowest levels of education, job tenure and organisation-provided training were the "least likely to have access to family friendly work practices".**
>
> (Gray & Tudball 2002)

And employees in this group are the least likely to be able to afford fees for childcare.

2.8 Evaluating claims of time poverty

Sociologist and time-use researchers have come to use the term 'time poverty' to describe the phenomenon where dual income families feel as though they are endlessly engaged in tasks related to work or family activities. Although many studies show that ample free time is available to people in the United States (Robinson & Godbey, 1997) and Australia (Bittman, 1999; Gershuny, 2000) and the quality of leisure has not diminished, parents in dual income families are finding themselves busier than ever before and the notion of time pressure is contributing to a life style crisis. Furthermore, deregulation of the Australian labour market is sponsoring a significant fragmentation of working-time arrangements (Campbell & Brosnan, 1999) with many parents now working across weekends and a greater range of hours across the 24 hours clock; this change in work hours impinges on the time traditionally used by families to be together, on evenings and weekends.

Sociologist and time-use researchers have been unable to determine with certainty, if 'time pressure' has actually increased in contemporary society. Consequently, there is debate and controversy among those who measure time use and those who seek to understand its relationship to family life (Eriksson et al., 2006; Schor, 2000; Sirianni, 1991; Sullivan & Gershuny 2001; Smeeding TM Marchand, 2003; Gershuny, 2000). Despite this debate, the popular media and popular literature have successfully marketed the notion that there is a time famine (Schor, 1991; Paton, 2006).

On the basis of Australian and US data Goodin et al., (2005) conclude that:

> **"There is little doubt that total time spent in paid and unpaid household labour is increasing overall, as increasing numbers of**

> **working women and dual earner couples more generally put in a 'second shift' at home after a full day in paid labour."**
>
> (Goodin et al., 2005: 43)

However, Goodin et al., (2005) suggest that much of the unpaid work embarked upon by couples, single parents and parents in a dual income family is of their own choosing (discretionary) and the time spent may not be entirely necessary. That is:

> **"They spend more time in unpaid household labour and personal care than strictly necessary to keep themselves and their household up to minimally acceptable social standards."**
>
> (Goodin et al., 2005: 44)

For a dual income family discretionary time spent on unnecessary unpaid tasks amounted to 33.02 - 48.20 hours of unpaid labour a week (Goodin et al., 2005). Consequently, actual free time appears less. This data needs to be viewed with suspicion as discretionary time (free time) was calculated as a residual of time left after working to secure an income just above the poverty line. Few individuals would define free time in this manner because poverty is appreciated as a state of mind rather than a pecuniary amount. Secondly, Goodin et al., (2005) recognises that: "Men have more potentially uncommitted 'discretionary time' than women across all household types." (Goodin et al, 2005:59).

Mattingly and Sayer (2006) also found that the effects of objective time constraints vary by gender; by comparing United States time diary data from 708 individuals in 1975 and 964 individuals in 1998 Mattingly and Sayer (2006) concluded that even though free time increased for both sexes the sense of 'time pressure' increased. This paradox affected women more than men. Women's time pressure increased significantly between 1975 and 1998 but men's did not.

> **"Our findings suggest that persistent inequality in gendered time-use patterns is paralleled by gendered experiences of time pressure."**
>
> (Mattingly & Sayer (2006: 205)

The potential negative effects of parental work commitments on children, parents and families are often summarised as time 'squeeze', role overload stress and the deterioration of parent-child or marital relationships (Millward, 2002). In research seeking views from children and parents about the effect of work on family life, Lewis, Hand and Tudball (2001) found that time spent at work was

but one of a complex interplay of work related issues impacting on relationships between children and parents.

2.9 The psychological and physical effects of childcare

This section establishes that there are substantial and longstanding problems in generating evidence to show that childcare outside the family is beneficial or at least, has no negative effects on a child's growth and development. Those parents seeking to make a decision on what is the safest available care, based on best evidence so far, are likely to be dismayed by the lack of definitive evidence. Consequently, many mothers and fathers face the moral crisis of not knowing if childcare causes their child harm. Secondly, the discussion just presented supports the inclusion of attitudinal questions about childcare and parental responsibilities in the household survey 'Men's health practices in dual income families' that is central to this thesis.

Parental attitudes toward institutional childcare rest mainly on the practicalities of equating supply and demand (McDonald, 2002; Drago, 2002), affordability (Hofferth & Wissoker, 1992), women's right to work (Marchbank, 1996); geographical accessibility to childcare (Henderson & Hoggart, 2003; Halliday & Little, 2001); options for meeting special cultural and religious needs of their child (Hall et al., 2004); children in need of special support (McDonald, 2002); reservations over quality and effects on the child (Evans & Kelley, 2002; Wise et al., 2002); along with the strength of linkage to early childhood education (McDonald, 2002).

The Australian National Childcare Accreditation Council (1993) reported that a child can spend as much as 12,500 hours in paid childcare before starting school. This figure is only 500 hours less than a child would spend in the school setting during their entire 13 years of education (National Childcare Accreditation Council, 2006). The effects of this type of exposure are still to be evaluated revealing that institutional childcare for working mothers remains a huge social experiment not driven by systematic research in support of evidence based practice.

> **"There is a great deal of research on the effects of maternal employment and of day care on children's health, wellbeing and learning, but it is very inconclusive."**

(Evans & Kelley, 2002:189)

Key researcher bodies highlight the complexity of the task and limitations to research.

> **"The NICHD Study of Early Child Care provides an exceptionally rich data set for addressing questions about the significance of varying contexts of development from infancy through middle childhood... Results from Phase I of the study, covering the first 3 years of life, make it clear that the impact of early child care experiences cannot be adequately assessed without reference to children's experiences in their families.**
>
> (NICHD Early Child Care Research Network, 2001: 487)

Key researchers continue to point to shortfalls in research method (Andersson, 2003; Nomaguchi, 2006, NICHD, 2002; Clarke-Stewart, 1982). Firstly, a persistent confounder to assessing the combined and individual effects of out-of-home childcare is the finding that the quality of maternal care-giving is the 'strongest' predictor of development (NICHD, 2001a; NICDH 2001b). Those researching fatherhood record that a father's involvement can also make a positive difference in preschool children's outcomes but how this factor may mediate the link between maternal employment and childcare outcomes is unknown (Pleck, 1997).

Secondly, research conclusions are likely to vary depending on the individual characteristics of the childcare setting in which the data is collected (Love et al., 2003). The National Institute of Child Health and Human Development studies (NICHD 1998a; NICHD, 1999) show the quality of care is the most 'consistent' predictor of desirable outcomes from childcare with higher quality of care strongly linked to less personal anxiety, less problem behaviour (at both two and three years of age) greater social competence and cooperation, as well as an easier transition into school. Conversely, several studies have shown that more time spent in low-quality care and more numerous / less stable care arrangements was a predictor of negative outcomes for children age two years (NICHD, 1999b; ECCRN, 2005). The implications of these findings are that all children should have access to quality childcare; finding an equilibrium between price and quality features prominently as a parental workload (Harrison & Ungerer, 2005). There are few studies that have been able to control for quality of institutional childcare when examining the effects of maternal employment on child development (Han et al., 2001; Clarke-Stewart, 1982). Some studies suggest that high-quality care,

when available to low-income children, may make a positive difference to their development, more so than it does to those from high-income families. However, hours spent in quality care, family characteristics, the child's personality and age at which care begins all mediate the effects of care (Han et al., 2001). The principal conclusion, from a recent large-scale research project, using multi-site data (Anme & Segal, 2004) was that child-rearing behaviour by 'the caregiver' may be more important in explaining children's early social, vocational, motor, and intellectual development, as well as ability to adapt to social situations, than access to high-quality childcare facilities or the length of time children spend in these facilities.

Thirdly, research findings may be regionally specific. Harrison and Ungerer's (2005) recent comment on the lack of applicability of overseas childcare research findings to the Australian context further reduces the amount and quality of evidence on which many parents would ideally like to base their decisions.

> **"...the vast majority of child care research studies have been done overseas, where the context of care and its regulation and monitoring are very different to Australia. Hence, the generalisability of these findings to the Australian context must be questioned."**
>
> (Harrison & Ungerer, 2005: 27)

Lack of definitive evidence to support a decision about the appropriateness of childcare, at what age to commence childcare is likely to create tension among dual income earners and a moral crisis of confidence. Societal attitudes also indicate concerns over the appropriateness of placing infants and toddlers in even part-time day-care (Evans & Kelley, 2002; Wise et al., 2002). Concerns over how to balance cost and quality are also prominent; although some researchers report that many parents are more concerned about the price of childcare than quality issues (Hofferth Wissoker, 1992). There exists a high price elasticity in demand for childcare in Australia, meaning that relatively small increases in price curtails demand quickly; such price fluctuations 'create insecurities for workers' and confound women's decision making on the profitability of their labour (McDonald, 2002: 202; Wilson et al., 2007; Viitanen, 2005; Wetzels, 2005; Cobb-Clark et al., 2000; Doiron & Kalb, 2005).

2.10 Childcare linked to physiological stress for mother and child

Contemporary researchers and mothers continue to hypothesise that: children attending regular childcare experience higher levels of psychological stress than those in home-care. Higher levels of psychological stress are thought to have detrimental effects on a child's growth and development. Research findings linking childcare to physiological stress and possible health problems are likely to be taken seriously by parents who want a safe environment for their child whilst they commit to employment. Cortisone is a hormone that is released into the body at higher levels in response to stress. An analysis of saliva provides an easy and reliable means of measuring the body's cortisol level. Dettling et al.'s (1999) study, replicating a previous study, showed that very young children, and those with more immature social skills, were more likely to have rising cortisol concentrations as their day in childcare progressed. Sim et al., (2005) were able to show that cortisol levels increased across the day for those children attending poorer quality childcare compared with other groups. It is not known how high, and for how long, cortisol levels need to be elevated to create an unacceptable risk to health and wellbeing of children (Sims et al., 2006). Complicating the assessment and characterisation of stress in children attending childcare is the understanding that children also respond to their mother's levels of stress and non-coping behaviours. Moore's (2007) discussion of the evidence leads to the conclusion: "The natural development of maternal and infant behaviour occurs in a dyad characterized by synchrony and reciprocal interactions" (Moore, 2007:45).

Women who experience stress from job strain may raise stress levels in their child independent of the effects of childcare (Lundberg & Hellström, 2002). Job strain is associated with elevated free cortisol concentrations early in the working day and morning cortisol is a sensitive indicator of work overload in women (Lundberg & Hellström, 2002; Steptoe et al., 2000). Luecken et al., (1997) found working mothers excreted greater amounts of cortisol; this finding was independent of other factors (social support network or marital status). Chryssanthopoulou et al., (2005) found that mothers who reported their jobs as emotionally exhausting or less rewarding had higher levels of cortisol and the children of such mothers had evening cortisol levels of more than double that of children whose mothers experienced greater job satisfaction.

Although researchers have established an association relationship between stress and a variety of physical and psychological health problems in adults, the long term effects on infants and children are less clear. Turner-Cobb (2005), having performed a systematic review of the research that assesses the relevance of psychological and stress hormone correlates to disease resistance and other childhood health indicators concludes that:

> **"Differing research perspectives offer valuable insight into the often assumed but largely unexplored links between early life experience and subsequent physical health outcomes in adulthood."**
>
> (Turner-Cobb, 2005: 47)

And consequently:

> **"Longitudinal studies incorporating measures of acute physical health outcome and of learning and memory are clearly needed."**
>
> (Turner-Cobb, 2005: 47)

The crisis faced by working parents is that research shows that children in childcare have elevated levels of the stress hormone cortisol and it is assumed that there is an association between stress and future health problems. Secondly, working mothers who experience job strain have elevated cortisol levels and their children also have elevated cortisol levels. Lack of consistent research findings leave working couples to ponder on the potential harm their life style may have on their children.

2.11 Attitudes to working mothers

A discussion on the inadequacy of policy in support of working mothers has already taken place in Section 2.5 – 'Support for working parents: an international comparison'. This section explores societal attitudes towards working mothers; in so doing it supports the development of attitudinal survey questions used in this thesis to explore the tensions between women's right to work and maternal responsibilities.

A continuing emphasis on traditional male employment patterns and normative societal attitudes toward women's traditional roles of child raising come into conflict with women's right to equal employment opportunities. This inequity is a source of ongoing tension and even social crisis for many women (Marchbank, 1996; Russell et al., 1999). Time spent at work reduces opportunities to enrich home and family life and there is a long held concern within society, that

employment gains for women are at the expense of the other family members, particularly young children who are seen as vulnerable and in need of direct maternal support and nurturing (Wise et al., 2002; McDonald, 2002). Thornton and Young-DeMarco (2001) contend that American society is becoming more tolerant of the working mother.

> **"Many Americans also continue to be concerned about the effects of women's employment outside the home, with many believing that family life and especially children suffer when mothers are employed. However, the fraction who believe that children suffer as a result of their mothers' paid employment has declined substantially over the past two decades, with that decline continuing into the 1990s. This may make it easier for mothers to work in the future."**
>
> (Thornton & Young-DeMarco, 2001: 1037)

However, attitudes to fathers' employment patterns have remained universally traditional because men are unable to escape the gendered psyche of the male breadwinning role held by their forefathers (Park et al., 2007). Murphy (2002) asserts that although policies are moving toward family friendly practices it is too early to talk of the demise of the breadwinner role. Consequently, breadwinning remains a presumption around which men's inflexible and full-time employment continues.

Whilst women could become the major income earner and the father / partner could adopt a caring role sociological analysis undertaken over two decades ago found that issues concerning masculinity, authority, marital stability and pride emerge as factors that deter women from adopting the breadwinner role (Mc Kee & Bell, 1985). Contemporary researchers contend that the threat to masculinity from spousal employment remains a robust theme across cultures (Bolak, 1997; Mannon, 2006). And most recent research confirms the need for males to maintain a power relationship within marriage when the wife earns more (Tichenor, 2005). Davies et al. (1993) conducted a rigorous review of the literature investigating the relationship between unemployed men in Britain and their spouse / partner's participation in the labour force. They concluded that women choose not to seek work because it would be demeaning to their man's perceived role of breadwinner; this association was strongest in households with children. Larsen (2004) contends that spouses / partners of unemployed men do

not seek work because they do not consider their spouse / partner to be capable of childcare in their absence (Larsen, 2004).

Even when social policies have been successful in creating an egalitarian workforce attitudes within the family, about the family, continue to focus on longstanding gender roles. Motiejunaite and Kravchenko (2008) explored employment and gender-role attitudes in Sweden and Russia where both countries had family policies targeted at facilitating female employment. Notably, Sweden had placed a greater emphasis on shared parenting through flexible work arrangements and Russia had a greater proportion of dual earner as well as female led families (women being the main income earners). The researchers concluded that despite the success of family policy in support of female employment, policy on its own "does not necessarily bring changes in gender-role attitudes" (Motiejunaite and Kravchenko, 2008). Ergo, society still perceives women's place as in the home and rearing children. Even where there are signs of improved attitudes toward equality of men's and women's roles within the family a purported change in social values does not necessarily play out to changes in family roles / practices. Thornton and Young-DeMarco (2001) examined five US data sets: the National Survey of Families and Households, Monitoring the Future, General Social Survey, International Social Science Project and Intergenerational Panel Study of Parents and Children, to explore trends in family attitudes and values across the last 40 years of the 20th century. The review revealed that "a substantial majority of Americans endorse most dimensions of gender equality" (Young-DeMarco, 2001) However, more women than men accept equality and there continues to be a strong undercurrent of support of a gendered division of labour. (Thornton & Young-DeMarco, 2001: 1037). In addition, the opinion of male partners appears to strongly influence women's decisions to engage in employment (Kangas & Rostgaard, 2007).

There are limitations to interpreting the applicability of attitudinal data to everyday life. Maume (2006) determined that men's stated support for egalitarianism between the sexes becomes less convincing when such progressive ideologies are easily overturned or ignored should employment and / or career gains come into conflict with family demands. For example, Robertson (1991) argues that income generated from male salaried occupations, such as those held

by tenured employees, grow incrementally over the working life and are often linked to extra financial interest such as employers' contribution to housing, pensions and health insurance. The accumulation of work based assets and preferential male employment gives men more reasons to renege on ideals of equality of labour within dual earner families. Maume (2006) recommends supplementation of attitudinal research with further research linking attitudes to action.

Corrigall and Konrad (2007) hypothesised that if men were truly egalitarian it could be expected that men and women would similarly prioritize work and family obligations. Using two samples of full-time married workers from the 1992 National Study of the Changing Workforce to examine the restrictions placed on work effort / time so as to meet family needs, Corrigall and Konrad (2007) found that women used more job trade-offs than men, leading to the conclusion that: "Prioritizing work and family obligations is governed more by gender traditionalism than by egalitarianism". (Maume, 2006:859)

Although some research suggests that fathers are spending more time with their family it is likely that this choice relates to a temporal notion of the new fathering (the sensitive new aged guy) rather than an attitude of supportive egalitarianism toward the working mother. In support of this notion a study by Yeung et al.'s (2001) on American dual earner families found that increased time with children occurs on the weekends and not during the working week, a time when mothers might appreciate a little assistance to balance work and family commitments. Yeung et al.'s (2001) analysis of data led to the conclusion that: "Mothers' work hours have no effect on children's time with fathers." (Yeung et al, 2001: 136)

A key theme in the literature is the attitude that women's work in caring for others is not attractive to men and is less valued. Practical support in caring is rarely quantified in the literature and there are few accounts of the lived experience of men who care equitably beyond reports of the exceptional case. Reasons for men's lack of contribution to caring / childcare are complex but Segal's (1990) statement is echoed by many social researchers:

> **"Persuading and enabling men to share child-care and house work entails a struggle on three fronts: personal, ideological and social. The last is important given that the obstacles to change are very real and the conditions of parenting and caring for others are so**

> **often appalling - whether it is women or just occasionally men who undertake them.”**
>
> (Segal, 1990: 58)

Women’s attitude toward the effects of work on their daily lives is well documented. Women’s attitude to paid work is less than optimal when they have been unable to devolve their traditional workload to others to compensate for commitments associated with paid employment. Arber et al., (1985) aptly present the viewpoint held by many working mothers in the statement:

> **“Freedom to work is a dubious freedom when it means that such women have little time to do anything else except paid work, unpaid domestic tasks and child care”**
>
> (Arber et al., 1985: 397)

British women’s attitudes to work have also changed toward a more traditional role; the 2005 survey data of British Social Attitudes recorded that 84% of full-time working women would like to spend more time with their family, where as in 1989 only 75% felt that way. And 58% of full-time working women said that the demands of their job interfered with their family life “at least sometimes” (Crompton & Lyonette, 2007).

A major influence on attitude toward working mothers is the price and quality of replacing maternal childcare.

> **“The decision to become employed is jointly modelled with the decision to use formal childcare, both of which are influenced by the conventional determinants such as the expected price of the available childcare and the expected wage of the mother.”**
>
> (Viitanen, 2005: 150)

A mother’s care for her child costs nothing to the family but if there are opportunities for her to be employed then potential income is lost. This is to say, a mother’s own childcare should be valued at the income she may have earned if employed (minus the cost of the childcare she must pay others when she works).

Attitudes towards working mothers often hinge on the public’s absorption of the media debate; where concerns over the questionable quality of non maternal care and possible ill effects abound (Paton, 2006). McDonald et al., (2005) studied ex-employees of an Australian university using surveys (*n*=112) and interviews (*n*=24) to record attitudes of working mothers to childcare. The study found that whilst stay-at-home mothers held negative views for all non-maternal childcare, working mothers held notions of acceptability for out-of-home childcare.

> **"Women working part-time believed nonmaternal care is acceptable if for a limited period of time and where the child is likely to derive developmental benefits ...Women working full-time were more positive about nonmaternal care, although a substantial degree of guilt and ambivalence was expressed."**
>
> (McDonald et al., 2005: e content)

Evans and Kelley's (2002) study of the attitudes of Australians towards women's work and childcare concludes:

> **"Australians have reservations about formal childcare which have some impact on their approval of maternal employment, although concerns about deleterious effects of employment on mothering have an even stronger impact."**
>
> (Evans & Kelley, 2002: 188)

The attitude of children towards women's roles in society also plays some part in influencing a mother's decision to engage in employment. The negative outcomes stemming from long or unsocial hours are keenly felt by children of dual income parents. Australian children are looking for more time with parents rather than benefits gained from additions to family income (Pocock & Clarke; 2005). The finding by Pocock and Clarke (2005) reinforces conclusions from other studies recommending policy interventions to contain long or unsocial hours for working mothers (Millward, 2002; Lewis et al., 2001).

Ongoing surveys of 'British Social Attitudes', continue to report that i) a great majority of respondents prefer families with preschool children to have the father working full-time and the mother performing only home duties and ii) irrespective of social class or income, women are no more likely than men to want to break from these traditional arrangements where young children are concerned (Crompton & Lyonette, 2007; Hewison & Dowswell, 1994:9). Data from the 2007 British attitudes survey showed most men in dual income earning families continue to work full-time; although 80% of men now prefer to spend more time with children and family; compared with 70% in 1989 (Park et al., 2007).

Child health problems or illness generally evoke societal attitudes that positively support the caring and nursing skills provided by mothers and these qualities are often perceived to be innate attributes of females. Childhood sickness and injury are anticipated yet unpredictable factors that modify the employment patterns for mothers. Few working mothers are able to locate, at short notice, a family member who is competent to provide the necessary care and few mothers are able

to purchase this type of childcare from a suitably qualified provider. Although many women have become competent in traditionally male forms of labour many working mothers lack confidence in their spouse / partners ability to care for a sick family member (Tucci et al., 2004; Larsen, 2004). Consequently, there is a societal expectation that mothers be the parent responsible for negotiating special leave with their employer so as to provide the necessary nursing care for their ill or injured child. Part of the household survey 'Men's health practices in dual income families' was devoted to assessing attitudes about men's capability and willingness to be an equitable parent, including health care of children.

2.12 What happens when children get sick?

The anticipated yet unpredictable occurrence of illness or health issues in infants, children and adolescents causes a workload crisis for many working mothers. This section identifies factors that contribute to the crisis of workload for working mothers and is an important prelude to the chapters "*Acute illness, Chronic illness, Mental illness, Terminal illness, Accident and injury prevention and Health promotion*", that identify the incidence of illness and injury among children and the health practices of fathers. Information on the health practices of fathers and their willingness to care for a sick child is an indication of equitable parenting and differentiation of gendered work. More equitable parenting, across a range of tasks and skills theoretically provides better support for working mothers and arguably improves the wellbeing of dual earner family members.

2.12.1 Division of parenting responsibilities

In has long been recognised that mothers are the primary providers of health care within the family and are responsible for forming an effective nexus between family members and those health professionals providing routine and specialist health services (Graham, 1993). Hannay (1979) acknowledges that most child health care is undoubtedly carried out without the involvement of health professionals and mostly by mothers in the home. It is estimated that between 84% and 90% of minor illness episodes are diagnosed and treated at home by the mother (Spencer, 1984; Hewison & Dowswell, 1994). Fathers rarely make adjustments to their work routines to accommodate the commitments of employed spouses / partners and childcare centres have policies that refuse the care of ill

children. As early as 1992 the American Academy of Pediatrics and the American Public Health Association jointly published guidelines outlining criteria for the necessary temporary exclusion of sick children from childcare because of the risk of cross infection or need for specialist care (Copeland et al., 2006). In the absence of support most working mothers are left to problem solve the child illness situation. There is little doubt that mothers experience anxiety at the thought of having to approach their employer for leave in order to care for a child that is ill (Hewison & Dowswell, 1994; Cunningham-Burley et al., 2006).

Key researchers note that there are few studies that seek to determine the role of fathers and even less that quantify their health practices in the care of an ill child (Hewison & Dowswell, 1994; Bailey, 1991; Hallberg et al., 2007). The study conducted by Hewison and Dowswell (1994) is unique, in that it compares how episodes of childhood illness were managed in households with working mothers and non-working mothers. The sample was taken from families who lived in Leeds and had children aged between six and seven years attending school. Hewison and Dowswell found that, over a seven-month period, there were 282 episodes of illness resulting in an absence from school. Overall 86% of children were absent from school at least once (Hewison & Dowswell 1994: 58). In 84% of episodes of illness the main carer was the mother. This was possible because 30% of working mothers were able to reschedule their work by swapping shifts with a co-worker or making the time up. A further 4% said they were able to take holidays at short notice. Others were able to take their work home with them or take their children into work. In only 15% of episodes of illness (five out of six episodes) did the mother rely on other primary carers. For these episodes, 21 grandmothers, nine other relatives, eight fathers, four non-relatives and two paid helpers were used as carers. In about a third of episodes there was more than one carer for the child (Hewison & Dowswell 1994:89). Hewison and Dowswell (1994) acknowledge that their findings cannot be generalised to other communities in the United Kingdom or other countries because of existing social and demographic variations. However, Hewison and Dowswell (1994: 15) note that more detailed information than that provided by their study is hard to find, even for those episodes in which professional care is involved.

Women carry a greater emotional burden and have greater physical demands associated with their health practices and caring for others. In their study of young people, health and the family, Brannen et al., (1994: 90) found that the amount of worry was one of the most gender differentiated aspects of parenthood. Out of 54 mothers interviewed, 26 said they worried ‘a lot’, while only two of the 30 fathers reported the same.

Substantial social costs and loss of productivity to the economy are incurred because of acute illness in young children; there is parents' time lost from work and family responsibilities as well as children's time lost from educational programs / school (Carabin et al., 1999; Bell et al., 1989; Nurmi et al., 1991). The cost of care might also pose a crisis for the dual income family where the mother performs part-time work, has low wages for semi skilled work and poor job security (Jordan, 1986). Wyn et al.’s (2003) study, based on a US nationally representative sample of working women, has been reported by other key researchers highlighting that:

> **“Only 39% had someone they could call on to help with child care the next time their child is sick.”**
>
> (McConnochie et al., 2005:1274)

The women (49%) stated that they either would need to miss work, or (7%) wouldn't know what to do when a child became ill during their scheduled work time (Wyn et al., 2004).

Carabin et al., (1999) sought to comprehensively include and aggregate all costs associated with the care of an ill child attending Day-Care Centres (DCCs). Fifty-two DCCs were included in the study and participating parents were called bi-weekly to report the information on a calendar for a total of 273 toddlers. After six months follow-up the costs were aggregated with the result:

> **“Average costs per child for medication and consultation were $47.47 (standard deviation [SD] = 52.76) and $49.10 (SD = 51.34), respectively, whereas they amount to $11.51 (SD = 51.19) for care by a babysitter, $35.68 (SD = 94.74) for care by a family member, and $117.12 (SD = 210.29) for a parent missing work (when using opportunity cost). The overall adjusted average total costs per child incurred to the parents and society was $260.70 (SD = 301.25).”**
>
> (Carabin et al., 1999:556)

Moon et al., (1998) determined that children under the age of six incurred medical costs that were 45% of the total costs for children under 15 years. The cost estimates provided by Carabin et al., (1999) and Moon et al., (1998) indicate that parents are substantially burdened by children's illness in ways outside of direct caring.

Shoham et al., (2005) studied the cost of Community-Acquired Pneumonia (CAP) a respiratory illness in children postulating that it is a significant burden / crisis for both patients and their families. Data was collected for the expenses, loss of work routine, and decrease in quality of life incurred in the care of a child with CAP in a dual income family and in a control group. Shoham et al., (2005) concluded:

> **"The patients' working mothers lost an average of 2.5 additional workdays compared with mothers in the control group. The expenses of transit to medical visits and loss of workdays were found to be the major component of parental costs during a respiratory syncytial virus infection as well ... A calculation of the total financial burden is beyond the scope of this article, but the total household expenses for the child's medical condition declared by the patients' parents was estimated to be 415 to 943 NIS ($101–230 US) ... thus making the parents' estimates ~5% to 11% of the average net income per family."**
>
> (Shoham et al., 2005: 1218)

The study by Shoham et al., (2005) forms the basis for performing cost-benefit analyses to determine the suitability of using vaccines for CAP on children and their families.

2.13 Conclusion

This chapter has established that the number of dual income families has been steadily increasing in Australia and countries with similar market economies. The necessity of dual income status is borne out of i) an increasing demand for labour, ii) the growing cost of rearing children and iii) a quest by women for gender equity within employment; these points emphasise the need for evaluating the impact and consequences of dual income status on the lives of what is a substantial proportion of the population.

Within what is considered to be a large social experiment, women have been left with a conundrum to reconcile; state support for traditional values associated with

motherhood are at odds with encouraging mothers into the workforce when there are insufficient resources for them to devolve their childcare responsibilities. A consequence of this 'doctrinal confusion' is that many women either defer motherhood or accept low skilled and low paid part-time work to achieve the flexibility they need to meet their parenting responsibilities. Underpinning women's work choices are the choices afforded to men; most fathers are unable to escape the psyche of 'breadwinning' and the inflexible nature of male full-time employment.

Even where the state fully supports full-time employment, working mothers experience a moral crisis as they seek to determine the effects of long term childcare on their child's health and development. Parents who work full-time also claim to experience the crisis of 'time poverty', and despite the rhetoric of family friendly work arrangements parents struggle to achieve a desirable work-life-balance. Researchers have concluded that opportunities for equity in labour markets for women have resulted perversely in a double burden; that of commitments to paid labour and undiminished family responsibilities resulting in maternal exhaustion and dissatisfaction (Hochschild, 1989; Oakley, 1974). Requests from working mothers, made to their spouse or partner, for a more equitable sharing of parenting responsibilities and home duties have generally been met with a substantial shortfall in contributions from these men. Although there is evidence of some increases for male involvement in domestic work, long standing normative gender roles remain tenacious and as such underpin social relations in and between work and home (Dex, 2003). Whilst single issues (childcare, female equity, failure of supportive policy, the necessity of dual incomes) sometimes lead to crisis it is argued in this chapter, that an aggregation of so many issues puts most working parents at crisis point for much of the time.

Establishing the issues and tensions faced by parents in dual earner families provides the context for understanding how child health problems can influence the work choices of working parents and often bring the dual income family quickly into crisis. The upcoming chapters '*Masculinity*' and '*Fatherhood*', provide theoretical frameworks for understanding what may induce and what may hinder men's acceptance of practicing health within the family and mainstream health services. The suggestion is that working families may avoid crisis brought

on by child illness and injury, if fathers were able to substitute for maternal health practices.

The argument that dual income families are in crisis, as set out in this chapter, relied on evidence showing a lack of support for working mothers in the areas of sharing home duties, childcare responsibilities and illness care for children. These findings support the inclusion of questions, in the household survey, measuring men's attitudes towards equitable parenting. The questions are located in: Section 1.4 *Combining work and the family* and Section 1.5 *Parenting in dual income families*. Questions that measure the amount of gender equity, the sharing of parental responsibilities, are set out in Section 2.2 *Childcare arrangements*, Section 2.3 *Episodes of illness* (who usually looks after a sick child), Section 2.6 *Sharing of home duties* and Section 3.2 *Looking after a new born child.*

PART 2 :

DEVELOPING AN ANALYTICAL FRAMEWORK

THOMAS
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CHAPTER THREE:
Theoretical framework - Masculinity

3 Introduction

This chapter explores the influence of masculinity on men's behaviour and in so doing provides a framework for developing an understanding of how and why men practice health towards their children. The initial sections present a brief review of findings to show that gender is not determined by the biological factors XY chromosomes and sex hormones (androgens). The following sections provide a review of the research literature and critical commentary revealing that masculinity is socially constructed. Theories exploring the social construction of masculinity have implications for developing strategies that may modify the way men view health and the health of others. Subsequent sections highlight that masculinity is a form of social control used to establish a division between the types of work appropriate to men and women in society and the home; men are often reluctant to alter an established division of labour when they have been socially privileged by it (Brittan, 1989). It is argued that men have created barriers to their practicing health because they have undervalued / devalued the health work performed by women and as such they are reluctant to adopt women's work (Oakley, 1974). A gendered division of labour also occurs in the structuring and provision of health services, where a high concentration of female nurses involved in direct care have feminised most health care practices. The socialisation of women as primarily responsible for the health and safety of children also feminises health care practices in the home. Consequently, women may construct barriers to men's participation in child health because they perceive health as a core feminine role (Fagan, 2003).

Linking men's masculinity to the work ethics provides an understanding of how work can limit men's opportunities to participate in family health. Masculinity continues to be closely associated with men's role of breadwinner and this commitment to waged labour effectively precludes men from direct contact with their children for much of their waking hours. An additional factor, not addressed in detail in this chapter, is the knowledge that masculinity is linked to a

group of anti-social / deviant behaviours precluding men from responsible care of vulnerable others, especially children. The closing sections of the chapter suggest that social change, brought on by gender equity policies and workplace reforms, has positively influenced men's perceptions of their role within the family, has pragmatically positioned them with more free time to participate directly in child raising, and will ultimately result in a broadening of their parenting skills. The work by Connell (1995) is heavily referenced in the section theorising masculinity as the sociological and psychology literature continue to refer to this seminal work.

3.1 Theorising masculinity

If medical science were able to show that masculinity and femininity were present at birth and attributable to biological determinants formed in utero, there would be little need to create a social theory of gender. At the present time the concept of *masculinity* is widely recognised as being socially constructed (Clatterbaugh, 1990; Hearn 1994; Beynon, 2000; Kimmel, 2001; Addis & Cohane, 2005) with ongoing empirical research still seeking biological explanations.

Social theories on masculinity are often intended to hold some utility by offering explanations for why men do what they do based on the assumption that there is a patterning of men's behaviour linked to their socialisation (Connell, 1995; Henwood et al., 1999; Mahalik et al., 2003). By mapping male attributes and behaviours (Henwood et al., 1999) it is assumed that socially desirable traits can be engendered into a new generation of young males (Kenway, 1997; Department of Education, Training and the Arts (2008); Biddulph, 1995; Biddulph, 1997). If theorising of masculine behaviours were well developed and there were reliable predictors for male behaviour it may be possible to create an explanation for why some men choose to engage in health practices for their children and some do not; currently no such model exists.

3.1.1 Can masculinity be biologically determined?

Current evidence suggests that masculinity is not determined by the existence of XY chromosomes (male) and androgens (male hormones). The work by Hines, et al., (2003) recognises that androgens play a role in forming male physical sexual characteristics but when these hormones are absent, the presence of a XY

chromosomes alone, does not contribute to male characteristics or masculine behaviour. Put another way, Hines et al., (2003) found that existence of XY chromosomes in individuals with Complete Androgen Insensitivity Syndrome (CAIS) does not lead to male sexual characteristics but female. Consequently, the person with CAIS must determine if they are masculine because they have an XY chromosome or feminine because they have no male sexual characteristics. The role of androgens in determining gender is also complicated by the condition congenital adrenal hyperplasia (CAH) where excess androgens result in the presentation of ambiguous male genitalia in girls. Liao (2005) critiques the need for gender reassignment by surgical intervention based on the surgeon's understanding of what determines gender, stating:

> **"The importance of girls and women with CAH to psychologists is obvious, for if excess androgen masculinizes female genitals, might it not also masculinize the brains and behaviour of girls and women – despite their female rearing?"**
>
> (Liao, 2005: 428)

Liao's (2005) review of case studies of intersex persons informs psychologists that anatomy formed by male hormones alone cannot construct a gender identity and therefore should not be used to guide the need for correctional surgery to sex organs. Liao (2005) contends that medical science researchers need to look beyond their discipline and consider the social determinants of gender in order to provide a balanced view on the appropriateness of gender reassignment surgery.

> **"The concept of (biological) sex differences is so important that researchers may continue to compromise scientific rigour for another 30 years. The argument that certain behaviours are intrinsically masculine or feminine and that these somehow provide independent criteria for some biological reality known as 'masculinity'or 'femininity' is tautological."**
>
> (Liao, 2005: 428)

However, psychologists' understanding of gender is far from complete and therefore their support for intersex individuals is less than optimal.

> **"The women, quite reasonably, expect psychologists to offer information on the origins and nature of M–F over and above what is considered common knowledge."**
>
> (Liao, 2005: 428).

Furthermore, psychology research has not been able to determine the influence of personality on masculine behaviour or conversely if masculinity ideology is a superordinate organizer of personality attributes, attitudes, and behaviour (Smiler,

2004; Krampen et al., 1990). Connell (1995) argues that whilst positivist science could conceivably construct a model on the basis of physical and anatomical differences between the sexes this would mean that any action by a man in the world would be an instance of masculinity. Consequently, this positive model would prove to be 'unmanageable and vague' (Connell, 1995).

3.1.2 The social construction of masculinity

Few researchers doubt that the social construction of masculinity occurs as a systematic process. However, theorising masculinity has proved to be problematic for twentieth century researchers because it is not an isolated object (Connell, 1995; Kimmel, 2001). What constitutes a man? How should men act? How can men care? These are questions confronting men as they enter an era where there is uncertainty about their role within the family and concurrent uncertainty in the discourse relating to masculine ideologies. According to Hearn (1994) there has been a substantial research gap in terms of understanding masculinity. Although issues of masculinity are now being dealt with in substantial depth and breadth, those doing research on men and masculinities still face difficult sociological issues concerning definition, theoretical orientation, method, the use of historical sources, structure and agency, the relationship of the researcher to the researched and the relationship of practice and theory (Good et al., 2005; Smiler, 2004).

Connell (1995) contends that formulating a workable definition of masculinity is problematic on several counts. Firstly, masculinity cannot be defined merely in terms of an individual's identity because masculinity per se is deeply enmeshed in the 'historical trajectories' of institutions and of economic structures (Connell, 1995:29). Secondly, although all societies have cultural accounts of gender, not all have the same concept of masculinity. In Western culture the conception of masculinity varies according to the individual, culture and class in question. Thirdly, what masculinity is depends intrinsically on who decides what it is. Moreover, gender is not fixed in advance of social interactions, but is constructed through interaction. Fourthly, any analysis of masculinity, as configured by social practice, must account for contradictions. These contradictions indicate that a number of different logics are simultaneously imposed in order to reconcile a number of structural relationships (Connell, 1995: 73). Consequently, a

deterministic model has not been forthcoming. At the time Connell's (1995) work was published, Pleck (1995) emphasised the importance of masculine ideology, stressing the importance of an individual's: "Beliefs about the importance of men adhering to culturally defined standards for male behaviour." (Pleck, 1995: 19). Not achieving these standards was seen as a source of role strain for men. Smiler (2004) in a review of psychologists' theories and measurements of masculinity echoes Connell's concern by outlining the complexity of the task (deterministic model):

> **"Within each movement, discussion focuses on the underlying theoretical basis of prominent theories, the positioning of masculinity as residing within individual men and/or the larger culture, the number of masculine forms allowed (i.e., masculinities) and specification of the content of these idealized forms, identification of problematic masculinity, and masculinity's relation to femininity."**
>
> (Smiler, 2004: 16)

Coherence of theory is also impeded by a large number of discontinuities found in the defining of manhood and masculinity, as explored in ethnographic and role model studies. In view of these difficulties it is acknowledged by eminent theorists Clatterbaugh (1990), Hearn (1994) and Connell (1995) that a coherent knowledge of masculinity is best achieved through the understanding that masculinity exists as a 'gendered relationship'; a point of social demarcation and cultural opposition between men and women.

In recognition of the absence of any archetypal ideology of masculinity it is widely accepted that a number of masculinities co-exist. Further, masculinities are configurations of social practice structured by gender relations within historical and Pilotical and cultural processes. Without objective scientific evidence to show that sex hormones (androgens) are primarily responsible for creating gender identities and without a deterministic model, most theorists have embraced Connell's (1995) conclusion:

> **"It is gender relations that constitute a coherent object of knowledge for science, and that knowledge of masculinity and femininity arises within the project of knowing gender relations."**
>
> (Connell, 1995: 44)

A poignant insight into the friction between 'gender relations' is acknowledged by psychologists Good et al., (2005)

> **"Men learn to devalue characteristics associated with femininity in women just as they are taught to devalue those characteristics in themselves (O'Neil, 1981). In addition, men are in the ambivalent position of both having something to gain (e.g., emotional freedom) and something to lose (i.e., male privileges and power) from efforts to equalize power between the genders. Amidst these complex interactions, it is critical for therapists to be understanding and empathic to this struggle in male clients."**
>
> (Good et al., 2005: 701-702)

Smith (2004), after reviewing the nature of empirical psychological masculinity theories and measures over the past 30 years, concludes that there has been an important change in the disciplines approach to theorising / researching masculinity. The impetus for change came from key theorists (Pleck, 1995; Wade 1998) who contended that masculinity resides within the individual and is modified by external social factors that change over time. Smiler's (2004) analysis of changes in research on masculinity is congruent with Smith's (2004) and is summarised as:

> **"…a softening of the acontextual position that was prominent before the 1990's, and this extends to recognition that there is no ideal type or state of complete stability for the individual or society."**
>
> (Smiler, 2004: 18)

The shift away from a single masculinity, to negotiated gender relations is also highlighted:

> **"The positioning of masculinity as partially opposed to femininity, but neither completely opposed nor completely independent, is also historically recent and widely accepted."**
>
> (Smiler, 2004:18)

In addition, many health practitioners (Gray et al., 2000) and psychologists (Good, 2005; Smiler, 2004; Liu, 2005) perceive the need to use their understanding of masculinity to assist men with social and health problems but are challenged by a lack of information an men's growing diversity of roles; Good et al., (2005) contextualise the problem as:

> **"… men are increasingly expected to assume greater interpersonal involvement as fathers, partners, and co-workers in ways requiring greater emotional awareness and relational skills than men typically acquire through traditional masculine socialization experiences (Bergman, 1995; Good & Sherrod, 1997; Levant, 1995; Pollack, 1995; Real, 2002)."**
>
> (Good et al., 2005: 699)

and

> **"Whereas empathy has been viewed as a necessary condition for client change (Rogers, 1951), empathy for male clients can be challenging."**
>
> (Good et al., 2005: 701)

The points delivered in this section indicate that contemporary theorists, psychologists and health practitioners have moved away from the quest for a deterministic model of a single masculinity and are seeking to apply a gender relations approach to understanding men in – context.

3.2 Masculinity and health

The way men define health and practice health will play a substantial part in shaping the way that they practice health within the family. This approach is supported by the works of Blaxter (1990), Radley and Billig (1996) and Katz et al., (2000) who clearly pronounce that concepts of health affect ideas about responsibility toward promoting health for self and others.

3.2.1 What health means to men

Leege (1992) argues that formal definitions of health developed by health professionals / experts are unlikely to contribute a great deal to men's conception of health; this is because the discourse used by health professionals often has specific meaning for those wanting to advance an issue. Even between experts there are contentions over the applicability and meaning of terms such as, 'absence of disease' and the notion of 'wellbeing' vis a vis the World Health Organisation's definition of health (Legge, 1992). Stainton-Rogers (1991) concludes that men's views on health with respect to public health policy, officially sanctioned definitions of health and their personal beliefs, and health practices of social groups are diverse and complex. Radley and Billig's (1996) work, whilst not concerned with gender differences vis a vis health definitions, notes that men's perception of what it is to be healthy is subject to wide individual, social and cultural interpretation; the findings from prominent national surveys substantiate the notion of diversity. In an early Australian survey, conducted by The Better Health Commission, 1,266 people over the age of 14 years were asked to choose from descriptors of what health meant to them; health was described as:

> **i) "being free from illness, by 26%**
> **ii) feeling well and being able to cope, by 25%**
> **iii) being physically fit and active, by 31%**
> **iv) being able to do the things one tries to do, by 18%."**
>
> (McMichael, 1986)

Men were much more likely than women to choose options iii) and iv), and those options were defined as 'action orientated' by the researchers. Women, particularly those of child rearing age, chose the options related to 'being able to cope'. McMichael's (1986) findings contrast with the UK National Health and Lifestyles Survey of 9,003 adults in which Cox et al., (1987) found 55% of men (18 years and over) described health as feeling 'psychologically fit (e.g. happy, able to cope)'. Only 25% of men in the National Health and Lifestyles Survey saw "fit, strong, energetic and physically able" as the main components of health. Notably, as the respondent's age approached 60 years there was a decreasing importance placed on action categories (fit, strong, energetic and physically able). In general, the population's description of health differs between men and women and these differences correlate well with gender norms concerning men and women's traditional roles in society (McMichael, 1986; Cox et al., 1987).

3.2.2 Masculine parent and the health of others

Central to this thesis is the location of literature that describes how masculinity might influence men's performance of health practices toward their children / other family members. Literature on men's perceptions of the health of others is scarce. Despite a widespread search of the literature using PsychINFO, CINAHL, Google Scholar, Medline (OVID), and PubMed and Wiley inter-science no key publications or surveys could be located on the topic using key words 'father / parent', 'masculinity', 'perceptions / understanding' ,'health', 'child'. The only survey located that focused on an individual's health beliefs vis a vis the health of another person was the 1987 Health and Lifestyles Survey (Cox et al., 1993) for the UK. The Health and Lifestyles Survey (1987) asked 9,003 adults to consider "what it is to be healthy yourself" as well as describe "someone you know who is healthy"; respondents were offered a range of definitions to choose from and multiple choices were allowed. Copies of the survey were on-line but none of the definitions or questions viewed were related directly to family members. Although the Health and Lifestyles Survey was repeated in 1994 the

questions on the health of others, found in the 1994 survey, were not repeated. Petrie and Weinman's (1998) work on perceptions of health and illness, 'Current Research and Applications' revealed no systematic approach to exploring men's understanding of their children's health. The most recent UK survey, 'Families and Children Study' (FACS, 2006) did not investigate parents perception of health but limited questioning to identification of actual health problems of respondents' parents and children. Questioning was extended to investigating whether or not the respondent took time from work / changed to part-time work to care for a child with illness / disability (FACS, section 3.1 'Children's health').

Radley and Billig (1996) argue that researchers should shift their attention from beliefs about what health is to "accounts of health". This argument is based on the understanding that peoples beliefs about what health 'is' cannot be seen as a fixed expression of inner attitudes or shared social representations; instead people's conceptions about their actual health practices, as revealed by their gendered accounts to researchers, are more important measures. In accord with this view there has been burgeoning literature linking masculinity to men's individual accounts of physical illness, particularly in relation to male specific health problems (Wall & Kristjanson, 2005; Gray et al., 2000a; Gray et al., 2000b; Sand et al., 2008). Although accounts of women's actual mental health practices have been highly featured in the literature (post natal depression, eating disorders) it is only recently that men's accounts of similar problems have appeared (Sanfilipo, 1994; Murnen & Smolak 1997; Drummond, 1999; Drummond, 2002) and been targeted toward influencing the practice of health professionals (Laws & Drummond, 2001; James et al., 2005).

3.2.3 Masculinity influencing health practice

There have been attempts to explain how masculinity influences the health practices of men by contrasting these practices with those of women but these have been tentative steps in an ambitious theory seeking to link masculinity to a range of poor health behaviours among men. Acceptance of mainstream masculinity is reinforced by images portrayed in the media and advertising (Connell, 1995; Martin 1994) and journalists have played a substantial role in creating the social perception that men and boys are having 'a bad time' across a wide range of health and health related social variables (The Observer, 1999).

Underpinning the media's work is a common belief that the socialisation of males into traditional patterns of mainstream masculinity both creates and reflects social circumstances that impinge on men's health. The characteristics of the traditional form of masculinity are summarised as:

- Competitiveness;
- Physical endurance;
- Self-reliance;
- Containing emotions and the avoidance of signs of weakness;
- Being homophobic;
- Risk taking; and
- A preference for socialising with mates
  (Taylor et al., 1998; Smith, 1994).

It is tempting to identify these masculine traits as causative agents in men's health problems. Common issues arising out of the literature are that men generally exhibit poor self-care in comparison to women, they exhibit risk taking behaviour inside and outside of work, they make life style choices that predispose them to illness and premature death, and fail to seek help from health professionals as often as women or they seek help only when a problem becomes unbearable and often too late for effective treatment to be commenced (Brannen et al., 1994). Courtenay (2000) refutes the idea that most men neglect their health by emphasising the diversity in male health behaviours, stating:

> **"It should be noted that some men do defy social prescriptions of masculinity and adopt healthy behaviours, such as getting annual physicals and eating healthy foods. But although these men are constructing a form of masculinity, it is not among the dominant forms that are encouraged in men, nor is it among the forms adopted by most men."** (Courtenay, 2000: 1385)

There are several problems associated with this linkage between gender and health problems. Firstly, Kandrack et al (1994) recognise that our knowledge of what promotes and deters men from seeking help for health problems is ostensibly incomplete and the gaps in research substantial.

> **"Knowing whether women frequent doctors more than men, or whether women rate their health in more modest terms than men only becomes important if we can uncover the reasons underlying**

> **such patterns. Furthermore these experiences must be understood in their own right, and not simply as reflecting dichotomies based on sex / gender"**
>
> (Kandrack et al cited in Fletcher 1994).

Secondly, Addis and Mahalikand (2002) identified several theoretical and methodological obstacles that limit understanding of the variable ways that men do or do not seek help from mental and physical health care professionals. Thirdly, the identification of masculine traits that promote health and detract from health has been hampered by the fact that the theorising on masculinity is intensely complex and in many cases has relied on the impetus created by feminist theories and research initiatives (Connell, 1995: 31). Lack of knowledge about men and Coronary Heart Disease (CHD) exemplifies this point. Although there is a growing understanding of the risk factors for CHD, researchers cannot explain why men are more susceptible to heart disease; Weidner and Cain (2003) suggest that there is an urgent need to identify causes and solutions in the behavioural and social arena. Gaps in the research literature concerning men's lived experience of health and ill health also abound. For example, White and Lockyer (2001: 1016) deduce that:

> **"Despite most research being undertaken on men we are not much closer to an understanding of how men experience coronary heart disease. This is due to the failure of much research to acknowledge the gender sensitive nature of coronary heart disease and thus to treat gender as a variable to be controlled. Gender effectively becomes invisible, resulting in research that does not consider the issue of masculinity and men's acknowledged difficulty in managing their health."**
>
> (White and Lockyer; 2001: 1016)

The literature also recognises the need for understanding the role of gender in men's experiences of mental health problems (Addis & Mahalik, 2003; Kessler, 2002; Murnen & Smolak, 1997; Sands et al., 2008; Sanfilipo, 1997; Pilgrim & Rogers, 1993).

3.3 Gendered participation in health care

This section presents a brief but necessary overview of gendered relations existing between health professionals (e.g. doctors to nurses) and their influence on the structuring of health services. Connell (1995) contends that: "Masculinity must

be understood as an aspect of large-scale social structures and processes." (Connell, 1995: 39)

The structures and processes include, but are not limited to, the dominance of medicine (fraternity) over other health professionals, societies' valuing of the type of knowledge and philosophy used to underpin nursing (a predominantly female health literacy with little masculine ideology), and medical practitioners' understanding of how gender might influence access to and need for service (Courtenay, 1999). The emergence of men's health as a public issue and the attempts to shape policy to improve men's health are a clear indication that society sees gender as an important factor in determining health status (NSW Health Department, 2000; Lumb, 2003).

3.3.1 Women's socialisation in health

Feminism, successfully Piloticised by suffrage and affirmative action, spurred on changes to health policy and practice. Throughout the 1960s –70s moral conflicts between women and doctors were at their highest; the women argued that they had special needs but doctors were merely treating women's health as a sub-speciality of mainstream medical services. In terms of standards of care, women were particularly critical of the medical management of gynaecological and obstetric matters, claiming they have been deprived of control over their fertility, pregnancies and birth experiences (Bates and Linder-Pelz, 1988). Further, many women offered the criticism that doctors were often negligent in their practice, showed lack of interest, and were hypocritical in their judgements in relation to their women patients' right to self determination (Bates and Linder-Pelz, 1988: 51). In light of these criticisms and the potential for conflict, many women preferred to use doctors only as advisers rather than be passive recipients of male advice and instructions (Bates & Linder-Pelz, 1988: 52). In response to women's long standing dissatisfaction with the medical profession (Australian Department of Health, National Advisory Committee for International Women's Year, 1975) the federal government implemented the National Women's Health Policy (Commonwealth Department of Community Services and Health, 1989).

The gender conflict and women's actions just outlined indicate that women are now closely engaged in shaping health care services for themselves and their families. In addition, women have amassed a substantial body of health literacy

and social capital within their employment and careers. The work of teachers and childcare attendants is associated with children's health and wellbeing. The number of nurses and midwives educated in Australia, the USA and the UK is substantial, offering a broad basis from which feminine physiologies of caring, for self and others, can be practiced (Cheek & Rudge, 1995).

3.3.2 Men's socialisation in health

In contrast to the development of the women's health movement there was no unified 'men's health movement' protesting about the standard or appropriateness of health services. Fletcher (1994) records that men's health initiatives have been driven by health workers rather than a groundswell of concern by men.

> **"Men's health initiatives have been largely introduced by workers within the health system and have begun with specific programs aimed at personal change".**
>
> (Fletcher, 1994: 11)

Health policy for men in Australia has lagged behind that of other countries and there has been little linkage to fathers' concerns over their children's health needs and access to services (Lumb, 2003; Smith, 2007).

Far fewer men than women gain health knowledge and skills through employment in the health sector of the economy. Whilst the number of females entering medical training and practice has risen substantially over the last decade a similar influx of men into nursing has not occurred. A common explanation for this phenomenon is that sex-role stereotypes often deter men from performing health work that has been traditionally performed by women (Muldoon & Reilly, 2003). Implicit in male's rejection of female work is that it has lower status and fewer rewards than men's work.

> **"The low status of nursing and the way in which the work of nurses is devalued, especially when compared to other health professionals, can at least in part be explained by its gendered nature."**
>
> (Cheek & Rudge; 1995: 312)

The emergence of feminism resulted in literature that raises diverse issues about caring. Pro-feminists believe that there is a philosophical rift between feminine approaches to caring and masculine approaches to caring.

> **"...femininity – with its stress on dealing with dependency, acknowledging emotions and intimacy and nurturing others –**

> **comes to represent qualities that are feared and denied in masculinity, qualities that at best are seen as to be contained and allocated to a different sphere, and at worst are repressed or treated with contempt.”**
>
> (Davis, 1995: 183)

The body of health literacy and social capital among men and fathers is not as well understood as that of women. The transmission of health knowledge and skills from woman to woman has taken many forms; women’s family magazines often carry family health issues and information. There is little evidence of the transmission of any health knowledge and practices from men to boys/ fathers to sons (Laws & Bradley, 2003).

Men are also largely ill-informed about their own health; they are poorly informed consumers of screening tests and are less than satisfied with the information they receive about medical treatment options prior to giving their consent to treatment. These points are most salient in relation to male genito-urinary medicine (Laws, 1998; Crapp, 1998; Laws et al, 2000; Drummond & Laws, 2001; Laws 2004). From a series of 19 focus groups (N=137 men) from a broad demographic background Pinnock et al. (1998) concluded that:

> **“Men expressed consistent concern about urinary symptoms, prostate cancer and sexual function. They revealed misunderstanding and a desire for more information about all issues”.**
>
> (Pinnock et al., 1998: 368)

Carmen Luke’s (1994) study of how popular culture constructs parenthood found that in relation to fathers knowing about how to care for the health and wellbeing of children:

> **“Men for the most part are excluded from the visual and textual discourse. Their presence is token, stereotyped, disengaged from domestic and child care…”**
>
> (Luke, 1994: 295)

The effect of the media in terms of shaping parental responsibilities and prompting child health and safety is difficult to refute. Without common images of men practicing health within the family it is unlikely that they will spontaneously take up that role.

3.4 Gender division of labour

This section establishes that the behaviour of hegemony and patriarchy of men in the labour market plays a key role in defining masculinity as well as the gender division of labour in public and private life up until this day. In addition, opportunities for men to practice health towards their children are few whilst men continue to work in order to maintain their labour market dominance.

3.4.1 Work defines men

It is argued in this section that men's reluctance to take on a more equitable share of parenting has to do with the inextricably link between masculinity and male work that is typified by paid employment. Harris (1995: 73) illustrates this point through the use of a common question asked of male children; 'What would you like to be when you grow up?' The general reply is not 'I want to be a loving, sharing, caring individual' but 'I want to be a pilot, policeman.' That is to say, the child defines their aspirations for future-self in terms of a masculine job because they recognise this to be an expected form of reply, rather than holding a genuine belief of what they want for themselves. Connell (1995: 33) explains that men aspire to do 'good work' and establish a career, in order to appreciate a positive self-image. Connell's explanation is epitomised by the positive image of masculine effort embodied in the Protestant work ethic. The ethic purports that human beings are fallible and unworthy of God's praise unless they work hard in the name of God; men who subscribe to this view try to dignify themselves in society through working hard and believe that the product of their labour will bring them success in life and happiness (Seidler, 1989; Weber, 1958). In recognition that Western religious edicts now play a much lesser role in the lives of men, Connell (1995) reduces his analysis to: "The cultural function of masculine ideology is to motivate men to work." (Connell, 1995:33).

The primacy of men's work to their masculinity can also be understood by exploring the consequences for men who are underemployed or unemployed. According to Manning and Lichter (1998) unemployment per se has a detrimental impact on men's self-esteem and often changes the character of family and social relationships. The strongest evidence in support of the assertion that work defines men comes from a plethora of research, across many countries, correlating

a diminution of men's mental and physical health with their dislocation from paid employment (Osler et al., 2003; Leino-Arjas et al., 1999; Lewis & Sloggett 1998; Ferrie et al., 2001; Morris, 1994; Winefield, 1996; Lawless et al, 1998). Although poor health and self-esteem might trigger unemployment (Arrow, 1996), many longitudinal studies, using a variety of approaches provide good evidence to link unemployment itself to negative health outcomes (physical and mental) (Martikainen et al., 1996; Gallo et al., 2004), with associated greater use of health services and higher mortality rates (Goldblatt et al., 1991; Graetz, 1993; Morrell et al., 1990). Researchers continue in their efforts to isolate the effects of unemployment on health and whilst taking account of the influences of underlying social and economical conditions (Durkin & Davidson, 1999). In a comparison between male unemployment and female unemployment, Coyle (1984: 122) argues that women are not subjected to the same conditions of hardship, either economically or emotionally, because they are mostly supported by the family and occupied within it.

3.4.2 The impact of men's work on family

Measurements of the impact of men's work on the family are often undertaken using measures of :

i) time spent away from the family (a cost)
ii) the income earned (a benefit)
iii) the opportunity cost to the spouse / partner for having gendered their labour as unpaid work in the home (opportunity missed for full-time work and promotion).

3.4.3 Time spent away from the family

Time spent away from the family by fathers varies between countries and over time (Gauthier et al., 2004). Fathers of under-fives in Britain work the longest hours in Europe, with more than a third working 50 hours per week (Hewison & Dowswell, 1994: 3). With strong governmental support Danish fathers work an average of 41 hours in a week (Carlsen & Larsen 1994: 53). In Australia the average time men devote to paid work fell from 50 hours per week in 1974 to 44 hours per week in 1987 (Bittman 1992: 27).

Gauthier et al., (2004) studied data from 16 countries that had experienced similar demographic, economic, and social changes since the 1960s. Despite the increase in women's labour force participation and despite the time pressures from work, parents today ‘appear to be devoting more time to childcare than they did 40 years ago’ (Gauthier et al., 2004). Yet employed mothers devote less time to childcare than non-employee mothers, suggesting that fathers need to pick-up more time. However, men’s increased contribution to childcare remains less than women’s and comes from a very low base. There is conflicting evidence as to whether better educated / professionally employed fathers spend more or less time with their children than fathers from manual occupations. The chapter *Fatherhood* details the impact of a father’s employment on children’s wellbeing and development.

3.4.3 Male earnings

The income earned by men is most often used as a rationale in support of men’s continued commitment to full-time work. Men’s average income in Australia is approximately twice women’s average income, when all men and women are taken into account (Connell, 1997). Sex differences in income begin at an early age:

> **“Those 21 to 24 year old wage and salary earners with the highest incomes tend to be single men with full-time jobs and a post secondary qualification and still living with a relative or in a group house. Those most likely to be low income earners are single young women with no post secondary qualifications working in the retail industry or studying.”**
>
> (Connell, 1997: 7)

Sex differences in income are commonly published in the form of average wages; as of February 2008, male average weekly earnings ($1,104.00) in South Australia were 17.7% higher than the corresponding female earnings (ABS, 2008). Women’s lower earnings can be used to justify why they should spend more time with their children rather than have equitable workloads and child health responsibilities.

3.4.5 Parents gendering their labour

The gendering of workloads within and outside the home is based predominantly on masculine power over women (Connell, 1987; Clatterbaugh, 1990).

> **"… women's involvement in child care and housework has as much to do with reproducing gendered power relations as it does with rational time allocations for the production of household goods, such as care for children (Ferree, 1990; Risman, 1998; Thompson & Walker, 1989)."**
>
> (Sayer et al, 2004: 1153)

A survey of sex segregated occupations across the world, conducted by Anker (1998), identified that male dominated jobs were more common than female dominated jobs and that female occupations tended to have lower pay, lower status and less opportunity for advancement. Promotion is less achievable for women; the term 'glass ceiling' is used as a metaphor to depict barriers set up by patriarchal forces to impede women's promotion to higher positions in paid employment. There is ample evidence to show that the glass ceiling continues to be in effect (Buzzanell, 1995; Arber & Ginn, 1995). Despite decades of active promotion of equal opportunity for women, a Swedish government study conducted in 1995 highlighted the failure of Swedish women to break down male dominance of management, particularly in the private sector (Carnegy, 1995).

Connell (1987: 104-6) argues that the gender division of labour is organised in such a way that it will:

> **"Exclude virtually all women from opportunities for the accumulation of wealth on a scale useable as capital, or form career paths that would lead to the control of significant capitals."**
>
> (Connell, 1987: 105)

And Connell observes, in relation to the press:

> **"…most mass circulation journalism is unrelievedly sexist …They are (*sic* [journalists]) participants in a collective project in which the power of men and the subordination of women is sustained."**
>
> (Connell, 1987: 108)

Over two decades ago Game and Pringle (1983) deduced that because a gendered division of labour was an essential and fundamental feature of capitalism it would be very difficult to remove. More recently, Chafetz (1990:12) observed that capitalist societies would continue to be run by and mainly advantage men, and in no cases has gender stratification of labour substantially disadvantaged men. A contemporary analysis of gender relations and employment opportunities by Warner – Smith et al (2000) suggests …

> **"With current patterns of social organisation, employment remains more liberating for men in general, because they earn**

> **more, do less housework and contribute a greater proportion of the household income."**
>
> (Warner – Smith et al, 2000: 8)

The continued structuring of labour markets to provide men with greater opportunities for advancement in employment and income explains why there is a greater tendency to have 'one-and-a-half' earner families, whereby women are persuaded to interrupt their employment to have, raise and care for their children (Lewis, 2001). A man's continued ability to earn greater income and job status acts as a powerful force in keeping fathers away from their children.

3.5 Facet: masculinity under review

Despite the gains men have achieved by the subordination of others, a growing number of men see the need for role change and negotiating new gender relationships with others. This section explores the need and opportunity for young men to develop new gender relations based on three issues. Firstly, the adherence to hegemony and patriarchy has negative health consequences for men and those in their families. Secondly, social images stereotyping men's roles need challenging and replacing with images that show men effectively performing roles traditionally assigned to women and mothers. Finally, teachers and fathers need to consistently role model masculinity in a way that rejects bullying at school and in other social settings. These points support the premise that men who embrace gender equity and reject masculine forms of oppression will be better positioned to engage in health practices that will benefit men and their families.

3.5.1 Changing what men do

Some men define their masculine relationship with others as a natural and therefore unchangeable identity (Donaldson, 1993); for these men masculinity is often exemplified by physical power, body size and a competitive ethos and they are ambivalent about their oppression of others (Connell 2000:8; Kimmel 1994:123; Seidler 1997:14). Hegemony among men creates major health problems particularly in relation to physical violence against minority groups such as homosexuals and ethnic men (Connell, 1995; Drummond, 2005).

> **"The dominant (or Hegemonic) model of masculinity is never universal. Indeed, it is defined against a range of subordinate and marginalised masculinities."**
>
> (Connell & Huggins, 1998: 295)

Clatterbaugh, (1990) and Connell, (1995) argue that as a consequence of men's domination over women, men's health has also suffered and both the 'pro-feminist perspective' and the 'men's rights perspective' support this view. Reilly (1998:5) has concluded that many men are disadvantaged by this type of masculinity.

> **"While not denying that many men benefit from the privileges of manhood, many masculine authors argue that men's public power is matched by private disadvantage."**
>
> (Reilly, 1998: 5)

Similarly, Biddulph (1994:4) claims that men are disadvantaged by loneliness as a consequence of lack of intimacy, by their competitive ethos that compels them to win at almost any cost and as a result of being socialised to withhold emotions. Biddulph (1994: 4) refers to this concept in terms of men dealing with walls 'on the inside'. Some gender analysts believe that the traditional male role has become lethal to men (Clatterbaugh, 1990; McCan & Haywood, 1997) because feminism has created guilt in men for their own socialisation, which men can claim is not their fault. These arguments go some way to explaining why men, initially ambivalent to the changes expected of them in relation to changes in women's lives, have been further hampered in adapting to social change and effecting personal growth (Clatterbaugh, 1990: 55). In short, many men are also victims as well as the perpetrators of equity problems.

Whilst the feminist movement used the theory of patriarchy as a focal point for women to come to understand and work through what they were experiencing in everyday life (sexual inequality), no singular theory is available for men to act as leverage for widespread change. Despite substantial social changes to the private and public lives of women, men have yet to develop a theory or direction that will support resultant changes to their everyday lives.

The agenda of the men's rights movement is to draw attention to sexism by fighting injustices such as divorce settlements and child custody battles in the courts (Lingard & Mills, 1997). However, as Wadham (1997) points out, the media have inappropriately promoted an inalienable right to fatherhood as a stand alone men's health issue.

> **"They are (sic [journalists]) participants in a collective project in which the power of men and the subordination of women is sustained."**
>
> (Wadham, 1987: 108)

Male solidarity in pushing for men's rights is theoretically unstable as men's collective action against women would occur in the context of masculinity and so cannot be used as a mechanism to correct problems caused by traditional masculinity (McCan & Haywood, 1997; Clatterbaugh, 1990; Hearn, 1994).

The rub between social equity and men's masculinity is most often highlighted in pragmatic terms. No longer can men expect to continue upholding their role as 'breadwinner' as the single most important role within the family, when women now make a substantial contribution to family income. No longer can men expect women to take prime responsibility for the care and raising of children when women have work commitments. No longer can men expect to draw a patriarchal divide between work and home duties when women succeed in both realms. This argument is tempered by recent findings showing that men are reluctant to give away the privileges of employment to care for family.

> **"Among the men in the sample, active care responsibility and the reduction of working time tend to correlate with lower income, lower work security and poorer career opportunities, while working overtime and outsourcing life seem to correspond with high job security, a good income position and better career opportunities."**
>
> (Halrynjo, 2009: 120)

The work by Connell, (1995) is exceptional in that he alone highlights that men within the 'environmental movement' remain in the minority among men because they are explicit in their call for equity, social justice for women in families and health for all (Connell, 1995).

3.5.2 Changing normative depictions of gender roles

Men's roles within society are shaped, reinforced and limited by images and descriptions of normative gender roles in the works of authors, social critics, the media and artists (Luke, 1992; Wadham, 1997). Connell (1995) contends that public images are crucial instruments in supporting as well as changing existing gender roles. Most recently there has been a stronger profiling of fathers in the popular media (Martinson, 2008) and an increase in the number of fathers as single parents. Social change of this kind may urge men to be more involved in

practicing health for their children. However, the document searches for men's health practices toward their children, set out in six of the upcoming chapters, could not locate an analysis of images depicting men's health practices towards their children.

3.5.3 The new generation of men

Opportunities to reshape masculinity and form new gender relations begin at an early age (Biddulph, 1995; Leaper & Smith, 2004). The cultural roles available to school boys are limited and young boys tend to emulate existing patriarchal and hegemonic patterns of behaviour. Increases in violence at school and bullying are also a worrying national trend (Clarke, 1995; Carosi and Tindale, 1995). Rigby and Slee (1991) found that not only did one in 10 boys in school suffer from bullying, but those involved in the act of bullying were four times as likely to become juvenile or adult offenders. One strategy being promoted as a realistic means of effecting change among men has to do with orientating teachers to their role in the socialisation of boys.

> **"One of the most worrying and obvious differences between the sexes is the higher level of aggression and violence in boys and boys groups. Often, such aggression is spoken of as being natural. As reflected in such phrases as 'boys will be boys'".**
>
> (McGrane & Patience, 1993: 38)

Browne and Fletcher (1995) have been instrumental in informing teachers and parents of the pitfalls of the current educational practices in terms of nurturing boys in the development of a masculine identity. There is growing evidence to suggest that mothers are keen to shape better health behaviours for their sons and are rejecting traditional notions of masculinity as a means of achieving this (Biddulph, 1997). However, Biddulph's work 'Raising boys' (1997) is not a rigorous piece of work nor does it pretend to be so. The popularity of Biddulph's (1997) work suggests that most families are conscious of the problems associated with their sons exposure to behaviour that subordinates others. Unfortunately, Biddulp's work is written mainly for women and the small section on fathers focuses mainly on them correcting masculine traits that set a poor example for their children.

Arguably the most effective method of gaining leverage for changes to gender relations in the family is to influence boys' masculinity and simultaneously that of

fathers. The next chapter explores how a father’s role can influence health practices in the family but recognising, as Hinckley et al. (2007) do, that expectant fathers are required to negotiate the role of parenting ‘in a female world’.

CHAPTER FOUR:
Theoretical framework - Fatherhood

4 Introduction

The purpose of reviewing the literature on fatherhood is to show an increasing plasticity of a father's role among some groups of men. Social change, accompanied by a change in social expectations for both maternal and paternal responsibilities, has highlighted the need for men to better understand the impact of father-child relationships on their child's health and wellbeing, as well as men's health. Identification of changes to fathering roles supports the need for an exploration of how men directly and indirectly practice health for their children (Hallberg, 2007; Ahmann, 2006; Fägerskiöld, 2006; Brown & Bailey, 1991; Bailey, 1991).

The chapter commences with an historical account of the changes to men's role in the family since the inception of the industrial revolution. This approach is supported by key researchers of fatherhood; Stearns (1991), Lamb (1991), Connell (1995) and Marsiglio et al., (2000) argue that fatherhood and motherhood are not stationary concepts or roles; they are historically contingent and therefore meaningful work can only be achieved by studying parental responses to new social contexts.

The second section highlights key social changes attributable to increasing diversity in fatherhood. The increasing tendency toward blended families, non-resident fathers and absent fathers, infers that many fathers have a minimal or non-existent role in practicing health directly for their child (Dunn, 2004; Bradshaw et al., 1999; Green, 1998). Fathers who are in-residence with the family but work long hours or are away from home for long periods (service men) are challenged by the expectation that they need to spend sufficient time to fulfil their responsibility in the area of care-giving.

The third section identifies differences in the public image of fathers and men's private lives within the family (Andrews, 2004). Reviewers of the fatherhood literature note that researchers have largely ignored the social context of men's private lives within the family (Smyth & Weston, 2003; Burgess, 1997).

Methodological difficulties have also hampered the application of the theoretical concepts of masculinity and fatherhood as explanatory frameworks for male parenting styles and determinants of paternal inputs into their children's health.

The fourth section identifies a narrow scope for researching fathers, recruitment issues and a general lack of research compared to researching mothers. This issue persists despite a decade of requests by key researchers to increase our knowledge of what fathers do with their children and why (Stearns, 1991; Lamb, 2000; Rohner & Veneziano , 2001).

The final section explores child health effects linked to fathering. A feature of this section is the scant research available to determine the type of health practices fathers are involved in and the impact of their parental contributions to their children's health and wellbeing.

The characteristics of good mothering and role modelling for young girls have been broadly publicised and promoted for over a century with little critical analysis on the need for role change (Wilson, 2006). Conversely, theorising on the development of fatherhood has received increasing attention (Featherstone, 2005), attributed to:

i) effects of absent fathers (Bradshaw et al., 1999; Siefken, 2006);
ii) men's continued preoccupation with breadwinning (Lupton and Barclay, 1997) and;
iii) the need for more equitable parenting, as a response to the growing numbers of working most mothers commitments outside the family (Haas et al., 1999, Russell, 1987).

The length of this chapter reflects the need to acknowledge the divergence of contemporary fathers' relationships with their biological children when compared with family configurations of the 1950s and 1960s (Lamb, 1991). As was anticipated, the literature concerning men's parenting practices was substantially limited in comparison with that of motherhood. There have been few books that take a systemic approach to exploring the research on fatherhood and this is sufficient reason for an emphasis being placed on the works of Lupton and Barclay (1997), Burgess (1997), Lamb (1987), Russell et al., (1999) in this chapter. Contemporary researchers also continue to refer to these works at

international conferences as a means to reiterate how little is known about the private lives of fathers (Featherstone, 2005; Smyth & Weston 2003).

4.1 Historical literature: a research approach

Historical research on fathering is still developing but remains central to understanding issues men face in their parenting role. Stearns (1991) asserts that a cautious approach is needed when trying to formulate generalisations about fathering as many early studies were skewed by the researcher's tendency to view fathers as economic entities and outsiders to the central family processes rather than 'integral actors' as revealed by pre-industrial accounts. More recently Marsiglio et al., (2000), having discussed the leading perspectives guiding the fatherhood literature since the 1990s, concurs with Stearns (1991) view on the importance of historical events and social reform in shaping changes to fatherhood.

> **"…our historical understanding of fatherhood is quite limited because materials are typically drawn from white middle-class sources and are seldom representative of their contemporaries from different ethnic, racial, cultural, and economic backgrounds. Although those interested in the history of fatherhood have been encouraged to study the unique historical events relevant to men from different ethnic or racial backgrounds and to focus on the unique combinations of these experiences across race and ethnicity, Burton and Snyder (1998) point out that little has been accomplished in this regard."**
>
> (Marsiglio et al., 2000: 1175)

In Western culture, the onset of the industrial revolution and two world wars has had a significant impact on father-child relationships. For Indigenous Australians their exposure to colonisation and subsequent lack of social equity has had a comparable impact in terms of dislocating family ties.

4.2 Father-child nexus in pre-industrial times

Prior to the industrial revolution English and European farmers and artisans worked from home or with their families in the fields. This created a sense of shared production for fathers and their children, particularly between men's sons and other boys – a sense of generational continuity existed.

> **"Generally ... fathers would find replicas of themselves in their sons, and this gave a wider purpose to life and work."**

(Stearns, 1991: 30)

As well as property, fathers gave their sons skills with which to make a living. Permeating the historical literature is a sense that men were intrinsically concerned about the welfare of their children. Until at least the early decades of the 18th century, it was the father who was considered to be the 'natural parent' and whose responsibility it was to shape the child.

> **"In early modern Europe, fathers were generally considered as more important than mothers in the caring, raising and education of children, including overseeing wet-nursing and feeding of infants and taking primary responsibility for older children's moral and religious instruction, preparing them for their adult duties."**
>
> (Lupton & Barclay, 1997: 37)

Nuances found most often in classic English novels (e.g. works by Charles Dickens), of men displaying their affection for and adoration of their offspring indicate that men were keen to foster their child's sense of wellbeing and ultimately promote good mental health and a sense of belonging within the family (Burgess, 1997; Stearns, 1991). Tosh (1996) records that it was seen to be a middle class father's role to ensure that their sons acquired proper manliness as they grew into adulthood. These accounts demonstrate the father's work in promoting their child's wellbeing but accounts of health practices are almost non existent. Stearns (1991) provides a rare glimpse of paternal perspectives in relation to accident and injury prevention.

> **"...many premodern fathers had little sense of what they might do to protect their offspring; accidents occurred that more modern parents would find readily preventable, but such was the lack of belief in the possibility of control that many premodern fathers could only bemoan the fate of a child who died in a fall down the stairs or into an unprotected well."**
>
> (Stearns, 1991: 31)

Overall, historical accounts provide numerous literary examples of the adoration and care bestowed upon children by fathers over past centuries (Burgess, 1997; Stearns 1991) but there is little or no attention paid by researchers to understanding accounts of health practices performed by fathers toward their children.

4.1.2 Industrialisation reduces the availability of fathers

A key feature of fathering in the 18th century was men's daily proximity to their children and Lupton and Barclay link this to more hands-on child rearing:

> **"The location of both men's and women's work within the home or its close environs that was characteristic of pre industrial society meant that men were in a position to engage more actively in child rearing."**
>
> (Lupton & Barclay, 1997: 37)

By the late 18th century the capacity for fathers to be proximal to their children was threatened because the factory work created longer work days linked to the needs of tireless machinery. By the middle of the 19th century, industrialisation had changed the relationship between men and their family in most Western countries (Parker et al. 1981). Rigorously enforced working hours and an increase in the time travelled to and from work effectively precluded men from family contact for most of the working week.

> **"Factory workers were absent from home and therefore from effective contact with young children and older girls, for 12-14 hours a day."**
>
> (Stearns, 1991: 38)

and

> **"While small businessmen could continue a family work link, most middle class occupations separated work from residence ... Even among rural families, where the home - work link separation was less salient, growing numbers of transient labourers, disproportionately male, suffered similar disruption for long periods if they had families."**
>
> (Stearns, 1991: 38)

The role of the mother was also altered by an expectation that women would stay at home to rear healthy children to become good workers. In reference to the newly acquired social role of motherhood, Lupton and Barclay (1997) point to the emergence of the perception that women had innate caring qualities as a parent:

> **"As a result of this shift in notions of parental responsibility from men to women, since the late eighteenth century mothers in particular have been singled out as primarily responsible for the health and 'normal' development of children."**
>
> (Lupton and Barclay, 1997: 38)

Women often continued to be the main parent outside working hours as men's ability to attune to family life at the end of the working day was dulled by the

effects of their labour. Poor working conditions frequently compromised men's physical and mental health. And men's work, though physically and mentally demanding, became less than stimulating as a result of increasingly specialised means of production. Rather than return home to support their spouse / partner and take on a parental workload many men sought respite; they preferred to spend their leisure time outside the family and in the company of other men (Burgess, 1997). Without daily spouse / partner support women in industrial societies increasingly relied on alternative resources to cope with parental responsibilities. As a consequence of older siblings remaining at home longer, grandparents living longer and communities stabilising around industries, there developed a pool of female kin who were able to share child rearing and care for the sick and disabled. These factors effectively heightened the division of labour between women and men in terms of their caring and health roles within the family (Burgess, 1997).

Hewison and Dowswell (1994) found that in modern Britain female kinship exists in contemporary society with many working mothers able to readily call on female relatives living close at hand to assist in caring for sick children. The division of labour in caring for children was further reinforced when a board alignment of social reforms in Britain supported the development of the male 'breadwinner' wage; women could now afford to stay in the home and specialise in child rearing, family health and home making (Seccombe, 1986). The literature concerning male roles in Australian society took it for granted that being a 'breadwinner' was a core part of being masculine (Connell, 1995: 28). Consequently, the core roles of fatherhood developed into a mono role typified by breadwinning, where commitments to paid labour increasingly separated men physically from their family. As a consequence of men not being available for family commitments and the specialisation of women's labour within the home, women became the nexus between health professionals, health care and the family (Evans & Saunders, 1992: 185).

Lupton and Barclay (1997) argue that because waged labour became a prominent feature of the industrial revolution, men have grappled for over a century with the feeling that they have been:

> **"... torn between the expectation that they should support the family economically and be successful in their career, and the expectation of them in relation to participative fatherhood."**

(Lupton and Barclay, 1997: 41)

Ergo, the most salient structural barrier to men's participation in child health practices has been the social expectation that fathers should be the main income earners within a family.

4.2 Social reforms

There is clear evidence to show that social reforms aimed at improving the quality of life for workers and their children had the side effect of dislocating men from their families.

4.2.1 Diminishing paternal guidance

Mandatory schooling and an expansion of curriculum served to subordinate a father's responsibility of communicating to his children an understanding of the world around them. Schooling also competed with the father's role of moral tutor. In Protestant homes, for some time after the inception of mandatory schooling, bible readings continued to provide a basis for earnest father – child conversations (Stearns, 1991). Harris (1995) cites Arcana's (1983) more recent classic work characterising the decline in the extent and quality of spiritual and emotional connections between father and son.

> **"Sons are unrealistic to hope for spiritual presence and emotional nurturance from their fathers. Men are not trained to care for children or for adults really – and they are not part of daily, family life. So that even those who are, as one mother said 'misfit' are hard pressed to spend enough time with their families to give and get loving."**
>
> (Arcana, 1983: 132)

In a review of religion and its impact on fatherhood Marciano (1991) notes the scantness of data for assessing a father's role in transmitting spiritual and religious values in contemporary family life; this finding is reiterated in a later work by Harris (1995).

4.2.2 Changes to family and fatherhood

Opportunities remaining for fathers to influence their child's wellbeing and other aspects of health are limited to the hours they spend outside work; even this time is often encroached upon when men take work home (Russell & Hwang, 2004). Renouf (1991: 42) uses the earlier work of Russell (1987) to depict normal father - child contact within Australian families over two decades ago. In his work on

parental socialisation practices, Russell (1987) focused on mother / child, father child relations and found Australian mothers to be more available and to spend more time with children than fathers did. Fathers' responsibilities over the six to eight year old group were for bedtime and for taking children to extra activities. For Canadian men, the average time spent with family members decreased by 45 minutes, from 250 minutes in 1986 to 205 minutes in 2005; this decrease in time was observed for all regions, for all levels of education and for nearly all age groups (Turcotte, 2006).

Studies that measure the opportunities fathers have to engage with their children and the quality of such engagements are most often cross-sectional, vary in method and have samples that are not homogenous. Ergo, it is rarely possible to compare populations of fathers. Trend data for time spent with children is also difficult to formulate because historical records of the private lives of fathers are largely incomplete and the rate of social change to family structure has been substantial since World War Two. More recently, there has been considerable debate amongst researchers and theorists on whether fatherhood is in a state of crisis or simply responding to a period of rapid change over the past three decades in family life has been undergoing rapid change (Skeen, 1997).

According to Sayer et al., (2004a), having reviewed existing research, the assumption that changes in families have led to decreased or increased parental investments in child rearing over the past 40 years is ubiquitous because of a complex interplay between fertility choices and patterning of dual income working patterns. Consequently, further work is needed to empirically assess explanations of parents' shifting time with children and to examine the implications of the time pressures for parental and child wellbeing (Sayer et al., 2004a).

Sayer et al., (2004b) reviewed diary data from 24,546 married mothers and married fathers in Canada, Germany, Italy, and Norway to determine whether the effect of education on childcare time varies cross-nationally. This unique cross-national study found that higher education had no positive effect on paternal childcare time in Norway, with only weak effects in Germany. A recent review of international data leads Chalasani (2006) to conclude:

> **"When it comes to gender differences in parental time, the best educated men and women clearly look more alike in terms of their time with children than do the least educated men and women."**
>
> Chalasani (2006: 30)

In an ambitious study exploring the changing rhythms of family life Bianchi et al, (2006) contend that in the US married fathers more than doubled their time spent exclusively on childcare activities from 2.6 hours per week in 1965 to 6.5 hours in 2000 and that a similar trend has occurred in France and other countries. However, Budig (2008) offers the critique that Bianchi et al's., (2006) purported increased uptake of parenting by fathers comes from a very low base and does not come close to an equitable parenting workload. Furthermore, the increase in men's unpaid work and childcare around the home did not equate to a direct reduction in unpaid work undertaken by women (Budig, 2008).

Family friendly workplaces exist largely in policy rhetoric with paternity leave only recently a reality in the UK and Australia (Burgess & Ruxton, 1990; Productivity Commission, 2008). Smeaton and Marsh (2006) provide a summary of the changes in the United Kingdom (UK) in mothers' and fathers' use of maternity and paternity provisions and their patterns of work between 2002 and 2005. Despite the percentage rise from 11% to 31% for new fathers using flexitime in that period, the uptake of part-time opportunities remained negligible, rising from just 2% to 4%. Australia and Switzerland provide only maternity leave, although Australian mothers may transfer one week of this time to fathers (Ray, 2008).

4.2.3 Absent fathers

The bourgeoning trend toward sole parent families, step-families and to a lesser extent same-sex couple families, has challenged the notion that the family unit is comprised of two biological parents and their children (Skeen, 1997). The absent father is a common phenomenon of family life for many children. The state and policy makers have struggled to come to terms within this category of male parenting and the lack of male parenting responsibilities in a number of Western cultures (Kiernan, 2005; Siefken, 2006; Bradshaw et al., 1999; Ferguson, 2004, Siefken, 2006). In developed countries, the number of men living with children is in decline. Schor (2003) abstracting from a report, 'The Task Force on the

Family', highlights that the majority of American families are without a resident father.

> **"Between 1970 and 2000, the proportion of children in 2-parent families decreased from 85% to 69%, and more than one quarter (26%) of all children live with a single parent, usually their mother. Most of this change reflects a dramatic increase in the rate of births to unmarried women that went from 5.3% in 1960 to 33.2% in 2000. Another factor in this change is a slowly decreasing but still high divorce rate that is roughly double what it was in the mid-1950s."**
>
> (Schor, 2003: 3)

In reference to absent fathers and the work of the Australian Institute of Family Studies reviewed by Smyth and Weston (2003):

> **"In recent years, increasing research attention is being paid to fathers… Yet we know very little about paternal disengagement and about the nature and quality of father-child contact where it occurs. The Institute is currently exploring these issues but much work needs to be done in this area."**
>
> (Smyth & Weston, 2003: 1)

Teenage fatherhood appears to be associated with similar consequences to those observed for teen mothers with a large proportion having little contact with their children (Jaffee et al., 2003a) because of delinquent paternal behaviour (Jaffee et al., 2003b). However, adolescent fathers have remained a largely understudied and underserved population (Tyrer et al., 2005).

4.2.4 Time spent with sons and daughters

Researchers assessing the time spent with daughters and sons show mixed findings. A study of girls by Simpson et al., (1995) suggested non- resident fathers are more likely to spend time with sons and another study by Seltzer (1991) reports that fathers spent more time with their daughters.

However, there has been:

> **"No evidence that gender differences modified the link between quality of child non-resident father relationship and children's adjustment."**
>
> (Dunn, 2004)

Why time spent with sons and daughters differs for resident fathers has been recently investigated by Raley and Bianchi (2006) who provide several plausible explanations for this phenomenon. The role modelling of masculine activities about the house brings men and boys together. Married fathers with sons are more

likely to stay married and mothers of sons report more marital happiness. Divorced fathers more often have custody of sons than of daughters and cohabitate with their son. What is not adequately explored by Raley and Bianchi (2006) is the proposition that men spend more time with their sons because mothers are spending more time with their daughters (Suitor & Pillemer, 2006).

4.3 Theorising fatherhood

Key researchers of the family and fatherhood argue that there has been a longstanding bias toward i) measuring time spent with fathers and ii) measuring the psychological significance of a variety of paternal interactions with children; and this bias has resulted in an underestimation of the importance of the social context of fatherhood (Lamb, 1991; Burman, 1994; Lupton & Barclay, 1997). This section explores issues that have arisen out of early theorising about fatherhood and psychologists' approaches to researching fatherhood, with the intent of supporting the need for more research into the effects of social context on fathers' parenting.

4.3.1 Interdisciplinary overspecialisation

Lamb (1991), in his critique of studies on fatherhood and parenting spanning more than two decades, supported by the works of Bronfenbrenner (1975, 1979), claimed that psychologists and sociologists had, in their push to establish their own empirical tradition created interdisciplinary 'overspecialisation'. As a consequence psychologists, between the 1950s and 1960s, had completely ignored the social context in which children were raised. In particular, they failed to account for the extent to which 'behaviours and values' are directly and indirectly influenced by the multiple contexts in which people, their families, and their communities are enmeshed. Lamb (1991) concludes that by not accounting for the broader social context in which children were raised 'fathers too were forgotten'.

> **"It was implicitly assumed that formative importance was somehow a function of the amount of time spent together, and this assumption, coupled with the general cultural devaluation of fatherhood in the 1950s led to the development of a literature based first on interviews with mothers and then on observation of mothers and children, or children and unfamiliar women."**
>
> (Lamb, 1991: x)

A 1970s interpretation of Sigmund Freud's clinical trials, highlighted that imagined parental roles and real behaviours played a crucial role in the formative development of children's lives; leading to the statement that fathers should not be the 'forgotten contributors to childhood development' (Lamb, 1991). According to Lamb (1991) most developmental psychologists frowned upon the clinical interpretations of Freud, preferring instead to systematically put questions to almost anyone that was not a father. That is, psychologists chose to research:

> **"…the most readily available and verbally-competent informants about children-mothers, particularly literate, verbal, middle-class, white mothers in urban areas."**
>
> (Lamb, 1991: x)

In a review of the contemporary literature on fatherhood, Lupton and Barclay (1997: 45) also declare reservations on the appropriateness of psychological research into fatherhood, noting that studies seeking to establish a differentiation of 'interactional styles' of mothers' and fathers' parenting styles simply mirrored traditional gender roles in their analysis. The notion that differences in parental 'interactional styles' are 'complementary' and are therefore functional to a child's developmental understanding of gender roles is an inductive point (Lupton & Barclay, 1997). Connell (1995) also reasoned that gender should be researched in the context of gender relations rather than research isolating masculine or feminine roles. Lupton and Barclay (1997) assert that there is very little psychological research that seeks to demonstrate similarities in parenting styles and capabilities between men and women (masculine and feminine).

The writings of Michel Foucault identify the ways in which notions of the human subject, for example fathers, are historically contingent and constantly created and recreated through discourse. Foucauldian theorising on the research into parenthood transcends individual disciplines' analysis of the phenomena. According to Lupton and Barclay (1997) an analysis by Foucauldian theorists of the part played by researchers in shaping contemporary fatherhood is convincing. They argue that the extraction of men from family work to take part in waged labour at the time of the industrial revolution shifted parental responsibilities onto mothers. Continued prosperity was dependent on securing a healthy, reliable and well-educated workforce. How this objective might be achieved was demanded by the state and other organisations through policy. In response, expert

knowledge systems such as science, medicine, public health and social science burgeoned. Maintaining objectivity in research when ‘measuring’ and ‘monitoring’ the population groups became problematic because the data was used as a basis for ‘regulating’ men’s daily lives to meet the goals of an industrial society (Lupton & Barclay, 1997). Foucauldian theorists refer to these phenomena as ‘normalistion’ of the population. Consequently, Foucauldian theorists assume that:

> **“The sites for the production of discourses in themselves, the health and social sciences cannot be isolated as separate from the social context in which they operate and construct certain types of individuals and social groups as “problems”.**
>
> (Lupton & Barclay, 1997: 35)

Linked to these theoretical perspectives, the ‘truth’ about fathers is strongly influenced by the power relations located at the level of everyday life. Normalisation of men’s daily activities effectively explains the way in which caring has undergone feminisation. Lupton and Barclay (1997:47) note that the literature on fatherhood has typically assumed that fathering is a ‘simple variety of mothering’ where new age fathers are seen as sharing and caring by taking on maternal tasks. This observation is congruent with Burman’s (1994:97) view that there has been little attempt to develop new theoretical and methodological paradigms to explore the ontology of men’s experience of fatherhood. In popular culture, men’s failed attempts to mimic women’s child management and child-rearing skills are a source of comical entertainment (Lupton & Barclay, 1997; Butch, 1992), the inference being that, in order to raise children appropriately men ought to be more like women. These works also serve to humble men and uphold the status of women, emphasising that mothering is a complex task that not just anyone can master. In reality, many women may strenuously resist the acquisition of traditional female knowledge and skills by men, as child rearing has traditionally been seen as the basis of evaluating self worth among women. Why would women allow men, who dominate public life, to encroach on women’s sense of self worth by also rearing children? Resistance to men acquiring mothering knowledge and skills is implicit in studies of working class mothers (Hewison & Dowswell, 1994). Further, many women experience a diminished sense of wellbeing when they no longer have children to care for (Radloff, 1980)

and therefore are resistant to any social change that reduces their share of time with children.

4.3.2 The nexus between masculinity and fatherhood

The public image of paternity has until recently relied heavily on featuring fathers as masculine entities resulting in a stilted stereotype (Burgess, 1997). However, theorists of gender and fatherhood clearly state the difficulties in assimilating theories of masculinity with fatherhood (Connell, 1995; Lamb 1986). The mounting pressure for men to equalise their parenting roles with their spouse / partner, has led many men to express uncertainty as to what this might mean for their masculinity. Some men express frustration in relation to their perception of mixed messages. For example to: "Be responsible for discipline but be soft and caring" and "be the family figurehead" but "share the decision making." (Skeen, 1998: 135)

This frustration is born out of melding their masculine roles with a new form of parental responsibility.

The close relationship between masculinity and fatherhood is not surprising given that fathers are most often, though not exclusively, the focal point for boys learning appropriate masculine behaviours and values (Russell, 1983; Connell, 1995; Flouri & Buchanan, 2002). Older boys, siblings, and images depicted on the media provide important images of masculinity (Greenfield, et al., 1999; Stibbe, 2004). And young boys, whether or not their father is in the home, study the behaviour of men in order to learn about masculinity (Harris, 1995). Contemporary theorising of fatherhood has a number of developmental parallels with that of theorising masculinity. Using a rationale almost identical to that of Connell (1995) in his refutation of any single workable definition for masculinity, Lamb claims:

> **"There is no single "father role" that somehow transcends time, place and social station; fathers play many roles in their families, and the nature and relative importance of these roles vary historically, intraculturally, and interculturally."**
>
> (Lamb, 1991: xi)

Researchers of masculinity and fatherhood identify common elements among those researched. However, contemporary theorists have noted that the usefulness of matching data to create commonalities between masculinity and

male parenting is limited because this practice only contributes to the formulation of stereotypes that, isolated from other data, do not provide a meaningful basis for guiding the successful transition of boys to manhood or fatherhood (Connell, 1995; Williams, 1996). Consequently, determining the extent to which fathers are responsible for providing realistic parenting role models for boys to carry into adulthood remains unclear (Connell, 1995: 52; Daly1995).

Featherstone (2005) notes, in reference to Lupton and Barclay's work (1997) and Hobson (2002), that there is**:**

> **"Neglect in the psychological literature of fathers as men and little link up with the men and masculinities literature… the men and masculinities literature appeared strangely silent about men as fathers".**
>
> (Featherstone, 2005: 2)

Whilst masculinity and fatherhood are inextricably intertwined these concepts have not been well defined, leaving most researchers to focus on describing their changing social context, recognising that these concepts are deeply enmeshed in the 'historical trajectories' of institutions and of economic structures (Connell, 1995; Burgess, 1997).

4.4 Researching fathers

Early fatherhood research from the 1950s was centred on the white male who, as a father lived within the family and had a primary role as breadwinner (Lamb, 2004). In effect, researchers of this period studied a homogenous group relative to the fathers who have been part of the social experiment of fertility control, gender equality in the workplace and rising youth unemployment (labour saving industries) (Burgess, 1997). This section seeks to identify research gaps in the study of fatherhood.

4.4.1 Knowledge of fatherhood is lacking

A search of the literature to identify characterisation of the father - child nexus, using sociological critiques of fatherhood, family health journals and men's health literature per se, revealed that many researchers had attempted a similar task but had fallen short of locating systematic literature on the topic. Several major authors and researchers investigating the history of family life have drawn

attention to the phenomenon that fathers are the missing figures in family research (Abbott cited in Burgess, 1997; Sternberg, 1996; Lamb, 1991).

Mary Abbot, a principal lecturer at Angelia University explored the history of English families form 1540 - 1920, and gave her conclusions by way of personal correspondence to Burgess, (1997) stating that:

> **"Although there has been much research into women in families, we as yet know very little about the family lives of fathers."**
>
> (cited in Burgess, 1997: 35)

A substantial review by Burgess, (1997) focusing on the private lives of fathers between 1790 and 1990, culminated in a conclusion similar to that of Mary Abbott. Firstly, the public image of fatherhood was dominated by the image of patriarchy whilst little was known about their domestic counterpart. Secondly, whilst we may know our own fathers in private life there is so little to inform us of other people's fathers. In order to fill this gap in knowledge: "We inevitably apply the public image to the private sphere." (Burgess, 1997)

Andrews et al., (2004) conducted a random household, telephone questionnaire (n=1,010) and determined the public's image of father was:

> **"A majority of the respondents agreed that most fathers fulfil responsibilities in the areas of caregiving, financial support, protection, cooperation with the child's mother, and moral or faith-based guidance."**
>
> (Andrews et al., 2004: 603)

Smyth and Weston (2003) openly declared that there are large gaps in the research concerning the private lives of Australian fathers: "In Australia, small pockets of research exist but the gaps in our knowledge remain large and fundamental." (Smyth & Weston, 2003: *e* conference paper).

However, Bozett and Hanson (1991) editors and author of the book 'Fatherhood and families in cultural context' proclaim that:

> **"Contrary to the situation in the early 1970s, there is now no paucity of knowledge about fathers, fatherhood, and fathering."**
>
> (Bozett & Hanson, 1991: iii)

Michael Lamb, author of the foreward to Bozett and Hanson's (1991) work suggests that much is left to do by way of 'attempts' to present a coherent appreciation of fatherhood.

> **"Both the title and the content of this volume illustrate the wide spread current attempts to develop broader, more inclusive, and more socioculturally – and historically – sensitive views of fatherhood."**
>
> (Lamb, 1991: xi)

Overall, the expert researchers Lamb (1991) Burgess (1997), and Smyth and Weston, (2003) have determined that there is insufficient literature on fathers and these observations outweigh Bozett and Hanson's (1991) claim of 'no paucity' of knowledge about fatherhood.

In 2003, Bruce Smyth and Ruth Weston presented a paper to the National Strategic Conference on Fatherhood, to draw attention to the status of research about Australian fathers, stating:

> **"In Australia, small pockets of research exist but the gaps in our knowledge remain large and fundamental....Fathers are overlooked in many areas of research. In the divorce literature, for instance, much of what we know about fathers comes from talking with mothers. The same is true of fertility research, and of research about caring for children. Yet we know that men and women often have quite different views and experiences."**
>
> (Smyth & Weston, 2003: *e* conference paper)

This type of comment adds support to the claim that the qualitative data collected in this thesis needs to be analysed to capture men's views and experiences rather than be limited to the preparatory phase of the survey instrument.

A rationale for the lack of literature to guide and support men in a caring parental role comes from an historical account of the transition of women into the middle-class and upper middle-class ideal of homemaker and child raiser (Lupton & Barclay, 1997).

> **"While fathers were still often mentioned in the American child-rearing literature of the early 1800s, by the middle of that century they were rarely mentioned, as it was assumed that mothers had almost sole daily responsibility for child rearing."**
>
> (Lupton & Barclay, 1997: 39)

Stearns (1997) makes the observation that as dual income families became commonplace.

> **"The...absence of any advice literature for fathers, in a period when their roles were changing so greatly ...is truly striking."**
>
> (Stearns, 1991: 41)

The lack of literature on fathering across diverse family structures and social circumstances, as outlined in this section, presents social science researchers with substantial challenges.

4.4.2 Scope of fatherhood research

Marsiglio et al.'s (2000) review, 'Scholarship on Fatherhood in the 1990s and Beyond', reveals a growing diversity in the transitional nature of men's experiences of fatherhood in recent years. The word diversity is used to put a positive spin on recent social events and invites researchers to:

> **"Explore how structural, interpersonal, and individual level factors influence the types and intensity of men's commitments to their biological and step children."**
>
> (Marsiglio, 2000: 1186)

However, this positive notion of diversity is tempered with a more realistic challenge for researching the disparate lives of fathers.

> **"Researchers are likely to become increasingly attentive to the significance of studying how pregnancy resolution dynamics and union formation and dissolution patterns, coupled with shifts in residency arrangements, affect paternal involvement in both low income and more advantaged familial environments."**
>
> (Marsiglio et al., 2000: 1186)

The dislocation of men from the family, as non-resident fathers, is most often associated with substantial emotional and financial challenges. Ergo, the point:

> **"Because the culture of fatherhood has grown more fragmented and Piloticized, scholars will be challenged to understand the familial, social, and legal processes through which men in diverse settings appropriate and negotiate their status as father."**
>
> (Marsiglio et al., 2000: 1185)

Overall, Marsiglio et al.'s (2000) review examining the relationships between dimensions of the father-child relationship and children's wellbeing and development suggests a bias / strong tendency towards researching fatherhood in the context of a failed social experiment. The diminution of the traditional family unit and emphasis on work away from the family have resulted in a reduction of fathers' input into the family and subsequently a reduction in the means of production of childcare, sickness support, food preparation, entertainment and companionship. Rather than focus on men in the family, research has focused on precursors to the proliferation of policies to protect fathers' and mothers' rights, and the use of social work, counselling and the legal system as a primary basis for

resolving conflict. The social tension caused by diversity of the family counselling has resulted in a form of youth impoverishness (social dislocation) that predisposed girls to teenage pregnancy and boys to be absent non-contributing fathers (Marsiglio et al., 2000).

Absent from the research is any systematic assessment of men who succeed as fathers in a long term relationship with their spouse / partner within the dual income family. And Marsiglio et al.'s (2000) only briefly mention the social capital that fathers introduce to their children by way of sensitising their offspring to the value of paid labour / skilled labour and connections to employment.

Little is known about men's formative years as fathers and their contribution to childcare. The claim of there being a substantial gap in the research is supported by Condon et al., (2004) who state: "In comparison to its female counterpart, the transition of men to parenthood has been relatively neglected in previous research." (Condon et al., 2004: 56).

Overall, a number of key researchers point to the diversity of fatherhood requiring ongoing and expanded research to inform on majority groups of fathers (Marsiglio et al., 2000). There is an urgent need for assessment of the effects of social change on a father's role within and outside the family (Lamb, 2004) and the effects on potential fathers' decisions on parenting / work choices (Russell & Hwang, 2004).

4.4.3 Recruitment of fathers into studies

Recruitment of fathers into studies is difficult for several reasons. Much of the Australian research exploring fathers in the context of their family is clouded by a notion that fathers are difficult to research and therefore data needs to come from some other source (Smyth & Weston, 2003).

Men are often less easy to recruit for studies on family life, and this is frequently attributed to men's lack of opportunity to break away from work commitments and their preference to spend time outside the family. Sharpe (1994) struggled to attract men to participate as contributors to her book 'Fathers and Daughters' because she met with a number of gendered difficulties.

> **"There are significantly more women than men in this book and this is because daughters responded more enthusiastically to the**

> **opportunity of participating than fathers. As a result of one of my newspaper advertisements, I received nearly 150 letters, and over ninety per cent of them were from women."**
>
> (Sharpe 1994: 6)

Many men agreeing to participate were often not good informants and did not provide rich data. Sharpe (1994: 6) in her study of father – daughter relationships highlights her disappointment and frustration at failing to get men to express their feelings.

> **"There were times in my interviews with fathers when I wanted to shake them and say 'yes, but what did you actually feel like?' "**
>
> (Sharpe, 1994: 6)

and:

> **"That is not to say that the men did not talk: on the contrary, many spoke at considerable length but they tended to talk either in a more distanced way, often intellectualising their feelings rather than really describing how they felt, or they avoided emotions and feeling altogether. Preferring to outline events...These men seemed ill at ease with emotions, especially their own."**
>
> (Sharpe, 1994: 6)

It is tempting to suggest that the gender of the interviewer played an important role in Sharpe's experience as the researcher but the author of this thesis has also experienced difficulties in gaining depth with men at interview, causing him to publish a paper on 'The complexities of interviewing Italo – Australian men', about their knowledge and experience of prostate cancer (Laws & Drummond, 2002a). Men may also be reluctant participants in research because they are sensitive to elements that might degrade their integrity. Williams (1996) structured her investigation into men's accounts of their fathers in the knowledge that men were more likely to talk about their experience where "there were no mothers, wives or children to interpret, correct or mock them." (Williams, 1996: vi). Despite William's precautions to protect men's private conversations, one man withdrew publication rights because he believed the information he gave was too sensitive and may harm others.

The more sensitive the issue to men, the more reluctant men become at disclosing their feelings and rationale for their actions / inaction. It is widely recognised that there exists an unspoken code among men who served in the military during war time not to reveal their experiences to others outside that group (Karner, 1996) and this extends to fathers talking to their sons about war time experiences.

Procter (2000) experienced the Balkans war at first hand noting a code of silence between men and others extending across large periods of history and even among men who lived in Australia, far away from the conflict. Conflict within the family is also not easily discussed by fathers. As an example, only women have been able to speak of the social taboo of incest and father-daughter rape (Ward, 1984). Consequently, accounts of what happened and the harm done are focused upon, rather than researching what prompted men to perpetrate such acts (O'Donnell & Craney, 1985).

4.5 Child health effects linked to fathering

Fathers have the potential to positively enhance the health and wellbeing of their children. This section seeks to identify the difficulty in determining the health and wellbeing outcome of fathers who are non-resident and those who are resident.

4.5.1 Non-resident fathers' contribution to child health

The potential for fathers to be in contact with their biological children is challenged due to changes to family structures. The number of non-resident fathers in Western countries is substantial and their numbers are growing (Dunn, 2004; Schor, 2003). Similarly in Australia, sole parent families, stepfamilies, and to a lesser extent same-sex couples families have challenged the notion that the family unit is comprised of two biological parents and their child (Skeen, 1998). Smyth and Ferro (2002) report that 30% of children living with one parent, do not see the other parent and 28% who see a non-resident parent in the day time never stay overnight. There is a substantial knowledge gap about which parent provides quality of care and:

> **"…there is lively debate about whether young children should stay overnight with non-resident parents and, if so, at what age and how often … This issue is of significant import to separated parents with young children."**
>
> (Smyth & Ferro, 2002: 54)

Strategies used by mothers to divert fathers from contact, often described as 'gate keeping', can negatively influence father-child contact and consequently child–father relationships.

However, the impact of this behaviour is not always easy to establish. On this point Dunn (2004) concludes:

> **"It is worth noting that children's opportunity to communicate with both sets of parents about issues that trouble them remains important."**
>
> (Dunn, 2004: 663)

The proportion of children with a non-resident father who experience the addition of a stepfather to their family worlds is substantial, yet their influence on the child's health and wellbeing is rarely recorded beyond a cluster of cases. Ergo, for those researching the effects of non-resident fathers it is important to consider:

> **"The child - nonresident father relationship within the framework of other family relationships, for example the relationships between father and ex-partner, between child and mother, and between child and stepfather."**
>
> (Dunn, 2004: 665)

Dunn (2004) in conclusion, makes an urgent call for longitudinal research to address the complex issues of how to promote the wellbeing of children with non-resident fathers and promote recognition of the difficulties faced by non-resident fathers in maintaining and developing close relationships with their children. Other contemporary researchers note that further work is needed to empirically assess explanations of parents' shifting time with children and to examine the implications of the time pressures for parental and child wellbeing (Sayer et al., 2004). These points infer that the mother provides much of the health practices, and there is little literature on health care by non-resident fathers who have contact with their child.

Non-resident fathers contribute, in the simplest way, by making child support payments and this financial assistance is linked to their child's improved development and scholastic achievement. Amato and Gilbreth (1999), having conducted a meta-analysis of 63 studies, found that across studies, payment of child support was associated with children's academic success, and fewer externalising problems. Although child support payment and child outcomes have also been linked to increased frequency of father - child contacts, improved outcomes and frequency of contact may have originated from already existing good quality child - father relationships (Amato & Gilbreth, 1999).

Marsiglio et al., (2000) also summarise the research on the effects of contact with non-resident fathers:

> **"In 38 studies published since 1990, researchers examined linkages between children's wellbeing and their relationships with nonresident fathers… Taken together, these studies suggest that the frequency of visitation and children's feelings about their fathers are not good predictors of children's development or adjustment…. In general, these studies suggest that it is not the amount of time that nonresident fathers spend with their children but how they interact with their children that is important."**

(Marsiglio et al., 2000: 1184)

However, the assumption that the authoritative parenting by non-resident fathers is associated with more positive child outcomes was confirmed in Amato and Gilbreth's (1999) meta-analysis.

Several studies cited in Bunting and McAuley's (2004) research review show that the majority of teenage parents are i) non-resident fathers, ii) have fewer financial resources to sustain child support payments, iii) are more likely to commit criminal offences / be involved in delinquency.

> **"The research available in America and Britain indicates that, as with teenage mothers, young fathers may experience a variety of difficulties once their children are born. These include poor educational and financial outcomes as well as potential involvement with drugs and other illegal activities."**

(Bunting & McAuley, 2004: 302)

The disadvantaged child of a teenage father has a high risk of becoming a teenager father in similarly deprived social circumstances (Bunting & McAuley, 2004).

An accurate profile of non-resident fathers' contact with their child has been difficult to achieve because of the complex interaction between social change, policy lags, policy initiatives and variations in their legal status. Two large studies have noted that drug and alcohol problems, antisocial behaviour, partner violence, and depression or anxiety problems were more common among young non-married fathers than married fathers in residence (Wilson et al., 2001; Jaffee et al., 2001). In a study of twins, the personality of the father, exhibited by anti-social behaviour was shown to have a negative effect on the child's wellbeing and development; therefore an absence of father - child contact may result in a better outcome than if the father had remained in the household (Jaffee et al., 2003). A

recent meta-analysis and overviews of research related to father contact and father - child relationship quality was the main focus of Dunn's (2004) work. Dunn outlines several ongoing methodological problems:

> **"…the significance of genetics in explaining connections between nonresident fathers and child outcome is rarely investigated; the twin study of antisocial behaviour and father–child contact (Jaffee et al., 2003) is a welcome exception."**
>
> (Dunn, 2004: 667)

The personality and position of the child in the family also influence emotional outcomes when fathers become non-resident parents.

> **"…siblings differ in their adjustment following parental separation, and make possible appreciation of the relative significance of individual child characteristics such as temperament, and family characteristics such as SES"**
>
> (Dunn, 2004: 668)

The concept of 'fratriarchy' is use by Hearn and Morgan (1990) to explain, in part, men's personality as a reason for their physical / emotional absence from their children and parental responsibilities. Fratriarchy is a mode of male domination that is concerned with a quite different set of values from those of patriarchy. Unlike patriarchy, fratriarchy is based simply on men's self-interest and association with the activities of other men. It reflects the demand of a group of lads to have the 'freedom' to do as they please, to have a good time (Hearn & Morgan, 1990).

4.5.2 Military service and fathering

It is difficult to locate precise figures on the number of fathers in Australia who have seen active military service. As of 2004, there were nearly 200,000 pensions attributed to conflict from the time of the Korean War. The Vietnam counselling services provided 39,519 consultations between 2003 and 2004. And the veterans' childhood education scheme supported 5,117 children (Australian Government Department of Veterans' Affairs, 2004).

Military service, even in times of peace, often results in men being away from their children for extended periods thus diminishing their availability for fathering (Stolz, 1954). Children whose fathers are on long-term military deployments may experience depression, withdrawal, aggression, and often develop sleeping problems as a means of grieving for their father's absence or over the

contemplation of his death (Kelley, 1991). War also deprives children of the opportunity of growing up with a father because he was either i) killed in action, ii) died from wounds shortly after, or iii) died as a Prisoner of War (POW). Some children may have a father but never know his identity beyond being informed that he was a soldier doing military service in their home country at the time they were conceived. It is now recognised that these children often experience negative health consequences from knowing that this was the extent of their father's commitment to them (Bemak & Chung, 1999). Men returning from active service in a war zone or policing a trouble spot are likely to have had traumatic experiences that either alter their psyche or result in mental health problems. Irrespective of whether formal mental health diagnosis is given, these men's experiences have been shown to have negative consequences in relation to the way they interact with their spouse, children and others in society (Westerink & Giarratano, 1999; Davidson & Mellor, 2001; Karner, 1996; Dansby & Marinelli, 1999). No matter how military service is viewed it has a substantial effect on men's ability to father and the quality of parenting they can provide. Despite this disruption to family life, the impact of war on marital relationships and family life has been generally 'disregarded and undervalued' (Peters, 1996). Consequently, we know little about fathering traits among a substantial number of men who have been psychologically affected by their wartime experiences.

4.5.3 Single fathers' contribution to child health

A growing number of Australian men are becoming 'single fathers'; though little is known about this group of men (Wilson, 1990). Nearly 2% of all families with children under 15 years are headed by a lone male (ABS, 2000). Permeating contemporary literature and the popular press is the vision of filial piety and affection, as well as of paternal commitment, love and devotion (Williams, 1996; Bozett, 1991; Wilson, 1990; Burghes et al., 1997). Coupled to this is an understanding that men's lives stand to be enriched by their increased involvement with their children irrespective of the type of family structure. An indication of the growing importance of this topic is the recent development of a policy on fatherhood in Great Britain (Burghes et al,. 1997). Awareness raising in terms of the need for men to father and take on a more equitable share of parental responsibilities raises a number of questions.

- Who are the men who want to father?
- Who are the men that want to expand their parental responsibilities?
- How are men prevented from expanding their parental responsibilities?
- How are men to be assisted in their role as fathers?

In contrast to men actively parenting, there are those fathers residing within the family who are rarely physically home, or when home are absent from a supportive role (Robertson, 1991).

4.6 Resident fathers' contribution to child health

There are general statements that can be made about fathers' ability to indirectly influence the long term health and wellbeing of their children. Buchanan (2002) determined, from a study of 17,000 UK children born in 1958 and followed up on 7, 11, 16, 23, and 33 years, that father involvement at age seven was positively correlated to educational attainment later in life. Conversely, fatherhood support groups interpret the literature as showing that reduced father involvement impedes growth and development. On almost every indicator of child wellbeing, children today fare worse than their counterparts just a generation ago. The reason: the dramatic rise, over the last 30 years, in the number of children living in fatherless households (National Fatherhood Initiative website: http://www.fatherhood.org/about-us.html). This section explores resident fathers' direct and indirect effect on child health.

4.6.1 Father - child emotional health

The study of father - child relationships underpins an understanding of a father's attempt to support the emotional wellbeing of his offspring. However, it is difficult to locate studies that directly ask fathers about their attempts to enhance their child's wellbeing. Literature on father - child relationship development is scant and what does exists tends to couch fathers as being problematic for children in terms of their absence, antisocial behaviour and ability to come to terms with their parenting role. Lupton and Barclay's (1997) review of the psycho-social literature revealed that fathers tend to be portrayed as 'potentially pathogenic variables' in relation to their children's health and psychological development (Lupton & Barclay, 1997). The identification of fathers as 'normal' and / or 'unproblematic' tends to be absent in the literature and ignored by

researchers. Lupton and Barclay (1997) also observed a predominate focus in the nursing and family health literature on the negative emotional impact of fathers.

> **"Research into fatherhood in the nursing and family health literature has predominantly focused on the early stages of fatherhood, taking up many of the concerns and methods of developmental psychology ....Like the psychological literature, these texts tend to represent fatherhood as a potentially pathological experience replete with upheavals and the need for major adjustments. Such terms as 'stress', 'strain', role transition', and 'psychological disruption' are frequently used in the literature to describe men's experiences of becoming a father."**
>
> (Lupton and Barclay, 1997: 48)

Several researchers have highlighted the need for daughters' emotional need for understanding their relationship with their father. Sharpe (1994), in her research reviewing the literature on the emotional connections between fathers and daughters, makes the observation that:

> **"In introducing a British anthology of women talking about their fathers in 1983, Ursula Owen similarly questioned why there was so little work on fathers and daughters, and then ten years later the situation has not significantly changed".**
>
> (Sharpe, 1994: 2-3)

Nielsen (2001) highlights women's need to know more about their fathers' emotional connection with them by identifing a high demand for a college course focusing on father - daughter relationship and the substantial imbalance of opportunities for studying father - daughter relationships compared with mother - daughter, stating that:

> **"College courses, workshops, therapy groups, television shows, and books that focus exclusively on mothers and daughters are common in our country."**
>
> (Nielsen 2001)

Using the findings from a systematic review of the literature Nielsen (2001) reveals that:

> **….there are roughly 1300 books about mothers and daughters listed by Amazon.com, the largest website for books published in the past 30 years -- and most are written for adult mothers and daughters. In contrast, there are only 900 books about fathers and daughters -- most of which are children's story books ... on the internet there are far more web site listings for mothers and daughters than for fathers and daughters. Clearly then many writers, publishers, readers, and internet fans believe the father-**

> **daughter relationship merits less attention than other family relationships.**
>
> Nielsen (2001: 280)

Analysis of father-to-son discourse often focuses on men's awkwardness in relating life matters to their son (Williams, 1996). On analysis of the testimonies made by Australian men about their relationships with their father, Williams (1996) concludes that fathers 'set the tone' for what are acceptable emotional displays and what are considered weak or effeminate. Fathers also play a vital role, often by way of non-verbal communication, in imparting knowledge of moral codes, social boundaries, and physical education. However, Williams (1996) identified a general stilting of verbal expression in relation to Australian fathers' ability to pass on their emotions and love for a son.

Father - daughter relationships are rarely mentioned in the literature because boys and men's masculine relationship dominate the literature on fatherhood (Connell, 2000). Theorising of fathering roles towards daughters has been limited to exploring claims that children learn gender roles from the same gender parent. Juxtaposed to this is the theory that the behaviour by opposite gender parents teaches the relational values of masculinity/ femininity (Marciano, 1991:146). However, there are a number of questions to accompany these theories:

- What issues do daughters hold in relation to being fathered?
- What do men see as appropriate fathering for their daughters?
- What do women see as appropriate fathering styles for their daughters?

The literature does not extend to identifying how men parent daughters differently to their sons for the purpose of engendering emotional health.

There is little information on fathers' ability to offer emotional support for a child with an emotional or mental health problem. For example, a large number of American children have been diagnosed with Attention Deficit Disorder (ADD) and Hyperactivity Disorder (HD) and this has supported a burgeoning of literature dedicated to understanding how 'parents' cope with their child's educational interactions and family living. However, there is little information on how fathers have been able to influence their child's emotional health. Evidence of this comes from Barney Brawney's dissertation (cited in Rosenfeld, 1998) revealing that out of 1,700 studies reviewed on the topics of ADD and HD, the word

'father' is mentioned only three times (Rosenfeld, 1998). Brawney's dissertation could be located using an electronic search for thesis in Proquest dissertations and theses. Father's specific health practices, towards a child with a mental health problem, are presented in the document search chapter "*Mental Health*".

4.6.2 Father - child physical health

For the purpose of assessing fathers' participation in health matters Lamb et al.'s (1987) concepts of paternal involvement, interaction, availability and responsibility provide a useful reference point:

Interaction: refers to the father's direct contact with his child through caretaking and shared activities. Availability: is a related concept concerning fathers' potential availability for interaction, by virtue of being present or accessible to the child. Responsibility: refers to the role the father takes in ascertaining that the child is taken care of and arranges resources, for example "...appointments with the pediatrician...." (Lamb, 1987: 125)

Marsiglio et al.'s (2000) review of fatherhood scholarship notes that Palkovitz (1997) extended Lamb and colleagues' notion of responsibility by introducing a more systematic and fuller treatment of the cognitive manifestations of father involvement; discerning 15 general categories of paternal involvement (e.g., doing errands, planning, providing, sharing activities, teaching, thinking about children). In addition, Palkovitz (1997) outlined some useful continua (e.g., time invested, degree of involvement, observability, salience, directness) for exploring the complex nature of father involvement.

A literature search was undertaken to locate any information that mentioned or discussed the health practices of fathers towards their children. The following databases were accessed: CINAHL, APAIS (consumer science, multiculturalism, family and society, public affairs) and AUSTHEALTH (Rural, Health and Society, Australian Medical Index). The following key words, 'father', 'fathering', 'health', 'practices', 'skill' were used in various permutations across these databases. The finding was one of scant data, confirming similar published searches by the author of this thesis (Laws & Bradley, 2003). The search was hampered by the use of the term 'parent' by many researchers. The author of this thesis has reported that even when the term parent is used in a study of child

health, there are few instances where the data is disaggregated into mothers / fathers care (Laws, 2003) making it difficult / impossible to clearly identify data relating to fathers.

In a rare comparison between resident and non-resident fathers' health practices, Hanson et al., (1988) investigated the relationship between adolescent self-health care for diabetes and the effects of an absent father using a sample of 30 intact families and 30 father-absent families. They found there were no 'between-group' differences for adolescents' metabolic control or social competence.

Of particular note is a recent comment by Hallberg et al., (2007) investigating Swedish fathers' views of child health:

> **"Very few studies have been conducted of fathers' views of their children's health. Thus, when searching Pub Med, using the key words 'fathers', 'children', 'involvement' and 'commitment', we found no studies similar to the present one."**
>
> (Hallberg et al., 2007: 1083)

A review of the literature by the author of this thesis, searching for evidence of transmission of health knowledge from men to boys and fathers to sons in the Australian context was undertaken and resulted in the finding:

> **"The authors of this work have had to rely on thin research in terms of identifying specific health knowledge and health practices transmitted by fathers and men to boys. Nevertheless, there appear to be opportunities for fathers to relate to their children in terms of health matters. Although key researchers have noted that the nexus between father and son has diminished there are opportunities to rekindle the depth and meaning of father sons relations in both groups."**
>
> (Laws & Bradley, 2003: 258)

A potential source of literature for understanding men's / fathers' participation in family health is the men's health literature per se. However, a review of men's health books by the author of this thesis (Laws and Drummond, 2002), revealed a heavy emphasis on medical knowledge for male specific problems with scant mention of family health issues involving men and boys (e.g. making informed choices on the appropriateness of male circumcision, sex education).

4.7 Conclusion

The historical accounts of fathering indicate that men have been dislocated from their family life by social change, alteration to family structures and continued

commitments to paid work outside the family. This suggests that they are not available to practice health.

The sociological literature revealed that the nexus between the concepts masculinity and fatherhood was not easily assimilated in theory or social practice, leaving most analysts to describe the changes to both in the context of their historical trajectories. An inability to assimilate masculinity and fatherhood means that they offer little in the way of developing a deterministic model to explain why some men practice health and others do not.

Researching fathers has moved from specialised approaches (psychology) toward more recent efforts aimed at understanding the social context in which men father. However, increasing trends toward diversification of fatherhood outside the family unit suggest that knowledge of non-resident fathers is lacking and difficult to ascertain. Knowledge of resident fathers' private lives is also lacking because it is assumed that men conform to the public image of fatherhood.

Key researchers continue to comment on the scantness of information about fathers (particularly in private life) and the lack of opportunity for men to engage in parenting responsibilities (Burgess, 1997; Lupton and Barclay, 1997; Smyth & Weston, 2003; Featherstone, 2005). In addition, the findings from the literature search (using the key words 'father', 'child', 'health') as presented in this chapter, revealed little information on men's health practice. Hallberg et al., (2007) and the author of this thesis (Laws & Bradley, 2003) support the claim that only scant information on the health practices of fathers can be found. In consideration of these findings, the author of this thesis determined a need to refine the search. Consequently, a series of document searches sought to identify fathers' health practices in response to illness groups (Acute, Chronic, Mental, Terminal), as well as the need for paternal injury prevention and health promotion. The findings from these document searches are presented after the chapter "*Methodology*".

The theoretical underpinnings used in the study of fatherhood, as presented in this chapter, contributed to the development of questions for the household survey; these questions are set out in Section 1.3 "*Fathering today*" and Section 1.5 "*Parenting in dual income families*". The concluding points to this chapter also correspond with the key works of other researchers measuring aspects of fathers' involvement in parenting; the Inventory of Fatherhood Involvement (Hawkins et

al., 2002) and the work by Lamb (2000; 2004) are discussed in the section "*Research method"* 5.14.3.

PART 3 : METHODOLOGY

*THOMAS
ALAN
CLIFFORD
LAWS*

CHAPTER FIVE:
RESEARCH METHOD

5 Introduction

The preceeding chapters highlighted a need for understanding men's health practices toward their children because a more equitable sharing of parenting responsibilities would bring benefits to the child, the working mother and fathers.

The purpose of this chapter is to extend the research approach, showing methodological coherency from the inception of the research questions to justification for the selection of data collection methods and analysis. Morse (2000) defines methodological coherence, stating:

> **"The aim of *methodological coherence* is to ensure congruence between the research question and the components of the method. The interdependence of qualitative research demands that the question match the method, which matches the data and the analytic procedures."**
>
> (Morse et al., 2002: 12)

Data collection commenced with a systematic documentary search for evidence of men's health practices across groups of illness (acute, chronic, mental, and terminal) as well as injury prevention and health promotion. Chapters Six through to Eleven present the findings from systematic document searches for evidence of men's repertoire of health practices, the frequency with which they are performed and men's experiences of practicing health (within the home and in conjunction with health care providers). Subsequent data collection consisted of focus group discussions and interviews followed by a household survey.

The choice of both qualitative and quantitative methods is explained as having benefits for exploring sensitive issues associated with cross gender work and extending parenting roles, as discussed in the chapters *Masculinity* and *Fatherhood*. Widespread support for mixed methods has grown since the 1980s (Pilot and Hungler, 1999) and most health researchers now believe they are 'imperative' for development of appropriate health service delivery and to improve health outcomes (Peat et al, 1998; NHMRC, 2001).

This chapter gives reasons for the use of both individual interviews and focus group discussions for collecting qualitative data. The decision to employ focus group discussion was based on Kitzinger's, (1994, 1995; Barbour& Kitzinger, 1999) work emphasising the advantages of this method for exploring health and sensitive issues. In this doctoral study, group discussion became an important means of determining men's reasons for engaging / not engaging in health practices and perceived barriers or support they may have encountered. Analysis of the qualitative data involved description and the formation of themes. Descriptive analysis allows readers of the research to become sensitised to the experience of the interviewee and develop empathy (Sandelowski, 2000). A 'thick description' does more than record what a person has to say, it gives context to what is said, and presents actions, emotions and conversations as text that can be readily interpreted (Geertz, 1979; Denzin, 1989; Ponterotto, 2006). Themes were identified by: "Bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone." (Leininger, 1985: 60).

The development of themes focused on determining how men's actions and lack of action were influenced by their perception of their spouses' / partners' role and perception of socially scripted gender roles around caring for children's health. Particularly salient to the development of themes was Connells' (1995) argument for the use of a gender relations approach to understanding what men do and why men do, as described in the chapter *Masculinity*.

The decision to use quantitative analysis was based on the literature review finding that there was no published knowledge of men's repertoire of health practices or the frequency with which they were performed. Although the qualitative analysis in this doctoral study exists as complete and important research in itself, the findings were fundamental to the development of the household survey. The descriptive data and themes contributed directly to the development of items within the questionnaire and its formatting. The questionnaire consisted of four sections; section one allowed for the recording of attitudes towards men's and women's role in society and parenting responsibilities among dual income families. Section two asked dual income parents to identify their actual parenting and health practices. Section three

assessed the parents' health knowledge and skills in caring for an infant and child with illness. Section four was devoted to demographic details of the respondent (age, sex, income, cultural identifiers). The final sections of this chapter describe the questionnaire design. Analysis of the questionnaire data took place using descriptive statistics as this method addresses the research questions, allowing for quantification of men's health knowledge, repertoire of skills and frequency of health practices performed. The attitudinal data within the questionnaire provided an opportunity for cross sectional analysis of respondent's values and beliefs about gendered work and shared parenting; this analysis allowed for a comparison of attitudes identified from the literature and the themes produced in the qualitative analysis.

5.1 Documentary searches for evidence of men's health practices

Documentary searches were organised on the basis of a schematic pathway developed from topic headings found in nursing, allied health and psychology literature *[Figure 5.1]*. This allowed for the compilation of discrete chapters on the topics *Acute illness, Chronic illness, Mental Health Problems, Terminal illness, Health promotion and Accident and Injury Prevention*. Documents were searched using the key words 'father', 'child' and words related to the topic area using data bases, CINAHL PsycInfo, Medline, Scopus augmented by manual searches. The data base SCIRUS was searched using the key words 'fatherhood', 'child', 'health' and 'care' because it provided a wide range of literature that might not have been available in the specialised data bases previously mentioned. Searches of the grey literature including government reports were also undertaken using the Google search engine and government department web sites. Further, national and international researchers were contacted who, in published works, had identified that there was scant data on men's health practices (Hallberg et al., 2007; Darbyshire, 1994). The data bases containing electronic theses were searched for studies that contained the key words 'fatherhood', 'child', 'health', 'care'. The data base *Australasian Digital Theses Program* contained Australian theses; the data base *Index to theses* contained theses mainly from the United Kingdom and the data base *Proquest dissertations and theses* contained theses mainly from the USA and Europe. None of the theses appearing in the data bases

aimed to systematically explore the health practices of men and those that did study fathers focused on a specific health issue within a limited scope of reference. Findings from the document searches are presented in Chapters Six through to Eleven. Each chapter establishes the parental workloads associated with actual and potential child health problems by highlighting the incidence and health care experiences revealed in the research literature. In the case of terminal illness the incidence is low (approx. 800 – 900 per year) but the physical and emotional workloads assumed by parents are profound. When a search of a broad topic area (e.g. chronic health) revealed little information, the search for fathers' health practices would be extended to include specific health problems. The health problems (e.g. asthma) were chosen on the basis that they had highest incidence in a particular age group (infant, child, adolescent). This was established by reference to government health data, summative publications from the Australian Institute of Health and Welfare as well as medical literature reporting populations most at risk of illness, life style problems and injury.

Document searches were conducted in the preliminary phase of the research to guide the selection and construction of questions for subsequent focus group discussions. The search data also assisted in the choice of items for inclusion in the questionnaire and informed on the appropriate sequencing of sections. The document searches were updated after collection of qualitative and survey data for the purpose of informing the researcher whether the emphasis on fathers' health practices in the literature had declined, remained the same or improved; this made the final report more poignant. All six document searches revealed scant information on men's health practices; this finding supported the need for additional methods.

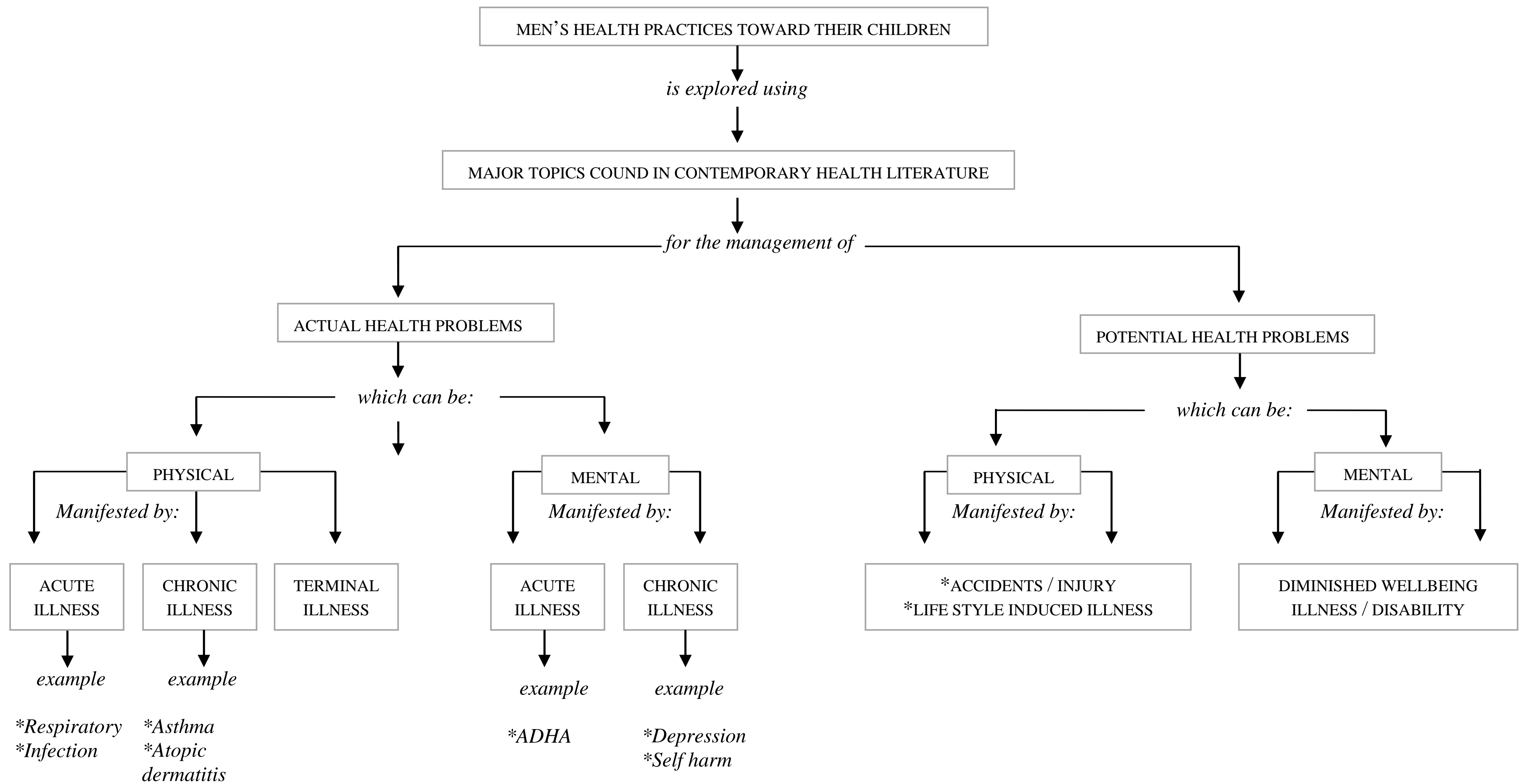


Figure 5:1: Schema depicting categories of literature used in the literature review

5.2 Qualitative approach enhancing quantitative data

An iterative design best describes the research methods used in this study. Pilot and Hungler (1999) summarise the iterative design as a dynamic process where:

> **"…the findings from one method are used as a basis for moving forward with further research using the alternative method (as typically the case with instrument development and refinement that is most applicable to understanding how men participate. In some studies, there is a single iteration, moving from qualitative to quantitative (or vice versa); in other studies, there might be multiple iterations, with a progressive reconfiguration of data collection, data analysis, and interpretation in a spiralling pattern of findings and insights."**
>
> (Pilot & Hungler, 1999: 265)

The finding that all six documents searches revealed scant information on men's health practices supports an iteration of the process using additional methods.

In this study there were two iterations:

i) The research gap, identified by the systematic searches of docments (Chapters Six through to Eleven), indicated that a qualitative study was needed to describe men's experiences and opinions on practicing health.

ii) A lack of data on the type and frequency of men's health practices indicated that qualitative data was needed to provide validity for the design of a questionnaire.

Qualitative methods have traditionally been employed simply as a 'preparatory phase' for questionnaire development (Quine & Taylor, 1998; Quine, 1998; Sandelowski, 1997: 126). Dillman (2000), a prominent author of quantitative survey methods, also suggests that qualitative inquiry can be cursory for the purpose of questionnaire design. Cursory attention to qualitative data collection was not appropriate in this doctoral study because the literature review had clearly established that little was known about the initiators and impedances to men's health practices, with gender roles being a primary and unpredictable influence for men's role change. The use of a quantitative data method as a means of providing valuable contextual material for qualitative data, as suggested by Silverman (1985), was also inappropriate because little qualitative data existed on

men's experiences of practicing health, particularly in the context of fathering or supportive spouse / partner.

Support for the use of in-depth qualitative research as an initial iteration in this doctoral thesis came from Sandelowski, (1997) Peat et al. (1998), Barbour (1998) and Court (1995) who strongly argue that qualitative studies are necessary components of quantitative studies because they enhance the clinical significance of numerical data. Coffey and Atkinson (1996) also support this view arguing that researchers' important ideas do not exist purely 'in the data' no matter how obsessively they are scrutinized.

> **"The generation of ideas can never be dependent on the data alone. Data are there to think with and to think about ....The real work of analysis and interpretation lies precisely in those intellectual operations that go beyond the data"**
>
> (Coffey & Atkinson, 1996: 153)

Filstaed (1979) had written on this point earlier contending that:

> **"Perhaps the bottom line in the integration of qualitative methods with quantitative methods …is that the qualitative method provides the context of meanings in which the quantitative findings can be understood."**
>
> (Filstaed, 1979: 33-48)

Weinholtz et al., (1995) point out that qualitative work may even salvage quantitative work by permitting real-world significance to be found in statistically insignificant findings and by preventing erroneous results.

The decision to use a qualitative method as a response to scant literature on the research topic is strongly supported by key researchers and research agencies. Barbour, (1999) asserts that it is appropriate to use a qualitative approach followed by a quantitative approach; this is particularly the case when a 'little researched phenomenon' has been identified as worthy of further scrutiny or when the subject is 'poorly defined' (Pilot & Hungler, 1999; Quine & Taylor, 1998). A lack of research on the private lives of fathers (Burgess, 1997) and the nexus between masculinity and health practices fits the criteria of 'little researched phenomenon' and 'poorly defined' as discussed in the chapters *Masculinity* and *Fatherhood*. The health agency, National Health and Medical Research Council of Australia (NHMRC), states that qualitative methods, as a primary source of investigation, are especially appropriate for investigations in the following areas:

- the influence of economic, Pilotical, social and cultural processes on health, illness and disease;
- understanding interactions between individuals, and within social settings, in relation to health care and health care decision making;
- eliciting contextual data in explaining the results of quantitative studies;
- eliciting contextual data in order to improve the methodological validity of survey instruments.

(NHMRC, 2001)

All of the preceding NHMRC points closely correspond to the objectives of this study; the influence of economic, Pilotical, social and cultural processes on health were identified in the preliminary chapter *Dual income families in crisis.* An understanding of interactions between individuals, and within social settings, in relation to health care and health care decision making, were identified in the chapters *Masculinity* and *Fatherhood.* And eliciting contextual data in explaining the results of quantitative studies has been explained in this *Research Method* chapter.

5.3 Combining quantitative and qualitative methods

The benefits from combining research methods are widely reported; Goodwin and Goodwin (1984) state that the primary advantage of using more than one method is the opportunity for cross-validating findings. Drawing on Denzin's work as far back as the 1970s, Mason (1997) argues that combining qualitative and quantitative methods allows for triangulation of data contributing to a minimisation of researcher bias because the use of differing accounts of reality "would add up to a more complete picture". How best to combine quantitative and qualitative methods reached its epoch in the late 1990s with multiple options described as plausible (Black, 1994). However, Pilot and Hungler (1999) note that the blending of two approaches in a single study is not always feasible, nor necessary or desirable. Quine and Taylor (1998) assert that: "There is limited literature on why and how to combine quantitative and qualitative methods," (Quine & Taylor, 1998).

Quine and Taylor (1998) suggest that the efficacy of combining of methods is determined by the 'best fit'; choosing methods that best address the research problem. Despite these issues, Popay et al., (1998) provide workable standards for analysis of qualitative works and Morgan (1998) provides practical strategies

for combining qualitative and quantitative methods specifically in relation to health research. These standards and practical guidelines have been utilised in the analysis of data using a mixed method for this doctoral study (See chapter – *Qualitative analysis*). The use of data from in-depth interviews and unstructured observations within a survey is commonly employed and effective (Pilot & Hungler, 1999: 273). O'Brien (1993) determines that focus group discussions are ideal for testing the practicality and applicability of a survey questionnaire; this approach was utilised in the preparatory phase of this doctoral study. Quine (1998: 527) states that a multi-method approach is useful in the design of questionnaires and other survey or research instruments required for 'more quantitative' research and Fuller et al., (1993) purport that multiple methods are essential for improving survey instruments or adapting them to new populations.

5.4 Focus group method

The focus group interview, a sociological research method originating in 1946 (Merton & Kendall, 1946), is a qualitative technique combining interviewing and observational skills for the purpose of gathering a large amount of data on a topic in a relatively short time. The most common purpose of a focus group interview is for an in-depth exploration of a topic about which little is known (Stewart & Shamdasani, 1990). Focus groups assist the researcher in gaining a better understanding of the field and generating propositions, themes, categories, test items and ideas for the development of research questions (Fray & Fontana, 1991). Consequently, focus group discussions have become a valuable tool for social science researchers (Frey & Fontana, 1993; Morgan, 1998) and are particularly useful in health education and health promotion research because the method enables the researcher to identify health issues, needs, experiences and problems for individuals and communities (Qunie, 1998: 527; Basch, 1987; Bryant, C. & Gulitz, 1993; Morgan & Krueger, 1993; Twohig & Putnam, 2002). Morgan (1996) having performed a content analysis of Sociological Abstracts over a ten year period, found that more than 60% of research employing focus groups was done in combination with other research methods. Focus groups may be used at any stage in a research study and are particularly useful in the initial or exploratory stage when little is known about the target group's views on the topic (Fray & Fontana, 1991). They are also particularly useful when a researcher

wants to explore people's range and depth of knowledge on a subject and their life experiences. And they can also be used to not only identify opinions but also how and why people / groups think the way they do (Kitzinger, 1995). In the literature review chapters it was concluded that there is no systematic research into men's health practices within the family and scant reference to father level and type of involvement in tasks linked to family health generally.

Rice and Ezzy (1999) provide multiple references to studies / writings in support of their claim that focus groups are suitable for: "Examining 'sensitive' issues or ... research involving 'sensitive' populations." (Rice & Ezzy, 1999: 74).

Their rationale is that, people may feel more relaxed about talking when they see that others have similar experiences or views. The division of labour within families, a central tenent in this research, is often a source for spouse / partner discord; ergo, men were very likely to be willing to explore this discord with other men. The group discussions and interviews in this doctoral study were inclusive of men only, beyond the scrutiny of other family members, facilitating frank and timely comment. Madriz, (2000) suggests that:

> **"Focus groups allow access to research participants who may find one-on-one, face-to face interaction 'scary' or 'intimidating'."**
>
> (Madriz, 2000: 835)

Madriz (2000) refers to Morgan's (1988) and Wilkinson's (1998) work as support for the assertion that: "Groups participants find the experience more gratifying and stimulating than individual interviews." (Madriz, 2000: 835).

Morgan (1997) summarises by stating that:

> **"The simplest test of whether focus groups are appropriate for a research project is to ask how actively and easily the participants would discuss the topic of interest."**
>
> Morgan (1997; 17)

Quine (1998a) asserts that the main advantage of the focus group technique over individual interviews is:

> **"It enables group interaction, both verbal and non-verbal, which has the potential to produce insights and uncover constructs that may be tapped through individual interviews."**
>
> (Quine, 1998a: 527)

The advantages to focus group interviews may be outweighed by factors that emerge during or after group interaction. A disadvantage of group interviews is

that: "The articulation of group norms may silence individual voices of dissent." (Kitzinger, 1995: 300).

An additional impediment to free flowing group discussion is that some information, particularly that of a sensitive nature, may not be proffered by individuals in the presence of their peers. Minichiello et al (1999) note: "A researcher cannot guarantee confidentiality because they have no control over the behaviour of group participants." (Minichiello et al., 1999: 426).

Consequently, the convenor of the group needs to request, at the outset of group discussion, that participants respect each others privacy in relation to the information they divulge. Kitzinger (1995), in evaluating the advantages and disadvantages of group discussion, asserts that on balance focus groups can be very empowering and:

> **"…it should not be assumed that groups are, by definition, inhibiting relative to the supposed privacy of an interview situation or that focus groups are inappropriate when researching sensitive topics. Quite the opposite may be true."**
>
> (Kitzinger, 1995: 300)

In relation to this intimacy factor, Twohig and Putnam (2002: 280) note that acquaintanceship and familiarity among participants assists in the free flowing of information but it may have negative consequences. As an aid to determining the net effect of participants knowing each other Twohig and Putnam (2002) offer the view that:

> **"More germane is the fact that it is very difficult to avoid acquaintanceship in many settings, including rural locales or where the recruitment pool is limited…Rather than adhering to an idealized view that participants should not know one another, what needs to be explicated during analysis is the effect of acquaintanceship."**
>
> (Twohig & Putnam, 2002: 280)

When sensitive issues are raised it may be necessary for the moderator of the focus group to arrange an individual interview for participants who do not feel at ease about disclosing personal circumstances.

> **"…it is important for researchers to recognise that in some instances other research techniques, such as individual interviews, may be more appropriate for the goals of the research. For instance, in a situation where a researcher needs participants to share very intimate details about their lives, a focus group would not be the most appropriate technique."**

(Madriz, 2000: 848)

In this doctoral study arrangements were made for men to debrief at individual interviews soon after the focus group with the purpose of allowing men to elaborate on sensitive issues raised in the group and outside the sphere of acquaintanceship.

5.4.1 Combining focus group with individual interviews

The use of focus group interviews and in-depth interviews is supported by Strauss and Corbin (1990) whose work provides details and rationale for the selection of sampling methods linked to theory development. Fontata and Fry (1994) also argue for the use of focus group interviews and in-depth interviews in the same study for the purpose of gaining greater depth of information. Fontata and Fry (1994) explain:

> **"The use of the group interview is not meant to replace the individual interview, but it is an option that deserves consideration because it can provide another level of data gathering or a perspective on the research problem not available through individual interviews."**
>
> (Fontata & Fry, 1994: 364)

And Morgan (1996) argues that individual interviews are a useful means of gaining greater depth of data following a focus group discussion, stating:

> **"In a complementary fashion, focus group studies have used follow-up interviews with individual participants to explore specific opinions and experiences in more depth, as well as to produce narratives that address the continuity of personal experiences over time (Duncan & Morgan, 1994)."**
>
> (Morgan, 1996: 134)

Individual interviews were conducted in this study as preparatory work for the development of focus group questions and to allow participants who experienced difficulties in group discussion to debrief in confidence with the researcher.

5.4.2 Role of the moderator

The role of the moderator is shaped by the purpose of a focus group and that is to: "discover information and not to impart it." (Twohig, 2002: 282).

Stevens (1996), in reference to other key researchers using this method states that:

> **"The genesis of focus groups lies in concerns about the overpowering influence of the researcher and the limitations of predetermined closed-ended inquiries."**
>
> (Stevens, 1996: 171)

The following points were salient in developing an understanding of this researcher's role as the moderator of a focus group and have implications in relation to the structure and function of the interview guide. In focus groups an air of 'egalitarian cooperation' should be encouraged rather than an appeal to the status of the researcher to control group conversation and elicit answers. If informality can be achieved among members this will encourage candidness and spontaneity contributing to depth of data beyond that which may be achieved by individual interview (Stevens, 1996). Rice and Ezzy (1999) point out that a focus group interview is distinctly different from a group interview in that it involves a discussion between members of the group rather than an interviewer interviewing a group. Kitzinger (1995) exemplifies this point when writing:

> **"This means that instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view."**
>
> (Kitzinger, 1995: 299)

According to Morgan (1988) the group moderator should make:

> **"Explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group."**
>
> (Morgan, 1988: 12)

Brown (1999) also emphasises the need for perceptive group work skills in stating that moderators need to:

> **"…play an essential role in the conduct of a successful focus group. Being a good moderator requires observational and facilitation skills. Engaging all the participants in the discussion, promoting a lively interchange, modulating conflict, and all the while following the interview guide..."**
>
> (Brown, 1999: 115)

And Bloor et al., (2001) provide a clear explanation of the expected outcomes of how this interviewer – participant arrangement works:

> **"In focus groups … the objective is not primarily to elicit the group's answers … but rather to stimulate discussion and thereby understand (through subsequent analysis) the meanings and norms which underlie those group answers. In group interviews the interviewer seeks answers; in focus groups the facilitator seeks group interaction."**
>
> (Bloor et al., 2001: 42-43)

The chapter titled *Analysis of qualitative data* discusses issues surrounding the analysis and validation of interactive data.

The possible effect of the moderator's gender on interviewe's responses is explored in the literature. Central to this study is an appreciation of how gender roles influence the amount and type of parental participation in family health and consequently the gender / sex of the interviewer may have an influence the type of responses gained. For example, a male researcher may elicit different types of information or greater depth at interview than a female who interviews males. However, the literature suggests that gender is not of paramount importance. Olsen (2000), in reviewing approaches to feminist research clarifies this point:

> **"Ann Phoenix's (1994) work on young people's social identities demonstrates that the assumption that matching race and gender of interviewers is too simplistic; Catherine Koholer Riessman (1987) points out how ethnic and class differences override gender in achieving understandings in interviews; D. Millen (1997) examines potential problems when feminist researchers work with women who are not sympathetic to feminism."**
>
> (Olsen, 2000: 227)

Carpenter et al., (1999) examined male and female interviewer outcomes for respondents declaring physical, emotional and sexual health symptoms and found that:

> **"Both male and female interviewers can be used successfully to assess participants' reports of physical, psychological, or menopausal symptoms."**
>
> (Carpenter et al., 1999: 276)

Whilst maintaining the same gender among group participants has been advocated, as a means of freeing up discussion, it is thought to be less important than it once was (Stevens, 1996).

5.4.3 Interview guide

A semistructured approach to interviewing was used in both the focus group discussions and individual interviews. Twohig and Putnam (2002) assert that interview guides are an important part of preparing for a focus group because they set the agenda, provide prompts and contribute to comparability of experiences across the group. Semi-structured interviews, guided by example questions derived from the literature allow the interviewer to freely explore, probe and ask questions that will elucidate and illuminate that particular subject. This approach is in accordance with Patton's statement that:

> **"An interview guide is a list of questions or issues that are to be explored in the course of an interview. An interview guide is prepared in order to make sure that basically the same information is obtained from a number of people by covering the same material."**
>
> (Patton, 1990: 283)

Formulation of basic questions and possible probing questions is recommended, however, it is important to maintain flexibility in questioning and discussion (Minichiello et al. 1995). In relation to these points Greebaum (1998) writes:

> **"A good moderator will be able to work effectively with the flow of the group rather than feel compelled to stay with the predetermined order of discussion provided in the moderator guide …The effective moderator is able to deviate from the guide to explore an important area and then circle back to ensure that other key topics are appropriately covered…"**
>
> (Greebaum, 1998: 220)

The appropriate number of topics and questions relies on the judgement of the researcher. Twohig and Putnam (2002) attempt to provide a rough guide to the appropriate number of topics, suggesting the more emotionally linked the topic and the greater the complexity of the research, the fewer topics can be covered. They pre-empt this by writing: "It is often difficult to anticipate the number of topics that can be considered in a session." (Twohig & Putman 2002: 282).

Minichiello et al., (1999) offer words of caution noting that:

> **"Too many questions will tend to restrict free-flowing discussion. Too few questions may result in not gaining enough data."**
>
> (Minichiello et al., 1999)

Generally only a few questions are asked as this allows time for an in-depth exploration of the topics to be discussed. *[Appendix 6]*

5.4.4 Interview setting

A residential lounge was chosen for group discussions and light refreshments provided with seating for up to 10 men. There were no telephones and no interruptions during the group discussions. These strategies were employed to allow the men to feel as physically and emotionally at ease within a short space of time, offering an opportunity for men to divulge information in a relaxed atmosphere. The focus groups took place in the rural region of the York Peninsula situated in South Australia because it was a central location for all participants.

5.4.5 Selecting participants

Stevens (1996) succinctly articulates the rationale for selecting a relatively homogenous group of participants arguing that homogeneity, especially in the areas of ethnic and racial background, socioeconomic circumstances and education, potentiates group cohesiveness. This cohesiveness is beneficial in the sense that:

> **"… identification with one another increases group members' openness of communication. Their interest in the research process is stimulated by what they hear others say….these elements allow the researcher to better discover aggregate values, perceptions, behaviors, and needs."**
>
> (Stevens, 1996: 171)

The men chosen for inclusion in two of the focus groups had all lived within a rural community all their lives and been educated in a rural school system and some had further education in an agricultural college. This group was chosen because the researcher considered that men in rural areas may view their role within the family somewhat differently from men in the Adelaide metroPilotan area or that there would be factors related to rural work patterns that affected these men's ability to participate in family health. For example, seasonal tasks such as harvesting may restrict men from being with the family because they worked long hours. Conversely, rural men had mostly flexible working hours because they were accountable only to themselves for planning workplace routines and meeting deadlines.

5.4.6 Sampling

In qualitative research, sampling strategies are not concerned with achieving representativeness (Mays & Pope, 1995), but rather are focused on exploring and reflecting the diversity of action and beliefs (Kuzel, 1992). Participants for the focus group and in-depth individual interviews were purposefully selected**.** Patton (1990) contends that the logic and power behind purposeful selection of informants is that the sample should be 'information rich'. This method of sampling is determined according to the needs of the study, and not according to external criteria, such as random selection. The choice of purposeful sampling for the focus group was also guided by the logic of Kuzel (1992) and Morse (1994: 229) who explain that participants should be selected because they are

representative of the same experience and knowledge, not so they can be evaluated as representative of the demographics in the general population. The context of similar experience pertains, in this study, to the men working in a primary industry and being fathers or carers of children within their immediate family.

5.4.7 Sample size

Selecting sample size in qualitative research requires, according to Patton (1988), "A classic trade-off between breadth and depth" (Patton, 1988: 97), the fewer the respondents the more detailed the information. For a given set of resources, short interviews could be used for a relatively large number of respondents (Patton, 1988). For the focus groups sampling ceases when 'saturation of themes' has been reached and it is evident to the researchers that new themes are nolonger emerging. The number of participants recommended as manageable for productive discussion, for any focus group, varies from as few as four up to 12 members (Stevens, 1996; Twohig & Putham, 2002).

The sample size was determined by the accuracy required for the response to each question. A sample size of 384 will provide responses to, at worst, + or – 5% given that there would be an expected 50% of people responding to a category; using a 95% confidence interval I expected 50% not to respond.

5.5 Ethics

Ethical approval was gained for this study from the University of Adelaide and was inclusive of the household survey and interviews (individual and group sessions) *[Appendix 7]*.

Potential participants were provided with information on the purpose of the study *[Appendix 3]* and informed that their consent was voluntary with all information being confidential. Members of the focus groups were cautioned about potential problems with focus groups discussion and confidentiality and this caution was guided by Minichiello et al., (1999):

> **"A researcher cannot guarantee confidentiality because they have no control over the behaviour of group participants. Consequently, the convenor of the group needs to request, at the outset of group discussion, that participants respect each others' privacy in relation to the information they divulge."**

(Minichiello et al, 1999: 426)

Confidentiality of data was provided for. Data was coded to promote confidentiality in transcripts, and where possible other identifying details were altered. Tapes and transcripts and an electronic copy of the data will be stored and locked at the University of South Australia for seven years.

Interviewees and focus group members were made aware that the interviews and group sessions were not designed to be therapeutic. Participants were informed of their right to withdraw from the interview process at any time without prejudice. Focus groups may generate unexpected and unpredictable interactions between participants because of sensitivity of some questions and the research process itself – researchers' probing questions (Parker & Tritter 2006; Richards & Schwartz, 2002). In the event that a participant became distressed the participant was to be offered direction to supportive care as guided by Glass (1998).

Participants were required to sign a consent form prior to data collection *[Appendix 4]* and were made aware of a process for lodging complaints *[Appendix 5]*. At the commencement of the focus group discussion information about the purpose of the research and ethical issues were reiterated. Individual interviewees and groups were also given information on the processes of audio recording data transcription, analysis and dissemination of research (Richards and Schwartz, 2002). As guided by the National Health and Medical Research Council (NHMRC, 2002) the researcher's respect for the rights and wellbeing of participants took precedence over the expected benefits to knowledge.

5.6 Qualitative data management

Audiotape interviews and focus group discussions were transcribed verbatim and the transcripts were then compared with synchronised field notes identifying periods of silence, men's body language and other interactional events. These notes were of particular importance for interpreting the interactions between men during focus group discussions. Rice and Ezzy (1999) point out that a focus group discussion is distinctly different from a group interview in that it involves a discussion between members of the group rather than between interviewer and individuals within the group. Ergo, focus group data makes:

> **"…explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group."**
>
> (Morgan, 1988: 12)

Data management included case summaries of both individual interviews and focus group sessions. All participants' names were changed to codes to conserve anonymity. Analysis of each transcript was made with reference to the written notes taken during and immediately following the interviews; this strategy aimed to reduce the risk of decontextualising the data.

5.7 Qualitative rigour

Qualitative research is as rigorous as quantitative research. There is no one accepted method of ensuring rigour in qualitative studies but there are criteria and these criteria differ according to the epistemological assumptions made and the methodology determined as appropriate by the researcher (Morse et al., 2002). Morse et al., (2002) outlines approaches for use in establishing rigour in qualitative research arguing:

> **"That reliability and validity remain appropriate concepts for attaining rigor in qualitative research. We argue that qualitative researchers should reclaim responsibility for reliability and validity by implementing verification strategies integral and self-correcting during the conduct of inquiry itself."**
>
> (Morse, 2002: 1)

The terms reliability and validity continue to be widespread among qualitative researchers in Britain and Europe. Guba and Lincoln (1981) substituted reliability and validity with the parallel concept of 'trustworthiness', a term that contains the four aspects of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). They recommended specific strategies be used to attain trustworthiness such as negative cases, peer debriefing, prolonged engagement and persistent observation, audit trails and member checks. Many researchers have interpreted Guba and Lincoln's (1981) notion of member checks as a process of asking members questions that cross check with previous responses as a means of ensuring validity of overall results. However, several methodologists (Hammersley, 1992; Morse, 1998; Lincoln & Guba, 1985) have warned against the practice of defining verification in this way. The logic behind this cautionary note is a tendency to define verification in terms of

whether participants judge the analysis to be correct; this forms a tendency for interview respondents to synthesize results, decontextualise the data, and to be abstracted from (and across) individual participants: “So there is no reason for individuals to be able to recognize themselves or their particular experiences”. (Morse et al., 2002: 7).

Secondly, reliability and validity should be actively attained through the characteristics of the investigator who:

> **“Must be responsive and adaptable to changing circumstances, holistic, having processional immediacy, sensitivity, and ability for clarification and summarization (Guba & Lincoln, 1981).”**
>
> (Morse et al., 2002: 6)

… rather than have validity simply proclaimed on the basis of findings / comments of an external reviewer as a post hoc evaluation. This is because: “Rigor does not rely on special procedures external to the research process itself.” (Morse et al., 2002).

That is, only after the data has been recorded, organised and formatted, it can verification proceed:

> **“In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a study. These mechanisms are woven into every step of the inquiry to construct a solid product (Creswell, 1997; Kvale, 1989) by identifying and correcting errors before they are built in … and before they subvert the analysis.”**
>
> (Morse et al., 2002: 9)

In this study the researcher ensured the common reasons for lack of rigour were avoided. Those reasons being:

- lack of responsiveness of the investigator due to lack of knowledge;
- overly adhering to instructions rather than listening to data;
- projects not manageable within the student time-frames, abilities and budgets;
- inadequate time spent collecting data and/or insufficient data collected,
- a narrow delimiting of the topics;
- inadequate data analysis using the chosen theoretical framework.

Although important, rigour has not been restricted to items such as a well maintained audit trail, member checks at and after interview, or that the researcher

was 'reflective'. Rigour has been guided by Morse et al.'s, (2002) insistence on attending to incremental contributions that ensure reliability and validity of the data which should be reflected in the quality of the text and the clarity of argument.

5.8 Analytical bias

Analytical bias was minimised by the researcher employing a process of reflexivity; an understanding of how prior assumptions and experiences can influence even the most avowedly inductive inquiries (Morgan, 1993). This researcher recognised his health professional status and first hand experience of men's lack of contribution to their child health needs at the time of becoming involved in the thesis; this reflexivity assisted in reducing analytical bias. Mays and Pope (2000) support this declaration of possible bias:

> **"Personal and intellectual biases need to be made plain at the outset of any research reports to enhance the credibility of the findings. The effects of personal characteristics such as age, sex, social class, and professional status (doctor, nurse, physiotherapist, sociologist, etc) on the data collected and on the 'distance' between the researcher and those researched also needs to be discussed."**
>
> (Mays & Pope, 2000: 51)

This study used a standardised open-ended interview guide, allowing the researcher to focus on issues relevant to the research with the aim of maximising the use of limited time and resources (Patton, 1987; Patton, 2002). The open-ended questions would also reduce the risk of the researcher imposing his values when initiating group conversation and discussion.

During a session, focus group members were able to refine their opinions, or at least modify their statements about them. Krueger (1997a) argues that when analysing the data the researcher needs to have an appreciation that opinions may have evolved, based on the give and take of discussion in the group. And Kidd & Parshall (2000) reiterate this point when stating:

> **"…before one can make statements with any confidence about what a focus group or series of groups had to say on a given topic, one needs to assess the extent to which responses may have arisen from conformance or censoring (Carey & Smith, 1994), coercion, conflict avoidance, or just plain fickleness."**
>
> (Kidd & Parshall, 2000: 249)

Non-verbal communication also has a powerful influence in promoting or impeding participants' responses. Cote-Arsenault and Morrison-Beed (1999) suggest that within and among group analyses are essential and must be undertaken by a researcher who was present at the group sessions. For example,

> **"Episodes of silence identified during transcript verification were a response to intimidation, but the principal investigator, present at the session, recalled that the quiet member had been engaged and nodding her head."**
>
> (Cote-Arsenault & Morrison-Beed, 1999: 282)

Carey (1995) states:

> **"An appropriate description of the nature of the group dynamics is necessary to incorporate (sic) in analysis - for example, heated discussion, a dominant member, little agreement."**
>
> (Carey, 1995: 488)

Whilst much has been made of the value of observing interactions between group members there are few reports on this type of data.

Kitzinger (1994) reporting on a review of 40 focus group studies noted:

> **"I could not find a single one concentrating on the conversation between participants and very few that even included any quotations from more than one participant at a time."**
>
> (Kitzinger, 1994: 104)

And Webb and Kevern's (2001) critique of focus groups in the nursing literature between 1990 and 1999 revealed:

> **"There were very few examples in the articles identified for this review in which there was any discussion of interaction in the focus groups studied."**
>
> (Webb & Kevern, 2001: 803)

The results given in this research do report on interactions and group reactions to comments made by participants, where relevant.

On completion of a focus group meeting the interviewees were debriefed by the moderator to clarify or extend comments they had made. This was an important strategy as one man stated that he was not prepared to reveal information within the focus group because of the sensitive nature of his personal circumstances. The man subsequently participated in an individual interview exploring the nuances of coping with a family member diagnosed with a mental health problem.

5.9 Qualitative analysis: descriptive & thematic

Analysis of data will take place using a descriptive method followed by formation of themes. The descriptive analysis was aimed at maximising an understanding of men's experiences at practicing / not practicing health care within the family and reflecting the views of the participants with low inference from the researcher (Sandelowski 2000). Authenticity was ensured by including raw narrative within descriptions and discussion. Salient issues raised within the focus groups were exemplified by selective quotations from narratives. The credibility and competence of the descriptive summaries were validated through checking with group members at the culmination of each session as described by Lincoln and Guba (1985).

As discussed by Sandelowski (2000), a leading qualitative methodologist, description offers a low inference analysis, its value is in the detail reproduced, allowing the reader to appreciate the participant's experience and reflections, thereby supporting the acquisition of insight and empathy. A 'thick description' does more than record what a person has to say, it gives context to what is said, and presents actions, emotions and conversations as text that can be interpreted. (Geertz, 1975; Denzin, 1989; Ponterotto, 2006). Geertz (1997) writes of the importance of verification in the context of 'thick description', arguing that the very 'thickness' and complexity of the description recorded is, in itself, a sufficient form of verification. Similarly Guba (1978), highlighted the importance of the 'verification' of qualitative data, by bringing an understanding to the researcher that their primary role is to act as a facilitator to help uncover the emergent data and not to "put an interpretive gloss on it".

Thematic analysis was based on descriptive data and men's interaction with each other guided by the analytical framework of gender relations, as discussed in the chapter *Masculinity* and parental responsibilities, as discussed in the chapter *Fatherhood*.

Thematic analysis as described by Kitzinger and Barbour (1999) involves the:

> **"Drawing together and comparing discussion of similar themes and examining how these related to the variation between individuals and between groups."**
>
> (Kitzinger & Barbour, 1999: 16)

Thematic analysis occurred in several stages with primary analysis taking place at interview followed by a familiarisation with the verbatim transcripts. Thematic analysis was grounded in the data, fieldwork and literature review rather than being imposed by an under-informed intuitive researcher (Robinson, 1999).

Explicit themes and non-explicit themes were identified. Typologies for themes were achieved using a manual coding in preference to qualitative software as Bryman (2001) highlights the real risk of decontextualising data when the text is electronically fragmented for coding and subsequent retrieval.

5.10 Qualitative Limitation

Patton (1990) and Morgan (1998) alert researchers to a common problem with focus groups; the moderator can emphasise, but not guarantee confidentiality of information disclosed. One man approached the researcher after a focus group with information he was not prepared to disclose within group discussion because he was cautious about the possibility of sensitive information being leaked to the community. The man stated that his wife had a mental health problem and had an important job. The man was able to provide information on his mental health practices towards his wife and implications for his children because the researcher was available for debriefing and individual interviews soon after the focus group discussions took place. Twohig and Putnam (2002) identity that acquaintanceship between group members, whilst assisting with homogeneity, can result in some members feeling reluctance about disclosing personal family details. Acquaintanceship did have a small but palpable influence in one of the focus groups because of the rural locality and proximity of participants in a small community. However, the issue of acquaintanceship did not appear in another rural group discussion or the metroPilotan locations.

5.11 Analytical issues

Analytical issues in focus groups are similar to other qualitative methods but how to analyse data remains limited to discussion on emerging themes and validation of interpretation. According to Morgan (1996):

> **"To date, most discussions of how to analyze focus groups have occurred within broader discussions of the method (e.g. Knodel**

> **1993), and only one article is specifically dedicated to analysis of issues (Bertrand et al 1992).”**
>
> (Morgan, 1996: 148)

More recently Patton (2002) declares there continues to be: “No precise or agreed-on terms describe varieties and processes of qualitative analysis”. (Patton, 2002: 453).

Reporting styles also vary. Sandelowski (1998) contends that there is no one style for reporting the findings from qualitative research. The writing of this report follows Sandelowski’s (1998) guiding point in that it is intended to be ‘practical’ and focuses on ways to structure qualitative findings largely within ‘realist’ conventions of scientific reporting (Hunter, 1990; Van Maanen, 1988) and Chenail’s (1995) recommendation of keeping the method simple because in qualitative research the complexity is in the data.

5.12 Questionnaire design: introduction

The design and purpose of the questionnaire was guided by data generated from a critical review of the literature, analysis of focus group discussions and individual interviews. An overview of the four sections of the questionnaire is presented as a map for explaining the process of validation occurring in subsequent sections of this chapter. Formatting of the questionnaire was guided mainly by Dillman (2000), a long term researcher of the method for mail and internet surveys.

Section One of the questionnaire contained attitudinal questions that correspond with the analytical framework described in the chapters *Masculinity* and *Fatherhood.*

Section One: Men’s and women’s role in society

Section 1.1 Men and work
Section 1.2 Women and the family
Section 1.3 Fathering today
Section 1.4 Parenting in dual income families
Section 1.5 Parenting in dual income families
Section 1.6 Equality of the sexes
Section 1.7 Sexuality

Section Two contained an initial question that divided respondents into those living in dual income families and those that did not. If the respondent had not

lived in a dual income family at any time in the past 10 years, they were directed to the last section of the survey – demographic details. Respondents from dual income families were directed to complete the survey commencing with section two; a recording of their parenting responsibilities focusing on who cares for the child during an episode of illness.

Section Two: Parents who work

Section 2.1 Family structures
Section 2.2 Childcare arrangements
Section 2.3 Episodes of illness
Section 2.4 Typical activities performed for sick children
Section 2.5 Health promotion
Section 2.6 Sharing home duties

Section Three contained questions that allowed for the recording of health literacy and skills as well as the frequency of health practices performed for children with health problems.

Section Three: Knowledge of health and health practice

Section 3.1 Knowledge of health and health practice
Section 3.2 Looking after a newborn child
Section 3.3 Family health problems
Section 3.4 Medication use
Section 3.5 Children and medication

Section Four contained items for the recording of demographic details (age, sex, employment group, cultural identifier).

Section 4: Your personal details

The demographic categories were extrapolated from those used in Census surveys by the Australian Bureau of Statistics. A complete questionnaire can be viewed in *Appendix 1*.

5.12.1 Validation - requirements

A survey needs to be as reliable and valid as possible but no survey item or index is perfectly reliable or has absolute validity (Bainbridge, 1989: 243). A valid inference occurs when there is no conflict between messages / results received as a result of the use of a variety of different methodological procedures (Zeller, 1997). There is no prescriptive procedure for maximising and establishing

validity; the appropriate selection of validation methods will depend on the situation (Punch, 1998). That is to say, validity requires some evidence that the researcher has correctly identified what an item in the survey means to the respondents (Bainbridge, 1989: 213). In this doctoral study the use of focus group and individual interview data combined with questionnaires is designed to increase the overall validity of the study. Reliability refers to the consistency of responses achieved by an item or index, and thus it can be evaluated 'simply' through statistical analysis of responses to it. However, the reliability of an item does not prove that it measures what we want it to (Bainbridge 1989). The challenges in the development and design of the questionnaire used in this doctoral study were to devise valid and reliable items / index for the socially constructed concepts of masculinity, fatherhood and motherhood; this required attention to construct validity.

5.13 Construct validity

Construct validity focuses on how well a measure conforms to theoretical expectations. Any measure exists in some theoretical context, and should therefore show a relationship with other constructs which can be predicted and interpreted within that context. Bainbridge (1989) asserts that many researchers would add the requirement that: "The index reflect some clear theoretical concept before being convinced that construct validity had been established." (Bainbrdige, 1989: 222).

The analytical framework and discussion presented in the chapters *Masculinity* and *Fatherhood* correspond well with the themes emerging from the literature concerning the division of parenting responsibilities between couples in dual income families. This data provided the theoretical context for constructing attitudinal questions for investigating men's and women's roles. To recapitulate, fathering is commonly associated with masculine behaviours and values and few researchers have doubted that the social construction of masculinity occurs as a systematic process. However, a deterministic model has not been forthcoming because multiple masculinities exist and men's social practices occur within historical and Pilotical and cultural processes; ergo, gender is not fixed (Connell, 1995). This explains why there are discontinuities in defining manhood and

masculinity in ethnographic and role model studies. Connell (1995) has successfully argued that knowledge of masculinity is best achieved through the understanding of the configuration of men's social practices, constrained by gendered relationship with others, in the context of Pilotical and cultural processes. The attitudinal questions in section one are set against the themes emerging from the literature and focus group discussions, to make clear the strength of the relationship between theoretical expectations and construct of topics for investigation *[Table 5.1]*.

Table 5.1 Men's and women's role in society (section one of the questionnaire)

Section One	Topic heading	Theme
1.1	Men and work	Explores perceptions of men's 'bread-winning role'
1.2	Women and the family	Explores the primacy of women's role in the care of children and child raising'
1.3	Fathering today	Explores perceived barriers to equitable parenting (e.g. men's lack of time with the family, parental skills level)
1.4	Combining work and family	Explores perceptions of women's right to paid work and need for paid work
1.5	Parenting in dual income families	Explores attitudes to more equitable parental workloads
1.6	Equality of the sexes	Explores assertions about normative gender roles
1.7	Sexuality	Explores hegemonic masculine traits

The creation of questions designed to specifically evaluate actual health practices performed by the survey respondent is justified on the basis that these questions and items commonly appear in family health literature and nursing literature. For example, over the counter or prescription medications are the most common form of treatment for illness and injury and these are most frequently administered by the parent / adult. Chapters Five through to Ten identify a wide range of skills performed by parents to maintain hygiene and promote comfort for sick children

(clean up vomits, toileting, bathing and general nursing care) as well as consulting with health professionals.

5.14 Criterion validity

To guide the composition of criteria for measuring attitudes towards fathers and mothers a review of the literature for existing scales of measurement was undertaken. The measurement of attitudes is greatly desired as a tool for understanding and modifying human behaviour. The term criterion group refers to a group of people; known (on the basis of conclusive, independent evidence) to have the characteristic that an item or index is supposed to measure. Two of the objectives of this study involved measuring attitudes.

- Identify the attitudes of men and women towards gendered work within the family.
- Identify the attitudes of men and women towards men's participation in child health matters.

Psychologists have developed criteria and scaled these in an effort to understand how changes in attitudes might reflect changes in society; these are now outlined for mothers, fathers and masculinity.

5.14.1 Criterial identifier – Motherhood

Items identifying the qualities of motherhood have been the focus of the study of the psychology of women since the 1970s. In their review of measurers of gender role attitudes McHugh and Hanson Frieze (1997) state:

> **"The Attitudes to Women Scale (AWS) constructed by Spence and Helmreich (1972) is the most widely used scale of gender role attitudes."**
>
> (McHugh & Hanson Frieze, 1997: 5)

However, there has been an on-going lack of consensus concerning how attitudes should be measured (Smith & Walker, 1991) with some reviews pointing out the limited usefulness of scales across cultural and temporal boundaries (McHugh & Hanson Frieze, 1997). A meta-analysis of the U.S.A. literature by Twenge (1997), suggests that the pattern of change, as assessed by the Attitude to Women Scale (AWS), has been unclear throughout the 1970s, 1980s and 1990s. Smith and Walker (1991) evaluated the British version of the Attitudes towards Women Scale (AWS-B) offering an alternative Criterial Referents Attitude to Women

Scale (CRAWS). Smith and Walker (1991) had argued that the Attitudes to Women Scale (AWS), like many other scales, assumes that the attitude domain, 'attitudes to women', can be represented by a single bipolar dimension. The attitudes are typically measured using a Likert agreement scale in which responses to items are summed to give an index of a respondent's 'attitude to women' (Smith & Walker, 1991: 209). Whilst a number of studies had compared responses on the AWS-B, Smith and Walker (1991: 7) claimed that 'no study has yet factor analysed the AWS-B. Yet Australian studies clearly suggested that the AWS (and by implication other similar scales) were not unifactorial.

Having evaluated the unidimensionality of the British version of the Attitudes to Women Scale (AWS-B), Smith and Walker (1991) concluded that it was 'conceptually hazardous' to use the scale to give a single score representing a person's 'attitude to women'. Several credible rationales were presented in support of this finding. Firstly, the construct of what is being measured is rarely, if ever articulated by those who construct and use such scales (1991: 9). Secondly, the assumption that low scores on the AWS represent an unfavourable/ traditional /conservative attitude to women and high scores represent a favourable / egalitarian / liberal attitude to women is not tenable. Thirdly, whilst enumeration of the many domains of women's behaviour occurs there is no attempt to evaluate which domains are more important than others. Finally Smith and Walker (1991: 9) contend that:

> **"For a scale to have a good construct validity its vulnerability to influences such as response bias and social desirability ought to be well understood. There is not evidence that the AWS is a clean scale – in the sense that responses are minimally affected by such influences – and some evidence that it is not."**
>
> (Smith & Walker; 1991: 9)

Cognisant of the limitations of the bipolar scale Smith and Walker (1991) proposed an alternative to measuring attitudes to women. Smith and Walker (1991) modified Kerlinger's (1984) Criterial Referents Theory (CRT), which provides an account of a hierarchical attitude structure to many social objects, to accommodate the structure of attitudes to a single object – the social category of women.

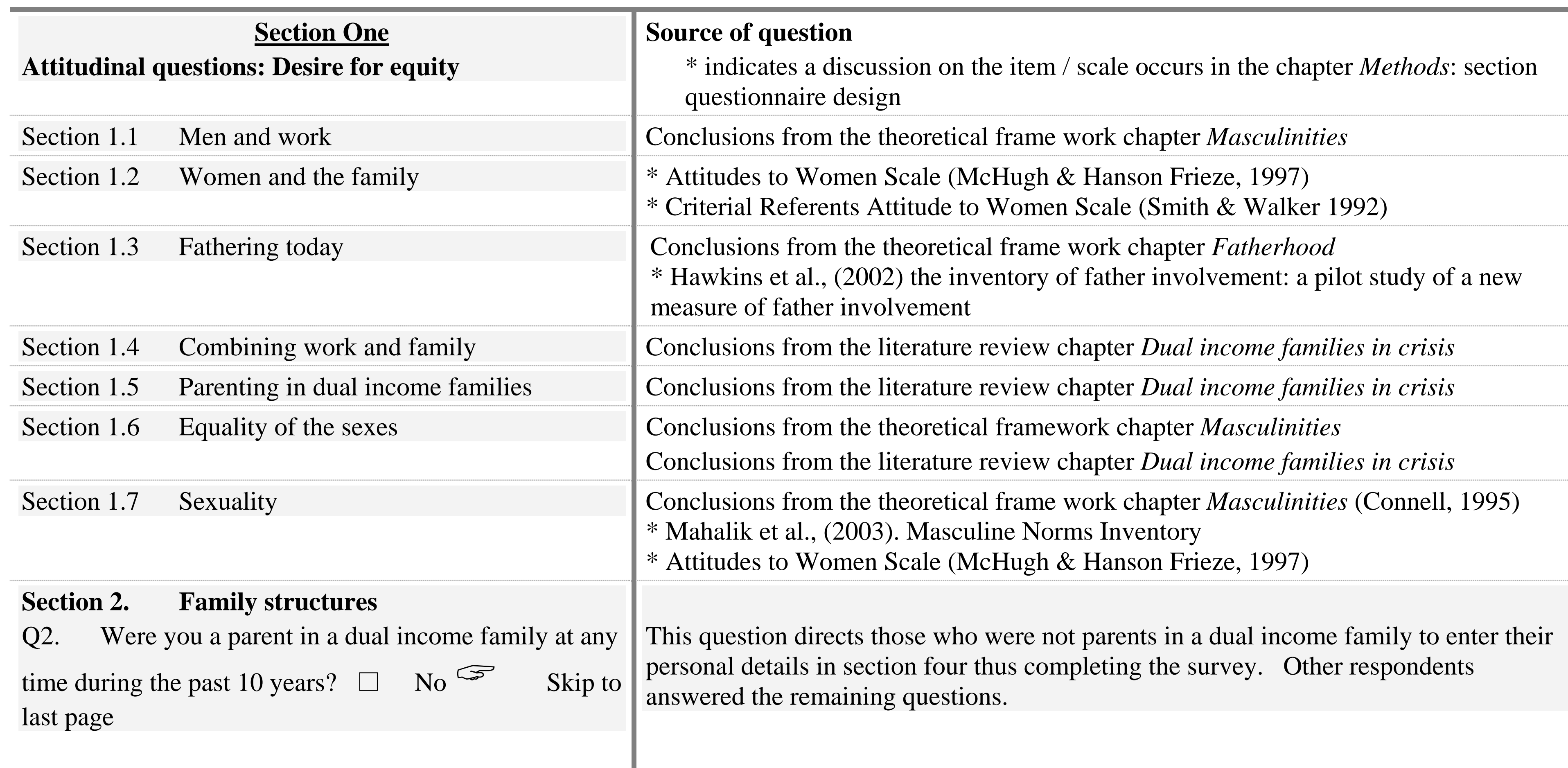
To investigate the proposed three-level hierarchical structure of attitudes, an 80 – item scale was constructed – the Criterial Referents Attitude to Women Scale

(CRAWS). This data was complemented by a ‘Women in society’ Questionnaire and data generated from a sentence completion ‘task’.

Smith and Walker (1991) found that, ‘in general’, a factor analysis of the CRAWS supported the hypothesis that the structure of attitudes, to a single object (women’s behaviour) was hierarchical. Further, Smith and Walker (1991) concluded that if a bipolar assumption were justified, the two poles typically employed in measuring ‘attitudes to women’ liberalism (egalitarianism) and conservatism (traditionalism) – would be highly and negatively correlated. In the CRAWS study tradition was only modestly correlated. However, Smith and Walker (1991) fell short of claiming that the thee-level hierarchical structure was the structure for examining attitudes to women. Instead they proposed that it was an ‘alternative to the bipolar method’ that they had so rigorously critiqued.

In this study the questionnaire bipolar assumption was justified by the ongoing use of the AWS in the field of psychology; the two poles typically employed in measuring ‘attitudes to womens’ - liberalism (egalitarianism) and conservatism (traditionalism). This is evident in the design of the attitudinal questions (referenced) in [Table 5.2].

Table 5.2: Question designs – summary of origins of questions



<u>**Section One**</u> **Attitudinal questions: Desire for equity**	**Source of question** * indicates a discussion on the item / scale occurs in the chapter *Methods*: section questionnaire design
Section 1.1 Men and work	Conclusions from the theoretical frame work chapter *Masculinities*
Section 1.2 Women and the family	* Attitudes to Women Scale (McHugh & Hanson Frieze, 1997) * Criterial Referents Attitude to Women Scale (Smith & Walker 1992)
Section 1.3 Fathering today	Conclusions from the theoretical frame work chapter *Fatherhood* * Hawkins et al., (2002) the inventory of father involvement: a pilot study of a new measure of father involvement
Section 1.4 Combining work and family	Conclusions from the literature review chapter *Dual income families in crisis*
Section 1.5 Parenting in dual income families	Conclusions from the literature review chapter *Dual income families in crisis*
Section 1.6 Equality of the sexes	Conclusions from the theoretical framework chapter *Masculinities* Conclusions from the literature review chapter *Dual income families in crisis*
Section 1.7 Sexuality	Conclusions from the theoretical frame work chapter *Masculinities* (Connell, 1995) * Mahalik et al., (2003). Masculine Norms Inventory * Attitudes to Women Scale (McHugh & Hanson Frieze, 1997)
Section 2. Family structures Q2. Were you a parent in a dual income family at any time during the past 10 years? ☐ No ☞ Skip to last page	This question directs those who were not parents in a dual income family to enter their personal details in section four thus completing the survey. Other respondents answered the remaining questions.

Table 5.2 cont'd

Section Two **Activity questions (what did the parent actually do?)**	
Section 2.2 Childcare arrangements	Published work of the author of this thesis: Laws TA (1997) Childcare arrangements in Australia: an argument for involving grandparents in a paid care role," Leisure for pleasure" Journal of Leisured Adults. Sept, l 2 (2), 18-23
Section 2.3 Episodes of illness	Documentary searches chapters 6-11 Clinical health practice of the author
Section 2.4 Typical activities performed for sick children	Documentary searches chapters 6-11 Clinical health practice of the author
Section 2.5 Health promotion	Documentary searches chapters 6-11 Clinical health practice of the author
Section 2.6 Sharing home duties	Bittman, M (1992), *Juggling Time: How Australian families use time*, 2nd ed. Canberra, Australian Government Publishing Services. Russell, G (1994) Sharing the pleasures and pains of family life, *Family Matters*, April 1994, 37:13-19.

Table 5.2 cont'd

Section Three **Health literacy and skills**	
Section 3.1 Knowledge of health and health practice	Documentary searches chapters 6-11 Clinical health practice of the author
Section 3.2 Looking after a new born child	Documentary searches chapters 6-11 Clinical health practice of the author
Section 3.3 Family health problems	Documentary searches chapters 6-11 Clinical health practice of the author
Section 3.4 Medication use and purchase	Documentary searches chapters 6-11 Clinical health practice of the author
Section 3.5 Children and medication	Documentary searches chapters 6-11 Clinical health practice of the author
Section Three **Respondents personal details**	Categories and questions were based on Census questionnaire used by the Australian Bureau of Statistics.

5.14.2 Criterial identifier – Masculinity

Although there are measures of masculinity these were not used in the construction of the questionnaire because of their limitations and methodological problems within the discipline of psychology (Connell, 1995). Smiler's (2004) review of the measurement the Male Role Attitudes Scale (MRAS) which assesses adherence to the dominant masculine ideology (Pleck et al., 1993) exemplifies this point. The MRAS is surprisingly short (only eight items) and emphasises adherence to the contemporarily dominant stereotype, and includes one item that is explicitly anti-feminine.

> **"A single score is generated, and higher scores indicate greater possession of a masculine ideology. Consistent with many prior measures, high scores are undesirable (because they indicate over adherence to the stereotypical masculine role)".**
>
> (Smiler, 2004: 21)

Thompson and Pleck (1995) had reviewed 18 instruments prior to 1995 but as the chapter *Masculinity* identifies there has been a shift away from measuring ideal types and more emphasis is now placed on multiple masculinities.

> **"Recognition of multiple masculinities has increased (Connell, 1995), which demonstrates a willingness to incorporate ideas from outside of the psychological tradition, but the psychological literature has defined multiple masculinities primarily in terms of demographic categories (e.g., Black, homosexual). This stands in contrast to the sociological literature that has defined masculinities in terms of their social and societal roles."**
>
> (Smiler, 2004: 23)

The more recent Male Norms Index (MNI) developed by Mahalik et al., (2003) assesses men's adherence to 11 different masculine norms. Smiler (2004) contends that the MNI 'may be a more useful measure' of masculine ideology. Further critiques of Mahalik et al.'s, (2003) instrument could not be located in the literature.

Psychologists continue to face debates on masculinity measures because there is no clear evidence that 'masculinity organises behaviour' versus the notion that 'personality attributes' are superordinate organisers of attitudes and masculine behaviour (Smiler, 2004). A more salient understanding of the initiators of

men's health practices with the family can be had by focusing on inventories of action and attitudes associated with a male role – fatherhood.

5.14.3 Criteria identifier – Fatherhood

Items identifying the qualities of fatherhood do not have a long developmental history when compared with measurement scales of attitudes to women and their social roles - motherhood. An Inventory of Fatherhood Involvement (IFI) was developed and piloted by Hawkins et al., (2002). Those investigating and theorising fatherhood have indicated the need for the constructs of father involvement to be measured more meaningfully than they have in the past. This improvement is necessary if there is to be a holistic understanding of child development, parental development, and family wellbeing (Hawkins & Palkovitz, 1999; Lamb, 1999; Marsiglio, Amato, Day, & Lamb, 2000). According to Hawkins and Palkovitz (1999) the term father involvement has been used in a limited sense for over 25 years restricting exploration of the concept to any temporal and readily observable phenomenon with much emphasis placed on the amount of time men spend with their children and providing a rationale for time not spent with children. This argument prompted Hawkins et al., (2002) to research wider criteria to measure father involvement.

> **"Time—or the lack of it—may be a crucial way that parents—men and women—think about their involvement with children (Daly, 2001; Hochschild, 1997). But time is not the only important dimension to father involvement (Palkovitz, 1997). Father involvement is a multidimensional construct that includes affective, cognitive, and ethical components, as well as observable behavioral components, and that includes indirect forms of involvement (e.g., providing, supporting mother), as well (Hawkins & Palkovitz, 1999; Lamb, 1999)."**
>
> (Hawkins et al., 2002: 184)

Hawkins et al., (2002) developed a broader and richer conceptualisation of father involvement using a pilot study and refined the concepts into the Inventory of Father Involvement (IFI). This inventory distinguishes nine distinct dimensions of father involvement (i.e., providing, support of the mother, disciplining and teaching responsibility, encouraging success in school, giving praise and affection, spending time together and talking, being attentive to their children's daily lives, reading to their children, and encouraging children to develop their talents). None of the dimensions were overtly concerned with fathers'

involvement in family health or health practices. There was only brief mention of a father's contribution to the general wellbeing of their child by way of:

- Providing your children's basic needs (food, clothing, shelter, and health care).
- Accepting responsibility for the financial support of the children you have fathered.

Nevertheless, the IFI as a seminal study provides validity for constructing a survey on men's health practices within the family as itemised events, as used in this study. Similar to the IFI, the survey developed for this study also includes items that tapped into behavioural, cognitive, affective, and moral/ethical dimensions of father involvement allowing for indirect as well as direct involvement. These dimensions are reflected in fatherhood questions listed in Table 5.2 and refer to the discussion that has just taken place.

The applicability of these questions to male respondents was supported by the literature on fatherhood and face validity checks (Section 5.16).

5.15 Linking qualitative data to questionnaire design

The analysis of group interactions, dialogue and content informed the researcher on how participants think and talk about a topic and as such was useful in the design of the survey instrument (Quine, 1998: 527). Focus groups are used to explore the range of feelings or opinions on a topic but they are unable to measure the strength of these variables. In this doctoral study a Likert scale was used in the questionnaire to measure the strength of feelings and opinions as well as the frequency of a set of health practices performed by men. The construction of questions and the discourse used in the questionnaire was guided by the language used by men at interview and the extent of their health literacy.

5.16 Face Validity

Face validity was an important part of refining the survey questionnaire. The questionnaire was piloted within focus groups and individual interviews as a means of qualification of process of questioning and as a form of validation of items, sequencing of questions and discourse (Walker, 1985). The fathers reported that the questions on the survey captured well their division of labour inside the family and the health problems experienced and necessary health

practice. There were very few suggestions for additional items. The men interviewed stated the questions were well sequenced in context and readily understandable. These were encouraging comments with several participants writing a note on the returned questionnaire as to the worthiness of such a research topic.

5.17 External validity

External validity refers to the generalisability of the study's findings; how far can the study's findings be generalised, or transferred to other settings (Punch, 1998: 30). In the vast majority of cases researchers would like to be able to generalise the results of their survey so that they can act as estimates of the 'real' population. There are two main impediments to generalising. Firstly, the results of a small survey do not automatically extend to the population and two small surveys using the same instrument are likely to provide different results. Secondly, the sample may not be representative of the population. For example, respondents (actual parents in dual income families and potential parents) are not homogenous; their characteristics (culture, age, personalities) vary. Therefore there is a risk that the sample is not representative of the population.

5.18 How big should the sample be?

Whist the power of the test was not calculated prior to distribution of the survey it was assumed that the size of the sample (n=1,000) with a response rate of 50-60% (possible using door knock accompanied by a brief filtering interview), combined with the validity checks undertaken in the thematic structuring and wording of the questionnaire (piloted at interviews and a focus group) would allow, on analysis, for some generalisability of data to the population (actual and potential parents).

The sample size achievable in this study was the delivery of questionnaires to 1,000 South Australian households. This size reflects cost, time and effort available, each of which represents logistical factors common to almost all research.

5.19 Questionnaire design – length and format

The questionnaire design and page format followed Dillman's (2000) 28 construction principles; these were supplemented by other authors' findings. The length of the questionnaire was 12 pages. Frazer and Lawley state that:

> **"Questionnaires up to 12 pages in length are generally regarded as acceptable for administration via mail. Response rates decline with questionnaires longer than 12 pages."**
>
> (Frazer & Lawley, 2002: 36)

The questions were printed in 12 font with the exception of headings highlighted in 14 font and bold type. Dillman (2000) asserts that there is: "No evidence that using a smaller font to decrease the number of questionnaire pages will improve response." (Dillman, 2000: 12).

The survey questionnaire was framed in four sections. Section one contained attitudinal questions, assessing beliefs and values pertaining to the gender division of labour.

5.20 Cluster sampling

Cluster sampling was chosen in this questionnaire survey because it reduces cost but still allows for a random sampling to take place within the cluster. Three clusters of South Australian households were chosen for their varied demography:

- Rural: the township of Murray Bridge
- Adelaide hills: the hamlets of Woodside
- MetroPilotan: the township of Mount Barker and Prospect

Cluster sampling is often used when it is impossible to put together a frame of all individual elements or when the complete random selection of individual elements is extremely expensive or ineffective (Singleton & Straits, 1999: 164).

5.21 Randomised block design

Random selection began by choosing blocks of streets and alternating street directions within each block. Houses were visited on both sides of each street. To optimise location of houses attended by occupants, the door knock survey was undertaken between 4 pm and 7.30 pm (after school hours and when most fathers / guardians were likely to have arrived home). The majority of people accepting

the questionnaire at the doorway were mothers / women with the vast majority of these handing the questionnaire onto their spouse / partner for completion.

5.22 Respondents - Selection criteria

Who should be asked to comment / respond on men's health practices within the family? The best informants on men's participation in health (type of activities and frequency of activities) are fathers and their spouse / partners. Fathers or step fathers / male guardians could complete the questionnaire themselves or confer with their spouse / partner on the details requested. Self reported data tends to exaggerate paternal involvement (Erickson & Gecas, 1991). Gilbert (1985), whilst using objective ratings as well as self-reports, discovered that 25% of fathers had exaggerated their own involvement in parenting. The strategy of collaborative responses employed in this survey was intended to moderate men's responses and enhance the reliability of details recalled by fathers / guardians. The questionnaire provided an item for recording if the survey had been completed personally or as a collaborative effort.

Who should be asked to provide their beliefs and attitudes toward the division of labour within a dual income family? Identifying social attitudes should rely on reports from those parents living the experience of being in a dual income family and those who have lived the experience in the recent past. Potential parents are likely to hold ideals and values about shared parenting and how that might work best should they choose to become a dual income family. These ideals and beliefs can be shaped by evaluating the costs and benefits they have gleaned from observing actual parents in dual income families. Consequently, the survey was addressed to men and women, over 18 years and under 60 years who were either actual or potential parents.

Selection criteria for respondents:

- Potential parents (males and females over 18 years of age)
- Parents who currently live in dual income family
- Parents who lived in dual income family at some time over the past 10 years.

5.23 Enhancing respondents' recall

Having reviewed the research literature Foody (1993) concludes that, whilst our understanding of memory processes is at best incomplete, it is widely understood that forgetting is a natural occurrence over time and follows some sort of exponential function. On the subject of recall *per se* Foody (1993: 110) asserts that even when the researcher is sure that the respondents have been exposed to an event or performed a task, it cannot be assumed that they will be able to remember information about it. Further, respondents are often not consciously aware of all the causes and motives associated with their behaviour. The challenge for the researcher is to take steps to facilitate accurate recall. Foody (1993) asserts that researchers should and can 'take steps to facilitate accurate recall" and in reference to Cannell's (1977) memory research identifies the practical utility of using 'cross cutting' questions to enhance recall. For example, instead of asking the respondent if they have been ill in the past year the respondents can be asked a series of questions linked to illness. In this survey men's health practices are not limited to asking about a specific illness event; cross cutting questions related to caring tasks are put to the respondents to trigger memories of such events.

Section 2.4 Typical activities performed for sick children

How often did you / do you - do these tasks when your child is ill?

and

Section 3.4 Medication use

How often have you visited a pharmacy in the past year?

Cannell (1977) suggests asking whether the respondent has had episodes of pain, taken time off work, needed to take any medication, to build up the respondents own cues and frames of reference for events.

Section 2.3 Episodes of illness

- *When did you last care for a sick child that had to stay at home?*
- *For how long did you care for the child?*
- *How did you find the time to care for the child?*

5.24 Time referents within questionnaires

The category 'actual parents' included all men and women who had cared for children in their home over the past 10 years. The rationale for this time frame has to do with parents' ability to recall certain health related events. Dillman (2000: 67), in referring to appropriate time referents within questionnaires, contends that people do not remember details about 'mundane activities' performed a month ago. However, it is argued here that providing health care to an acutely ill child, chronically ill child or terminally ill child is not likely to be considered mundane because of the emotional tug most parents experience in terms of their promoting their child's welfare. In additional to this emotional tug there are the difficulties associated with rearranging family routines to provide care and organise health services for the child. Providing care for an ill child is particularly difficult for parents in dual income families where at least one parent might have to rearrange work commitments in order to provide nursing care for the child or visits to doctors or other health services. These difficulties were presented in detail in the chapter *Dual income families in crisis*. Secondly, Herlihy et al's., (2002) investigation for discrepancies in details from the autobiographical memories recalled by asylum seekers at successive interviews has a bearing on the 'reminiscences' of parents concerning family illness. It is argued here that an illness within the family represents a critical incident and therefore, as in the case of asylum seekers, the details about the incident(s) are recalled and collaborated and reinforced with significant others (spouse / partner) over time. Herlihy et al., (2002) argue that the significance of the incidence, over time:

> **"May lead to the checking of memories with others who were present at the time, or the gradual remembering of more detail."**
>
> (Herlihy et al., 2002: 327)

Ergo, it is plausible that parents will recall details of incidents concerning health care within the family, where there has been a serious illness or episodes of acute

illness. The initial interviews with several men and subsequent focus group discussions made it clear that men were able to provide a detailed account of their health practices from long ago and provide a rationale for their actions / inactions.

5.26 Response bias

Response bias in surveys using a questionnaire method is a concern for all researchers. Grulich (1998: 115) gives the example of the differing responses that could be expected where there was a suspected relationship between a 'pain killer' and congenital malformations. He suggests the use of a bland introduction of the nature 'we are conducting a survey of the health of mothers and babies' as opposed to the specific 'we are studying the effect of drug X, which we believe to be related to…' may reduce response bias. For this doctoral study, the envelope and information sheet *[Appendix 2 & 3]* simply introduced the study as research about how men practiced health within the family, highlighting that there were 'no right or wrong answers' to the questions and that the researcher was interested only in 'opinions /attitudes' and 'what men did**'.**

5.27 Response rate - strategies

A variety of survey methods have had reasonable response rates. Goyder's (1988) review of over 500 face-to-face interview survey, telephone surveys and mail surveys report a mean response rate of 67%, 60%, and 58% respectively. However, response rates for these methods have been in progressive decline for over a decade (Maxim, 1999:148; Dillman, 2000). In a survey mailed to American fathers Hawkins et al (2002) reported achieving a 34% response rate (739 / 2,000). This was despite the researchers mailing out the survey on 'fathers day', limiting the survey to seven pages and sending out two follow up notices inviting fathers to mail back a completed questionnaire. Hawkins et al., (2002) summarised the response rate by stating: "This rate is typical of mail-in surveys for men with no incentive provided for completing the task". (Hawkins et al., 2002).

It was noted that Hawkins et al.'s (2002) survey was mailed to "a nationally representative sample of fathers" This maximised the chances of the survey

reaching the respondents targeted and conversely minimised reaching those who would be out of scope of the survey.

Although more time consuming, this researcher elected to use a door knock approach for distribution of the survey because it was likely to improve the response rate above other methods reviewed. Where the occupant was home a brief screening interview was conducted to determine if the occupants of the household were within the scope of the survey (a potential parent or living within a dual income family within the past 10 years). If the occupants were within the scope of the survey then verbal information outlining the purpose of the survey was given, followed by an information sheet, the questionnaire, and a reply paid envelope. Where no-one responded to the door knock, a reply paid envelope was deposited in the letter box. The address was recorded and a follow up letter was circulated two – three weeks after the interviewer had visited. The response rate of the mail box drops was minimal when compared with that of questionnaires given at the point of occupant contact.

5.28 Limitations – quantitative

Response rates from men are commonly low and the door knock distribution to households outside of working hours was intended to identify as many fathers in dual income families as possible. In hindsight a better response rate could have been had by approaching men known to be fathers and cohabitating with children. Improving response rates from men is an ongoing issue; Hawkins et al., (2002) tried mailing out questionnaires to fathers directly on fathers' day but failed to substantially improve response rates. Accessing fathers directly would also have reduced the need for respondents to rely on memories as far back as 10 years, when they were once in a dual income family.

5.29 Statistical analysis

There are two types of data; the first section contains attitudinal responses to men's and women's role in the family and society and other sections contain frequencies of actual health practices and skills. For the attitudinal responses made by men and women, Pearson Chi-square has been used to examine the relationship between pairs of categorical variables using the conventional

probability criterion of $p < 0.05$. The analysis involves multiple testing which is likely to inflate the possibility of a type one error. Consequently, the reader should give more attention to the patterns of results rather than the *p* values. Although the tables could have been ranked according to higher to lower *p* values this was not appropriate because of the way the questions have been grouped. Questions that do not directly relate to a section have been used for cross validating respondents' opinions. For example, in section 1.3 there are a set of questions on the theme 'fathering today' but a similar question about fathers also exists in section 1.2 with the theme: 'Women and the family' (respondents are asked to comment of the proposition that: "in a single family it is more important for the child to be with the mother than the father?"). By cross referencing similar questions throughout the survey it is possible to identify consistency and contradiction in respondents' attitudes.

PART 4 : RESULTS

Evidence found

in documentary searches

CHAPTER SIX:
ACUTE ILLNESS

6 Introduction

This is the first of six document search chapters investigating the health practices of fathers. This chapter presents findings to show that the incidence of acute illness among infants, young children and adolescents is substantial enough to create a large call on parents' time and personal resources. Acute illness data for dual income families is limited but the majority of children attending childcare are from dual income families and there is good data from this population.

The workload implications for acute illness care within dual income families is discussed on the basis that a more equitable sharing of parenting responsibilities is necessary to reduce the risk of working mothers becoming physically and emotionally overwhelmed from assuming multiple roles / workloads. It is acknowledged that researchers have placed emphasis on describing mothers' and working mothers' experiences of acute sickness care; to date this bias has been justified in terms of the fathers' lack of availability, attributable mainly to men's inflexible employment commitments.

Accounts of fathers' participation in health practices are explored using a systematic literature search and document search. An initial search sought to identify their health practices using the general term 'acute illness' and the key words 'infants', 'children', 'adolescents' and 'fathers'. Added to this was the key word 'medication' because most acute illnesses require over the counter medication use or prescribed medication to be delivered by parents [see section 3.8 *The administration of medication*]. The electronic literature and document searches of the health care data bases CINAHL, Medline, PsychInfo, Family health and sociological literature were supplemented by manual searches; within the time frame of 1960-2005.

Although no study identified men's specific health practices a small number of accounts of men's involvement in care were located under the more general topic of parent or mothers' responsibilities in caring for acutely ill children. That is to say, comments about fathers came as adjuncts to information about a mother's

role in caring for the acutely ill child. The profound paucity of data describing men's health practices across this literature, as detailed in all sections, indicated that a more specific search approach be used.

A secondary search was undertaken to identify men's practices in response to specific illnesses commonly diagnosed in children. The Australian Bureau of Statistics and the Australian Institute of Health and Welfare report the highest prevalence of acute conditions as:

i) respiratory illness

ii) ear infections

iii) diarrhoea and

iv) tonsillitis / tonsillectomy.

These conditions were chosen to be the focus of the second search because of their high prevalence (ABS, 2000; AIHW, 2001). These conditions were entered as key words in anticipation of a link with fathers' health practices. The search results are presented in detail for individual conditions within section 6.9 *Exemplars of common child illnesses: evaluating parental involvement*.

6.1 The health status of children

It is widely acknowledged that the true prevalence of childhood illness may vary between countries, socioeconomic groups (Saxena et al., 1999) and cultural groups (Neill, 1996) and that gaining reliable data is a constant challenge for health researchers. The majority of data used in this chapter is drawn from countries that have a universal health care system and attempt to keep credible records of health service utilisation for children. These include the United Kingdom (National Health Service / Department of Health), Australia (Medicare), Scandinavia and North America (Medicade).

The need for timely identification of acute health problems in children and their access to appropriate treatment and requisite standard of care continue to be a major public health concern in Australia and similarly industrialised nations (AIHW, 2005). Although children in developed countries are generally healthier across a wide range of indicators, paediatric health agencies in the United Kingdom, the United States of America and Australia are being overwhelmed by

parents seeking consultations for children with acute and serious illness. Craft (2005) characterises this phenomenon as a paradox.

> **"Children have never been healthier yet paediatric services in Britain are overwhelmed with work. Hospital admissions are at an all-time high but average length of stay is down to just over 24 hours."**
>
> (Craft, 2005: 1)

and

> **"One of the big issues concerning us at the moment is how to provide assessment and treatment of the acutely sick child or those whom the parents think is sick."**
>
> (Craft, 2005: 1)

A similar phenomenon was noted in 1988 when, in the United States (US), approximately 2 million children younger than 18 years (3.4%) were reported to have used emergency departments as a source of illness care (Halfon et al., 1996). In Australia, figures taken from the AIHW "National Hospital Morbidity" database show that: "...the number of children, aged between 0-14 years, hospitalised in Australia for the period 2002–03, was 544,325." AIHW (2005: 17).

and

> **"Diseases of the respiratory system were the most common reasons for children aged 1–14 years, accounting for 19.1% of hospitalisations."**
>
> AIHW (2005: 17)

Although there has been a lowering in the rates of major ailments in Australian children the data indicates that a substantial number of children require parental and medical intervention to optimise their health.

> **"Problems with significantly higher management rates in 2000-01 compared with 1990-91 included … contact/allergic dermatitis (3.1 v 2.5). Those managed significantly less often in 2000-01 v 1990-91 included acute otitis media (7.7 v 9.4), asthma (5.4 v 8.8), tonsillitis (4.4 v 6.0), acute bronchitis (3.8 v 5.3) and gastroenteritis (1.7 v 2.7). Asthma management rates rose from 2.4% of all problems managed in 1971 to 7.2% in 1990-91, then fell in 2000-01 to 4.6%."**
>
> (Charles et al., 2004:216)

The statistics presented thus far suggest that a large proportion of parents with young children, are inextricable engaged in activities surrounding the diagnosis, treatment and care of an acutely ill child.

6.2 The prevalence of acute illness in infants

Determining opportunities for men to practice health for their infant is difficult because although there is good data on the health service utilisation among children there is a gap in data concerning the illness prevalence of infants under the age of 12 months (Goldfield; 2003). The care of an infant with health problems is of great concern for most parents but first-time parents are particularly in need of support. Of all the women who gave birth in Australia in 2004, 42.2% were mothers for the first time (Laws, et al., 2006). Goodman (2005) undertook a meta-synthesis of qualitative studies using the data bases Cinahl, PsychInfo, MEDLINE, and Social Work Abstracts electronic databases from 1990 through 2001 using the terms 'qualitative', 'fathers', 'fatherhood', 'infants', 'father-infant' 'relationship', and 'postpartum'. This work focused on concepts and theories attached to the development of a new father's role. None of the data explored by Goodman (2005) informed the reader on the actual health practices performed by a father toward their new infant.

A lack of health data on infants has hampered the development of policies aimed at affecting a more responsive and coordinated delivery of health - services for these infants and parents.

> **"Knowledge of health service use is important for planning services in order to inform policy development, improve policy development, improve service delivery and create a more responsive, coordinated health-service system; however, in Australia published research regarding patterns of use in this age group is scarce…"**
>
> (Goldfeld et al., 2003: 249)

Records of medical consultation have been poor estimates of the prevalence of illness among infants because health visits by very young children are closely correlated with maternal consultation patterns; as a consequence only the mothes visit is recorded in most cases (Newacheck & Halfon, 1986). In addition, studies of service utilisation by very young children focus on one type of health visit; rarely is there an aggregation of data to show combinations of types of health service usage (Spencer & Coe, 2000). Gunn et al's., (1996) study of previously undocumented levels of postnatal services for mothers and babies identified that of the 6,404 services provided, 5042 (79%) were general practitioner consultations (GP), 804 (12%) paediatrician consultations, 319 (5%) obstetricians

consultations and 239 (4%) by 'other' specialists. Gunn et al., (1996) concluded that for the first six months of life there was on average 4.2 health visits for each infant. Gunn et al. (1996) made no comment on the father's presence at such visits.

Goldfield et al. (2003) studied 'parental use' of health services, in a community of well infants who were in their first year of life; the researchers claimed to be providing 'previously undocumented information' on such health visits. Using data from 173 dairies, recorded by Victorian parents over one year, Goldfield et al. (2003) determined that the mean number of visits to any health service (medical, hospital, Maternal and Child Health Nurse (MCHN) services, pharmacists, allied health services and naturopaths) was 35.7 (95% CI 34.7-36.6). The number of visits per family ranged from 1-85 per annum. The researchers concluded that:

> **"In a universal health care system, this high rate of health-service use equates to approximately one visit to a health service every 2 weeks in the first year of life".**
>
> (Goldfield et al., 2003: 249)

The data presented in this section indicates that one or both parents are dedicating substantial amounts of time and resources to their child's health from a very young age. The creation of maternity leave for women and men's continued role as the major breadwinner suggests that women, rather than men, have greater opportunities to provide healthcare for their ailing infant or be involved in screening activities / health promotion. Societal values have also normalised the gender division of labour around women's care of the newborn child and young children.

6.3 The prevalence of acute illness in children under 14 years

Numerous summaries of raw data show that the child under 14 years has a substantial burden of disease associated with acute illness. In Britain most children consult a General Practitioner about acute conditions at least once a year.

> **"During any one year, the majority of children and adolescents attend their GP. Two to five per cent present with emotional or behavioural problems, while the rest present with physical complaints."**
>
> (Kramer & Garralda, 2000: 287)

National data for Australia provides a breakdown of the number and types of consultations across several age groups. The Australian Bureau of Statistics (ABS, 1992) found that, for a two week period preceding their survey, children less than 14 year olds had 1,067,700 health related consultations; 645,000 were consultations with their doctor. Of the remainder, 242,700 under 14's attended dental consultations and 334,000 saw other health professionals (ABS 1992, Cat. No. 4376.0). Children in the under five years group accounted for 295,700 (23.8%) of total visits, with 16% of these children being scheduled for a follow-up appointment. The most prominent reason for a health visit was the prescribing of medication (62.8% cases) followed by the administration of or arrangement for an injection (10.2%) (ABS 1992, Cat. No. 4376.0).

For children aged between five and 14 years, there were 349,000 consultations with their doctor within a two-week period; with 22% having appointments arranged for a further visit. The most predominant treatment during the consultation was the prescribing of medication (58.3% of cases) followed by the administration of or arrangement for an injection (7.6%). Overall, 645,000 children less than 14 years consulted their doctor over a two-week period (ABS 1992, Cat. No. 4376.0).

Although consultations with GPs for children less than 15 years of age has decreased steadily since the late 1990s children have decreased as a proportion of the population since then (AIHW, 2005). There were:

> **"an estimated national annual decrease of 760,000 encounters with children (i.e. 4.5 million fewer encounters with children in 2004–05 than in 1998–99)"**
>
> (AIHW, 2005: 12)

The decrease in the number of GP visits may also reflect the increase in use of hospital emergency departments as the first source of consultation for children (as there is no cost to the parent for this service). Fewer home visits by GPs and 24 hrs-a-day emergency hospital services make this form of consultation more accessible to dual income parents.

6.4 Prevalence of childhood illness in dual income families

Establishing the prevalence of acute illness in children living within dual income families is difficult to determine because many studies, particularly those

appearing in the medical literature, include socioeconomic data / social class (UK) but do not record family structure as a discrete variable. The exception is the category of single parent (Fleming & Charlton, 1998), with researchers frequently comparing the health differentials between children of single mothers and those living in two parent families (Chen & Escarce, 2006). The paucity of data on childhood illness within dual income families can be attributed to the family's relative affluence, with the assumption that there are fewer links and weaker links between health resources and other social equity issues (Fleming & Charlton, 1998).

Determining the prevalence of acute childhood illness in dual income families is problematic because no medical records are kept of illnesses treated entirely in the home. Hannay (1979) acknowledges that most child health care is undoubtedly carried out without the involvement of health professionals and mostly by mothers in the home. Spencer (1984) found that up to 90% of minor illnesses are known to be diagnosed and treated at home. Holme (1995:65) used diary cards, kept by mothers of 323 infants, to show that 'parents managed 67% to 99% of infants' health problems without requiring a consultation with a health professional. Notably, Holme's (1995) data was not disaggregated on the basis of 'father' and 'mother' treatments, leaving the reader to postulate whether 'parental efforts' were the combined efforts of both parents or the term 'parent' was used synonymously with 'mother'.

6.5 Prevalence of acute infections among children attending childcare

An indication of the prevalence of acute childhood illness within dual income families can be gained from studies of infection rates in childcare facilities because the vast majority of children attending childcare have both parents in employment. With the increasing number of children attending day-care centres public health researchers have refocused their attention on determining trends for respiratory infections and other infectious diseases in these settings (Pönkä et al., 1991). There has been a long standing assumption that cross contamination between children is higher in day-care centres than in home based day-care (Labordeet al., 1993). If the assumption were true then parents who send their children to day-care, so as to free up time to be in paid work, would be at greater

risk of losing free time and money to managing episodes of child illness. In addition, working mothers with children in day-care may have to spend more time caring for a sick child than those mothers who do not work. Several researchers contend that dual income families are burdened by the cost of childcare as well as a possible loss of wages over the period they must care for their sick child, thus diminishing the financial benefits from dual incomes (Thompson, 1993; Richtsmeier & Hatcher, 1994; Callery, 1997). Where it can be shown that there is no difference in the incidence of illness, parents may be reassured that they are not subjecting their child to greater risk of health problems.

Slack-Smith et al., (2002) surveyed 130 homes providing day-care for children and 11 child day-care centres in Perth (Western Australia) to compare the prevalence of illness between the two types of formal childcare. Data from the survey questionnaire gave the prevalence for a wide range of conditions:

> **"Of all children, 39% had experienced otitis media, 11% glue ear and 26% allergies; 18% had been diagnosed with asthma; 10% had been admitted to hospital with respiratory illness, and 9% had experienced more than six respiratory conditions in the previous year."**
>
> (Slack-Smith, 2002: 29)

Slack-Smith et-al., (2004) researching widely on this topic for nearly a decade, note the methodological problems with comparing infection rates between children in childcare and those not attending, stating that:

> **"Many articles investigate one or two factors which affect illness but overlook or effectively ignore other potential confounding variables and the focus of research is generally on only one form of care. In addition, there are few longitudinal studies observing illness in childcare."**
>
> (Slack-Smith et-al., 2004: 30)

Slack-Smith et-al., (2004), concluded that many acute illnesses have a higher incidence in children attending childcare, however: "Some evidence suggests that group childcare does not present a high risk for serious infections". (Slack-Smith et al., 2004: 30).

Some studies show a decreased risk. Hurwitz et al., (1991) performed a comparative analysis of the risk of respiratory and other illness in children (age groups: 6 weeks through 17 months, 18 through 35 months, and 36 through 59 months) in various types of day-care facilities with mixed results.

> **"Although an increased risk of respiratory illness was associated with attending day care for children in all three age groups, this risk was statistically significant only for children 6 weeks through 17 months of age and children 18 through 35 months of age who had no older siblings."**
>
> (Hurwitz et al., 1991: 62)

It was hypothesised that exposure to older siblings posed an increased risk of respiratory illness; however, for children aged 36 through 59 months this exposure was protective against respiratory illness. Hurwitz et al., (1991) concluded that for all ages, an increased duration of exposure to day-care was associated with a decreased risk of respiratory illness.

Despite the methodological problems and the occasional researchers finding a decreased risk of infection, most studies have shown that children attending childcare centres have an increased risk of acquiring Upper Respiratory Tract Infections (URTI) (Wald et al., 1988; Fleming et al., 1987; Woodward et al., 1991; Wald et al., 1991; Andersson, 1992; Collet at al., Presser, 1988). Increased risk ratios are observed for children attending childcare (Collet et al., 1991; Douglas et al., 1994; Marbury et al., 1997). And there is an increased risk ratio of otitis media in day-care children compared with those that stay at home (Wald et al., 1988; Fleming et al., 1987; Hardy & Fowler, 1993).

6.6 Workload implication for dual income families

Early studies (Hewison & Dowswell, 1994; Slack-Smith et al., 1998) report that the workload of caring for children with acute illness has a greater impact on parents' physical and emotional reserves when parents are forced to renegotiate their once routine commitments to employment. Overall, the literature indicates that the parental burden of care, caused by their child's absence from childcare can be attributed mostly to acute infectious illness, particularly respiratory illness. Chronic disease, disability and injuries play a lesser role as causative factors for childcare absenteeism (Fleming et al., 1987; Celedon et al., 1999, Slack-Smith et-al., 2004). Details of the stresses endured by these parents and the burden of care borne by mothers were highlighted in the chapter *Dual income families in crisis*.

6.6.1 Parental responsibilities and workloads in caring for an acutely ill child

Episodes of childhood illness are inevitable, mostly unpredictable and frequently accompanied by a large increase in parental workloads and concomitant

disruption to the routines of family life (McKenna & Hunt, 1994). The following series of tasks typifies parental involvement. Caring parents, who are savvy on about the most common types of childhood illness are likely to perform a physical assessment of the child to determine if signs and symptoms support the need to seek a medical opinion. Prior to medical consultation there is often an interim administration of physical treatments and remedies (usually over the counter medications) intended to promote comfort and rest. This is followed by the transportation of the child to a doctor or health service and a recounting of a health history (Clarke & Hewinson, 1991; Saxena et al., 1999). Consultations are frequently followed by the purchase of a prescription drug that requires collection from a pharmacy. In general, parents who are committed to the welfare of their child require knowledge of illness, knowledge of the safe administration of medication and the skills and stamina to perform general nursing care that may be required at anytime of day or night. The responsibilities attached to caring for an acutely ill child are most often shared unequally with the mother performing most of the night time vigilance and nursing caring (Ferri and Smith, 1996; Witherspoon, 1998; Horner, 1997; Atkin &Ahmad, 2000; Darbyshire, 1994).

Although, there is a substantial amount of literature making note of the problems that parents encounter in providing sickness care for their actuely ill child, there is far less information on how parents cope with a range of infrequent illnesses such as chicken pox, measles and mumps (Taylor, 1995). The occurrence of less common illnesses requires the parent to locate and absorb new information and new health practices, thus adding to their workload.

Despite the litany of parental responsibilities and health practices associated with negotiating and the carrying out of effective health care a recent systematic search for literature by Neill (2000), aimed at identifying the parent’s perspective on managing acute illness in the home, located few relevant works.

> **“The majority of childhood illness is of short duration and takes place in the child's own home. Yet the research which addresses this area is limited.”**
>
> (Neill, 2000: 821)

Limited research helps explain why there is little evidence of fathers’ home health practices in the literature. The division of labour around the previos of health

care was explored in the chapter *Masculinity*: Section 3.3 *Gendered participation in health care*.

6.6.2 The administration of medication

The administration of medication represents a large portion of health practice for managing illness in the less than 15 years age group. Sloand and Vassey (2001) examined the self-medication practices of North American children aged 10-14 years. The study, using a small convenience sample of 86, found that 36% of the adolescents who had taken medication had self-medicated. This finding infers that almost two thirds of these children (64%) relied on adult guidance for medication use. Slack-Smith et al.'s, (1998) survey of medication use for 846 children under six years revealed that; over a 12 month period:

> **"Seventy-three per cent of the children were reported to have used over-the-counter medication at some time, whilst current regular use of prescribed medication was 11%. This proportion is comparable to the limited available data for children of similar ages in Western Australia."**
>
> (Slack-Smith et al., 1998: 183)

The researchers concluded that the over the counter medications chosen and administered by 'parents' for children attending childcare closely related to reported illness in their child. Notably, there was no disaggregation of the term 'parent' (father or mother) for administering the medications in Slack-Smith et al.'s (1998) year long survey.

Slack-Smith et al.'s (1998) study suggests that most parents have well practiced symptom recognition and are able to choose appropriate over the counter medication. However, a larger U.S. study conducted by Kogan et al. (1994), seeking to estimate the prevalence of recent over the counter (OTC) medication use in preschool-age children, suggests there are problems with parental pharmaceutical health practices. The study was conducted as a follow-up survey of a nationally representative sample of three year old children in the North American population by telephone or personal interview. The vast majority of the 8,145 respondents were mothers because the study was part of the 1991 Longitudinal Follow-up to the National Maternal and Infant Health Survey. Seventy per cent of mothers reported a recent child illness episode being treated with OTC medication; the higher the SES and educational level of the mother, the

more OTC medications the children were likely to receive. As a concluding point the researchers expressed concerns that:

> **"The high prevalence of use has occurred despite the dearth of scientific proof for the effectiveness of certain classes of OTC medications and the risks associated with improper use."**
> (Kogan et al. 1994: 1025)

There have been longstanding recommendations made for an expansion of the role of the pharmacist in assisting mothers in dealing with minor complaints in children (Cunningham-Burley & Maclean, 1987b). More recently, Echlund and Ross (2001) noted the 'efficacy of many OTC medications has yet to established'. Echlund and Ross (2001) studied the use of OTC medications by mothers (*n*=52); concluding that there is an urgent need for health professionals to use anticipatory guidance for parents because there exists a wide variation in competence and rationale for using these medications.

A search of the literature found little information on the prevalence of men's administration of medication to children or their ability to practice the safe administration of medication or determine if the medication was effective and with / without side effects. The data base Cumulative Index of Nursing and Allied Health Literature (CINAHL) was searched for articles published 1983 – 2005, containing the key words 'father' and 'medication'. Only three of the 1,150 articles containing the word 'father' had any cross reference with the word 'medication' and none of the three articles related to medication administration by the father. A similar search was performed using the key words 'father' and 'drug' revealing 26 articles, none of which were of interest. Conversely, a search that substituted the word 'mother' in the place of 'father' revealed five articles concerning either mothers giving medication or overseeing their child self-administering (Bender et al., 2000; de Oloverira & Cassiani, 1997; Laskey, 2002; Macke, 2001; Maiman et al., 1982).

6.7 Evidence of fathers' health practices toward infants or children with acute illness

There is very little information concerning a father's contribution towards facilitating health care for infants and young children with normal development (Bailey, 1991; Hewison & Dowswell, 1994). Men's employment hours often preclude them from practicing health care in the management of acute illness (Englander-Golden & Barton, 1983; Bailey, 1991). An early but important study by Turya and Webster (1986) investigated the health clinic attendance rate of parents from a disadvantaged area of London, where half of those consultations were solely for the purpose of health screening (infant's weight gain and feeding). Fathers were twice as likely to bring their young child into the health clinic if evening services were provided: "More fathers (45%) brought their children to evening clinics than to day clinics (20%)." (Turya & Webster, 1986: 93).

Although a similar study was undertaken (McIntosh, 1992) the research focused on 'mothers' perceptions of the clinic's functions and relevance as well as social and organizational barriers. Health professionals, conscious of the egalitarian tenet of shared parenting, continue to emphasise the need for their peers to overcome stereotypical views on maternal centred approaches to infant health.

> **"Nurses ought to reflect on that a father of an infant may feel slighted at the child health clinic if, as traditionally, the nurse turns only to the mother."** [the grammatical error "on that a" occurs in-print]
>
> (Fägerskiöld, 2006: 79)

And there are continued efforts to contextualise the fathers - infant nexus in the nursing literature (Goodman, 2005). In Scandinavia, where there has been longstanding policy in support of equitable parenting, child health nurses are still struggling to locate evidence on how best to involve the father in the health care of infants (Fägerskiöld, 2006). Procrastination on how best to affect support for fathers has been longstanding (Draper, 2003; Cabrera et al., 2000). Supporting the procrastination is an understanding that:

> **"Men realized they lacked the skills, experience, support, time, and recognition they needed for fathering. They felt helpless and inadequate in providing care to the infant and guilty that they were not being more helpful."**
>
> (Goodman, 2005: 194)

This lack of preparation for equitable parenting continues across much of the child's development and ensuing health care needs (Gavin & Wysocki, 2006). Bailey (1991) identified a gap in knowledge on this topic stating:

> **"... little information is available concerning father's involvement in the routine healthcare of normal children (Levi, Pleck & Lamb, 1983). In fact, a literature search suggests that only one study dealing with fathers' involvement in routine health care has been done."**
>
> (Bailey, 1991: 289)

Risman (1986), having noted the bourgeoning number of single father families investigated men's family activities by distributing 281 questionnaires and obtaining a 54% response rate from single fathers in the UK. Risman cites scores of previous studies as having consistently reported that few single fathers recruit either female, kin or paid help to perform traditionally female tasks. Two items appearing in Risman's questionnaire were related to men's health practices:

> **"Ninety two percent of the respondents have children's first aid supplies on hand, and 83% have an average of three emergency numbers posted for children or sitter's use."**
>
> (Risman, 1986: 98)

and

> **"The custodial fathers in this study are concerned that their children receive adequate health care. Nine out of ten fathers have a family physician or clinic. Nearly all children in this study visit a dentist at least once every year (91.4%)."**
>
> (Risman, 1986: 99)

Although there are suggestions in the literature that men are involved in their children's health and illness, there is no large or coherent body of work. Consequently, a search for contemporary literature was undertaken using the data bases Google Scholar, Blackwell Synergy, Oxford Journals (118 reviewed), to locate information on fathers' health practices. Using the key words 'father', 'clinic', 'illness' the search revealed over two hundred articles but none specifically related to the topic. An extended search of databases; CINAHL, Psychlit and Medline, augmented by hand searching of current journal issues using the key words 'father', 'parent', 'child', 'illness' revealed that researchers investigating child health problems have as their main focus the collection of data pertaining to the health practices of mothers assume that the absence of fathers

from their study or use of a very small sample of fathers is normal and as such does not affect the quality of the research. These points are often overtly acknowledged by researchers and are frequently supported by statements that mothers spend more time with their children and therefore have a better understanding of their child's normality and divergence from normal behaviour (Cunningham-Burley, 1990; Irvine & Cunningham-Burley, 1991) and that mothers are the better informed parent on matters of symptomatic diagnosis (Cunningham-Burley & Maclean, 1987a; Cornford S Morgan & Ridsdale 1993; Pattison et al., 1982). The literature search findings presented in this section do not differ from an earlier published search by Neill (2000).

Neill (2000) performed a critical review of British literature exploring the phenomenon of acute childhood illness at home from the parents' perspective. The search process included a review of the databases; CINAHL, Psychlit, ASSIA and Medline, and this electronic search was augmented by hand searching of current journal issues. Neill (2000) reports that:

> **"Where studies do include fathers, this is usually only when the father is the major carer at home. Consequently, even in these studies, fathers form a small proportion of the sample. There is no readily available data which explores the role of other family members in the care of the acutely ill child at home."**
>
> (Neill, 2000: 821-22)

Hallberg (2007) notes that:

> **"Very few studies have been conducted of fathers' views of their children's health. Thus, when searching Pub Med, using the key words 'fathers', 'children', 'involvement' and 'commitment', we found no studies similar to the present one."**
>
> (Hallberg, 2007: 1085)

Whilst Hallberg (2007), aimed to "study fathers" perception of, and involvement in, their children's health" the qualitative data presented from interviews with 237 fathers living in Sweden, does not itemise any health practices. This is an outstanding limitation to the study, given that the authors claim:

> **"The fathers state that they are involved to a large extent, and that they perform lots of activities with their children."**
>
> (Hallberg, 2007:1085)

Ramchandani and McConachie (2005) sought to identify ways in which parents can be supported when promoting their children's health; this included parents caring for a child with an acute illness. However, the authors note that substantial

gaps exist in the literature in terms of assisting men to up-skill their health practices.

> **"The papers describe a range of interventions designed to assist, support or educate parents. Interestingly, and perhaps unsurprisingly, much of the research here focuses on mothers as parents rather than fathers or the parental partnership. Although fathers were included in some of the studies (Sarkadi, Patterson), they are absent from most."**
>
> (Ramchandani & McConachie, 2005: 5)

Whilst investigating parental attitudes and options for caring for children who were too ill to attend childcare, Slack-Smith et al. (2000) noted that:

> **"The research resulted in ten successful focus groups with parents from eight different centres. With very low participation by fathers, the results here represent primarily the attitudes of the mothers."**
>
> (Slack-Smith et al., 2000: 578)

Ramchandani and McConachie (2005) claim that Sarkadi and Bremberg (2005) study included fathers however, a review of their work by the author of this thesis, revealed that the data provided was extremely limited because 'Most respondents (95%) were female'. The aim of a study by Sarkadi and Bremberg (2005) was to investigate whether users of a Swedish general parenting website perceived support in the parenting role. The researchers concluded:

> **"Internet use for general parenting issues in Sweden, mainly by women, does not seem to follow the digital divide phenomenon. Therefore, the internet provides an exciting opportunity for future infant and child public health work. The lack of fathers, however, was a surprising finding and introduces a gender bias into this seemingly socially unbiased medium."**
>
> (Sarkadi & Bremberg, 2005: 43)

The claim of a 'surprise finding', expressed by Sarkadi and Bremberg (2005) in relation to the lack of fathers in the study, is not explained by the authors.

Few researchers include accounts of fathers / guardians as competent and sensitive in their health practices; they are more likely to use accounts of male health practices to show ineptitude (Hawkins & Dollahite, 1997). For example, Rueson et al., (2001) in a study of children 0±15 years participation in decision making, provides an account of a father violating the child's right to pain relief.

> **"A 4-year-old boy we had to take blood sample from. I wanted to put on anaesthetic ointment, but his father thought there was no**

> **point in doing that. In the examination room the boy kicked and screamed. The father laid him down on the bed and held him while I took the blood sample, while the boy was screaming hysterically.”**
>
> (Runeson, 2001: 73)

There are few studies that seek to understand the health literacy of parents and how that influences their decision to seek assistance for acute childhood illness. Robbins et al (2003) followed 120 parents of new born children over a six month period to determine if education about minor illness resulted in a reduction in the use of health services. A key finding from Robbins et al.s (2003) work was the parents experience of a “great deal of anxiety” and “lack of confidence” linked to decisions surrounding the need for medical consultation. Robbins et al., (2003) study, like so many other studies (Laws, 2003) used the term ‘parent’ to describe the sample (control and intervention) but did not disaggregate the data into ‘mothers’ or ‘fathers’. Consequently the analysis and reporting of parents data adds no new knowledge to an understanding of men’s decision making around child health issues. Hopton et al., (1996) study of parent’s decision making provided a rare account of a man’s involvement in the decision to consult a doctor about a child’s asthma.

> **“The father, who had made the call, described another incident from a year before when the doctor had been called out and the child had had to go to the local children's hospital for nebulised oxygen for a few hours. The father explained that on that occasion they had thought that the child would ‘just’ need some medication and had not realised it was so serious as to require admission.”**
>
> (Hopton et al., 1996: 993)

This finding goes some way to reinforcing the stereotype of men’s lesser ability to be attuned to a child’s health status and suggests that health practices of men, in the area of health assessment / symptom assessment, are lacking (Goodman, 2005: 194; Hopton et al., 1996: 993).

Very few men take time from employment to be with a sick child. Englander-Golden and Barton (1983), using an anonymous self-reporting study in the US, identified that both parents used their sick leave allocation to take time from work to attend to their sick child, noting that mothers were more likely to do so. Bailey (1991) investigated fathers’ involvement in family health care tasks using a sample of 50 fathers from white middle class and intact families in the UK.

Fathers' participation was divided into three tasks, staying at home with a sick child and taking the child to a doctor / dentist. Bailey concluded that:

> **"Fathers' staying home with a sick child was significantly correlated with fewer hours at work and liberal attitudes toward women's rights and roles; these variables were not related to taking a child to the doctor or dentists."**
>
> (Bailey, 1991: 289)

It is widely understood that fathers are not homogenous yet there is very little information to determine the health practices of fathers within differing social, economic and cultural groups.

6.8 Health practices of fathers within socioeconomic and ethnic groups.

As a general point, Saxena et al., (1999) suggest that parents from lower socioeconomic groups are most vulnerable to the breakdown of parenting skills and therefore may fail to respond to their child's symptoms, thus seeking help at a latter stage and increasing the risk of morbidity. Overall, parents from lower socioeconomic groups are more likely to present their child to the doctor or hospital admissions services because of the link between poverty and poorer health of infants and young children (Petrou et al., 2006; Petrou et al., 2005; Herrod & Chang, 2008). Esmail (2000: 231) found a "low level of inappropriate admissions" of children to paediatric emergency departments regardless of social status and this was attributed to the effectiveness of primary health services in that region. Inappropriate admissions were most likely reflecting the clinical uncertainty associated with the assessment of acute illness in children (Esmail et al., 2000). A US study showed differential paediatric hospital discharge rates for children based on white / black categorisation of citizens and insurance status of the children (public vs. commercial) (Herrod & Chang, 2008). Although there are a plethora of intriguing research questions, researchers struggle to investigate the domain of father involvement with currently available methods and data, particularly with regard to low-income families. Coley & Morris (2002) claim:

> **"This dearth of information stems from three primary causes: simplistic measurement regarding father involvement, fathers' nonparticipation in research studies of child development and family functioning, and concerns about the validity of mothers' reports of father involvement."**
>
> (Coley & Morris, 2002: 982)

Ethnic status has been investigated in depth in the UK as a determinant of health for children. Cooper (1998) showed there was equity in access to child health care services for children from ethnic minority groups and a later study by Saxena et al. (2002), led to the conclusion that children's use of health services reflected their actual health status rather than social status denoted by ethnicity or economic background. Saxena et al., (2002) believe that this finding can be attributed to improvements in the equity of access to health care, however access to secondary care is less than access to primary care. Accompanying this knowledge deficit is a paucity of studies exploring parent-child relationships within:

a) non-Western society
b) the cultural variations within American families and
c) father - child relationship to health in Swedish and Australian families

(Chin-Yau & Fu, 1990; Hallberg, 2007; Cohen, 2003).

Whatever cultural information exists, it does not extend to an examination of health practices of fathers. Important to this thesis is the finding that there is a dearth of literature comparing the health practices of men from differing cultural and ethnic groups. This is not surprising as there has been little culturally specific men's health literature (Laws, 2000) and there is little knowledge of the transmission of health practices from fathers to sons between cultures (Laws & Bradley, 2003).

The preceding sections of this chapter and the findings of the literature search within have shown that very little information exists on the health practices of men toward children with acute illness per se. To augment the process the following sections search for evidence of men's health practice in connection with the care of children experiencing common childhood illness.

6.9 Exemplars of common child illnesses: evaluating parental involvement

The following sections are based on the assumption that the literature on the management of specific acute childhood illnesses would offer more in-depth analysis of the actual health practices of fathers. The exemplars have been selected on the basis that these ailments are the most common acute childhood health problems; upper respiratory tract infections (URTI), ear infections, and

diarrhoeal infection (Karevold et al., 2006). Although asthma does manifest as acute attacks in children this illness is explored in the chapter '*Chronic illness*' because asthma is rarely spontaneously resolved and normally requires ongoing medication and monitoring.

6.9.1 Exemplar: Respiratory illness

Respiratory illness is the most common reason for medical consultation in children under five years of age in most developed countries (Denny et al., 1986; Fleming et al., 1987; Slack-Smith et-al., 2004; West, 2002) and these episodes are important sources of distress for the child and parents. In Britain, nearly 41% of children received a visit from a GP for a disease of the respiratory system (as classified by the ICD-9, chapter VIII) over a period of a year (McCormick et al., 1995). The impact on parents is aptly put by West (2000):

> **"Upper respiratory tract infections are common and important. Although rarely fatal, they are a source of significant morbidity and carry a considerable economic burden."**
>
> (West, 2002: 215)

Children with runny noses may not have a respiratory infection but often have a form of allergic reaction (rhinitis) associated illness that normally requires parents to engage in health practices. Peroni et al., (2003) assessed school children, using a survey questionnaire, for the prevalence of rhinitis, sneezing, runny or blocked nose apart from colds. The prevalence of rhinitis, over 12 months, was 16.8% (n=1402). Peroni et al., (2003) concluded that in pre-school children rhinitis has a strong association with other illnesses.

> **"Rhinitic children compared to non-rhinitic children presented a significant increase of diagnosed asthma (20.8% vs. 6.2%, P<0.001), lifetime wheezing (43.2% vs. 21.6%, P<0.001), wheezing in the last 12 months (25.0% vs. 9.4%, P<0.001), atopic dermatitis (22.9% vs. 13.9%, P<0.001) and allergic sensitization (29.9% vs. 13.7%, P<0.001)."**
>
> (Peroni et al., 2003: 1349)

A literature search of the data bases Blackwell synergy, CINAHL, Psycinfo and Medline using the terms 'Father', 'respiratory', 'illness', 'rhinitis', 'child' revealed no works containing information relevant to the health practices of fathers. However, two researchers had included a very small number of fathers in studies of children with acute respiratory distress (Callery, 2003; Romanko, 2005); the vast majority of the data they reported was about 'parents' or

'mother's' health practices. Although Callery (2003) collected data from two fathers (14 mothers) the results were provided only for 'parents'. This assumes that there is no difference between fathers' and mothers' abilities to describe and assess for respiratory problems. Callery (2003) concluded that there was wide variation in parents' ability to distinguish the type of respiratory symptoms with parents relying mainly on their 'innate knowledge' of what was normal for their child rather than matching symptoms with an accurate diagnosis of the problem.

6.9.2 Exemplar: Ear infections

Hardy and Fowler's (1993) study, aimed at assessing the association between childcare arrangements and repeated ear infections in young children, gathered data on children younger than six years, from the 1988 National Health Interview Survey of Child Health. Overall, 17% (n=5818) had experienced repeated ear infections in the year preceding the interview. The factors significantly associated with repeated ear infections were age (1 to 2 years), race (white), sex (male), and medical history (repeated tonsillitis, enlarged adenoids, or asthma). In controlling for these factors Hardy and Fowler (1993) were able to show that:

> **"Children in a current child care arrangement still had a 50% higher chance of repeated ear infections than did children not in care."**
>
> (Hardy & Fowler, 1993)

The data presented adds support for the contention that children in day-care centres are at higher risk of infection than children cared for in homes.

A literature search of the data bases Blackwell synergy, CINAHL, Psycinfo and Medline using the terms 'father', 'ear', 'otitis', 'child' revealed no works containing information relevant to the health practices of fathers. And Slack-Smith et al., (2000) note that gaining even an idea of men's attitudes to these types of infections is difficult because recruitment of men into studies of this kind is difficult: "With very low participation by fathers, the results here represent primarily the attitudes of the mothers." (Slack-Smith et al., 2000).

6.9.3 Exemplar: Diarrhoeal illness

Diarrhoea is caused by infective and non-infective agents. Infective gastroenteritis is common in infants and children, where personal, domestic, and community hygiene practices are not to public health standard. There is a high

prevalence of gastroenteritis in Australian Aboriginal infants and children; this condition remains a major reason for their hospitalisation. "Aboriginal patients stayed in hospital for 4.8 days while other patients stayed only 2.2 days." (Gracey et al., 2004).

In the UK, population data for 1994 shows approximately 1 in 6 children per year consulting their General Practitioner with an episode of infective gastroenteritis (Armon et al., 2001). Jorm and Capon (1994), investigating outbreaks of diarrhoeal illness in children attending long-daycare centres (LDCs) in Sydney determined that although hygiene practices varied widely among centres. "Diarrhoea in children in LDCs may be caused predominantly by non-infectious factors". (Jorm & Capon, 1994).

Children may develop diarrhoea as a side effect of taking antibiotics. Antibiotics are commonly used by this group of children against the effects of respiratory and other infections. Consequently, parents have to deal with effects of infections and diarrhoea, both of which may have precluded the child from childcare and the parent from employment; this increases the cost of caring for the child (Hardy et al., 1994). Diarrhoea may also be caused by alterations to dietary intake. Children with a diarrhoeal illness caused by microbial or a virus are likely to suffer 'vomiting, poor appetite, lack of energy and fever' (Hjelt et al., 1987; Laborde, 1993).

The incidence of diarrhoea in childcare raises cause for concern among parents and those agencies prompting public health. However, the reporting of incidence varies between parents and childcare staff (educators). Carabin et al., (2000) randomly selected from 52 Québec (Canada) day care centres to evaluate the agreement between parent method and educator method for reporting the occurrence of diarrhoeal infections. "Educators and parents declared 261 and 582 days with diarrhoea, respectively." (Carabin et al., 2000).

Reports of this kind emphasise the need for vigilance of children's bowl patterns by parents. A literature search of the data bases Blackwell synergy, CINAHL, Psycinfo and Medline using the terms 'father', 'diarrhoea', 'child' revealed no works containing information relevant to the health practices of fathers. Although there is research exploring the: "Psychological health status of mothers

and the admission of children to hospital for gastroenteritis." (Fitzgerald & McGee, 1990:116) a similar study could not be found for fathers.

6.9.4 Exemplar: Tonsillitis and Tonsillectomy

Tonsillitis is one of the most common paediatric ailments and parents report a wide range of symptoms associated with the illness, fever, poor sleep, headache, ear ache, vomiting, pain on swallowing, and bad breath. Capper and Canter (2001) provide evidence to show that:

> **"… parents can differentiate between sore throats that they call 'tonsillitis' and other sore throats that they do not regard as tonsillitis. The two illnesses have very different symptom complexes. The ability of parents to make a clear differentiation between tonsillitis and other sore throats contrasts sharply with the disagreement amongst medical practitioners about the diagnosis of tonsillitis."**
>
> (Capper & Canter, 2001: 458)

The current recommended indicators for paediatric tonsillectomy are that, patients should have five or more episodes of sore throat (attributable to tonsillitis) per year; with disabling symptoms for at least a year (Webb et al., 2004). Tonsillectomy is the second most commonly performed operation in the paediatric population of the United Kingdom with rates varying between 142.79 per 100,000 to 210.81 per 100,000 depending on doctors' practices as they vary between regions (Webb et al., 2004). Given the rate of tonsillectomy and the number of episodes indicative of this procedure it can be deduced that 'parents' are inextricably involved in numbers of episodes of acute illness requiring visits to the doctor and pharmacists for medications to treat the problem. A literature search, aimed at locating a father's role in differential diagnosis and related health was conducted using Blackwell Synergy and the key words 'tonsillitis' and 'father' and ' parents', resulting in 56 hits. An identical literature search was performed in Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Medline (1966-2005) with zero results. A review of the 56 abstracts revealed only one study focusing on the father (Gwyn & Elwyn, 1999). The discourse analysis produced by Gwyn and Elwyn (1999) focused on the power relationship between the father representing the child's need for antibiotics and the doctor's preference for analgesia vis a vis tonsillitis. There was no information about the father's health practices beyond a paternalistic insistence on the use of antibiotics.

The problem of doctors mediating a parent's (mother's) insistence for antibiotics for respiratory infections has been well reported (Scott, 1998; Carr et al., 1994; Fraser, 1979; Butler et al, 1998). However, there is no indication that pressure for a prescription comes mainly from fathers.

Tonsillectomy is one of the most frequent as well as one of the most controversial operations performed in childhood (Wolfensberger et al., 2002). Despite debate about the efficacy of tonsillectomy in reducing morbidity, studies report a high level of satisfaction among parents following the procedure, with a large proportion of parents wishing they had had the procedure done earlier. Whilst Wolfensberger et al.'s (2000) and Conlon et al.'s (1997) surveys report a level of satisfaction the term 'parent' is not disaggregated into 'father's satisfaction' and 'mother's satisfaction'; nor are there fathers' accounts of health practices surrounding the care of a child following a tonsillectomy.

The number of tonsillectomies performed each year and the insertion of grommets, for recurrent ear infections, give a strong indication of the large amount of time and concern that could be devoted by parents to the wellbeing of their child during anaesthesia and surgery. A search of the peri operative literature was performed to locate information about fathers' health practices all along the peri operative pathway. The term peri operative includes the pre admission clinical, where children are assessed for type of anaesthesia, the giving of anaesthesia, the surgery and the period of immediate recovery from the effects of anaesthesia and surgery**.** A large number of studies have attempted to summarise the effects of parental involvement on children's experience of anaesthesia (Thompson et al., 1996; Litman et al., 1996; Vessey, 1994; Tiedeman, 1997). None of these studies offers data that informs on men's concerns regarding their child's preparation for imminent surgery. Some studies selected only mothers (Berenbaum & Hatcher, 1992; Hughes & Callery, 2004). The following literature provides only glimpses on men's involvement, all be it for an emotional link between child and parent. The study by Shirley et al. (1998), designed to measure anxiety levels in parents of children admitted for elective surgery, mentioned the father only twice. Noting that: "Mothers were identified as being more pathologically anxious than fathers." (Shirley et al., 1998: 956).

No other information about fathers' involvement with their child was noted. Messeri et al., (1997) surveyed 39 Italian speaking children aged 2−14 years who were undergoing minor surgery. Of the 43 children having surgery 39 had their fathers present at the preoperative assessment clinic. This indicates that men are involved in the lead up to their children's surgery. However, Messeri et al.'s, (1997) findings did not add to what is known about fathers; the researchers report simply reinforced the importance of the maternal role.

> **"Maternal presence, compared with the father's presence, is fundamental in helping to overcome anxiety in a child receiving anaesthesia."**
>
> (Messeri et al., 1997)

And:

> **"The STAI scores showed that the mothers had a higher level of anxiety compared with the fathers."**
>
> (Messeri et al., 1997:551)

The reader is left to conclude that if mothers were more anxious than fathers and parental anxiety had a concomitant affect on children's anxiety, then those children accompanied by their mother might logically have been more anxious. Secondly, the numbers in the sample are small:

> **"Within the sample, 74% of the children were accompanied by their mother (29 cases) and 26% by their father (10 cases). Thirdly, the sex of the children was highly skewed 92% were male children and 7% female."**
>
> (Messeri et al., 1997: 554)

Thirdly, the points discussed raise questions about father-son and mother-son emotional links for this age group. The researchers took no account of the influence of family dynamics in the choice of parent to accompany the child because in a third of cases the child chose the father to be with them in preference to the mother. Yet the authors use the point that:

> "**Numerous psychological theories suggest that mothers, during their child's illness or hospitalization, take on an important role which is already present at the child's birth and in the first months of life."**
>
> (Messeri et al., 1997: 555-556)

The findings from this literature show that the interactions between mother and child in the peri-operative period are more thoroughly researched than the interaction between father and child.

6.10 Conclusion

This chapter has sought to identify literature, in qualitative and quantitative form, identifying the health practices of fathers toward children with an acute illness. A search of the literature concerning the management of acute childhood illness per se established that there was a paucity of data about fathers. An expanded search of the literature, exploring parent involvement in the management of commonly occurring childhood illnesses / health problems and acute health problems also revealed no work specific to the thesis topic '*men's health practices in dual income families'*. A feature of both systematic reviews is a prolonged and unwavering focus by health researchers and family health experts on the role of the mother. Much of the literature focuses on the relationship between health professionals and the mother (diagnosis, treatment decisions, and consequences of expected outcome), maternal coping and maternal workload.

The scantness of data on fathers is partly explained by a research emphasis on mothers or the study of 'parents', a term that is really a proxy for mothers' health practices. Whilst fathers are included in many studies, their relative small numbers vis a vis total sample size, is an indication of i) either a bias in sample selection or ii) a lack of recognition by researchers for the need to determine the extent of equitable parenting. Research investigating how parents make a decision on the urgency and need for medical consultation is limited to a mother's assessment of the child's health status; this is evidenced by the titles from the following works (Osman & Dunt, 1995; Baker & Taylor, 1997; Cornford et al, 1993; Cunningham-Burley & Maclean, 1987a; Impicciatore, 1998; Irvine & Cunningham-Burley, 1991; Cunningham-Burley & Maclean 1991; Pattison et al., 1982; Thornton, 1991). Consequently, little is known about men's health practices in decision making, diagnosis and the nexus between GPs and fathers. This thesis offers qualitative data identifying that men are involved in this process and offers opportunities for closing this gap in the literature through post doctoral work.

Indentification of a knowledge gap for men's health practices toward children with acute illness provided support for the construction of survey questions that measureing such practices. In the household survey, the Section 2.4 *Typical activities performed for sick children* (e.g. treating fever, administering pain relief,

giving medication, cleaning up vomit) captures health practices commonly required in the care of children with acute illness.

CHAPTER SEVEN:
CHRONIC ILLNESS

7 Introduction

This chapter identifies the prevalence of chronic illness among children and the associated caring workloads, both physical and emotional, for parents. The nature and progression of chronic illness in young people is variable, ranging from the need for minimal parental guidance to debilitating conditions requiring a parent to provide home care for much of the time (Notaras et al., 2002).

An initial literature search sought to identify fathers' health practices using the general term 'chronic illness' and the key words 'infants', 'children' , 'adolescents' and 'fathers'. The electronic searches of the health care data bases CINAHL, Medline, PsychInfo, Family health and sociological literature were supplemented by manual searches; with the time frame of 1960-2005. This search approach is favoured by researchers because it allows for an exploration of common elements (the treatment intensity demanded by the illness, financial costs of treatment, the pattern of illness over time and subsequently the duration of the care) and is therefore better able to provide information that describes family functioning and reflects a view that:

> **"…the similarities between the problems of children with different chronic illnesses greatly outweigh the differences which arise because of the specific nature or treatment needs of individual disorders."**
>
> (Sawyer & Spurrier, 1996 13)

The literature search revealed scant information from quantitative studies for fathers' health practices and descriptive studies made only occasional reference to men's contribution to care (e.g. nocturnal attendance to an ill child or running errands). Highlighted in this literature was the burden of care incurred by mothers. The literature describing the parental experience of living with a child with a chronic illness identified a plethora of health promotional activites, journeying to medical appointments and the need for establishing partnerships between health professionals and mothers.

A secondary search was undertaken to identify men's practices in response to specific chronic illnesses commonly diagnosed in children. The publication "*A picture of Australia's children",* by the Australian Institute of Health and Welfare (AIHW, 2005; AIHW, 2001) reported the highest or rising prevalence of the chronic conditions:

i) asthma,
ii) diabetes, and
iii) atopic dermatitis.

Consequently, these conditions were entered as key words in anticipation of a link with fathers' health practices. The search results are presented in detail for individual conditions within section *7.4 Exemplars of common child illnesses: evaluating parental involvement.*

A feature of both systematic searches were descriptions of the work of mothers, with researchers qualifying this emphasis on the basis that women spend more time with their children and have the appropriate repertoire of health practices. Adjunct to the description of mothers' work are studies and comments identifying the consequences of this burden of care in terms of sleep deprivation, emotional stress and depression. The direct financial cost is compounded by a reduction in opportunities to engage in paid labour as mothers curtail employment so as to be available for direct caring or being on-hand for potential emergencies. Where studies do include fathers the analysis and summation of data is often presented using the term 'parents'; consequently, many researchers have not disaggregated the data into 'mother' and 'father' leaving the reader to assume that parents are homogenous in their perceptions of illness and actions (Laws, 2003b).

7.1 The prevalence of chronic illness among children

Chronic illness has been defined by the Australian Institute of Health and Welfare (2006) as a term applied to a diverse group of diseases …

> **"…that tend to be long-lasting and persistent in their symptoms or development. Although these features also apply to some communicable diseases (infections), the term is usually confined to non-communicable diseases."**
>
> (AIHW, 2006: 466)

and in a later publication:

> **"…an ongoing condition characterised by a diagnosis of a specific physical or mental condition, functional limitation, and service use or need beyond routine care (Sawyer & Aroni 2005; Westbrook et al., 1998)."**
>
> (AIHW, 2007: 36)

Establishing the prevalence of chronic illness provides an indication of opportunities fathers have to engage in health care for their child. Many Western countries encounter substantial problems with establishing the true prevalence of chronic illness among children because of variations between definitions, the method of study and the rarity of some diseases under investigation (Gortmaker & Sappenfield, 1984: 3; Westbrook et al., 1998; Perrin 2002; AIHW, 2007). This makes international comparisons nearly impossible (Suris et al., 2004: 938). At a US gathering of experts, over two decades ago, it was estimated that there are:

> **"one million children and adolescents in the United States with a severe chronic illness and an additional ten million with less serious chronic illness"**
>
> (Symposium on Chronic Disease in Children, 1984)

An aggregate of studies, published the year the Symposium on Chronic Disease in Children was held, suggested a prevalence of 10-20% (Gortmaker & Sappenfield, 1984). More recently, a United States report estimated that 31% of children experienced some form of chronic illness (Jolly, 1990: 10). Raw data from France, Switzerland, and Canada give an estimated prevalence of 10% for chronic illness in school aged adolescents.

Using 1992 Australian data, Boss et al. (1995) emphasize that:

> **"In Australia, boys aged 0-4 and 5-14 experience a greater incidence of serious chronic illness than girls in the same age group (13% and 24% compared to 10% and 16%). In the 15-24 age group, young women are more likely to have a serious chronic illness."**
>
> (Boss et al., 1995: 114)

Data for 2004-2005 show that 63% of young Australians, aged 12-24 years, reported a long-term condition with 34% stating they had multiple long-term conditions (AIHW, 2007). The top three causes of chronic illness are hay fever, allergic rhinitis (14%), short sightedness (12%) and asthma (prevelance is difficult to establish – see Section 7.4.1).

> **"Significant illnesses that are becoming more common or affect a large number of children include diabetes, asthma and mental health problems."**
>
> (AIHW, 2004)

The prevalence of asthma is difficult to establish with certainty because diagnosis may be based on limited symptoms or a combination of symptoms supported by empirical data (e.g. lung function test) (Woolcock et al. 2001). The ABS data from the National Health Survey 2004-2005 show 435,200 young people had asthma, suggesting a prevalence rate of 13% (ABS, 2006). Approximately 11,000 young Australians aged between 15-24 years have diabetes (2004-2005) and there has been a progressive increase in incidence of type 1 diabetes; these developments are consistent with that of overseas studies (Haynes et al., 2004; Taplin et al., 2005; AIHW, 2007). The prevalence of diabetes is estimated to be 0.4%, based on 2004-2005 data but this figure needs to be treated with caution because of the 'high relative standard error' (AIHW, 2007). National indicators of children's health status show that diabetes and obesity are chronic conditions where there is an unfavourable trend in health status (AIHW, 2006) and:

> **"Significant illnesses that are becoming more common or affect a large number of children include diabetes, asthma and mental health problems."**
>
> (AIHW, 2004)

Chronic illness carries with it a substantial risk of acquiring a co morbidity of mental health problems. Chapter seven *Mental Illness*, is devoted to identifying men's health practices towards a child / adolescent with an acute or chronic mental illness. The following data highlights the relative newness of complete data sets for children with mental health problems. The best available data describing the level of mental illness among Australian children comes from the National Survey of Mental Health and Wellbeing conducted in 1998 containing a component focusing on 'child wellbeing'. The survey indicated that for children aged 4-14 years, 15% of boys and 14% of girls had mental health problems (Sawyer et al., 2000). More recently, the Australian Bureau of Statistics (ABS) used parental reports to estimate that 7% of Australia's children aged 0-14 years had long-term mental or behavioural problems (ABS 2006).

7.2 Parental contributions to the child with chronic illness

Although unequivocal empirical evidence is difficult to obtain, most researchers accept that the incidence of chronic illness has not increased in Australia or other Western countries in recent decades. However, prevalence rates for children with chronic illness show a substantial upward trend (Gortmaker & Sappenfield, 1984; Gardner et al., 1997; Karvonen et al., 2000; Svensson et al., 2002; Magnus & Jaakkola, 1997). The increase in prevalence of chronic illness is attributable to medical technology that supports incremental improvements in morbidity and promotes survival. Successful treatment without cure does place more pressure on parents and the children (Draper, 1995).

> **"'Children and adolescents have the highest growth rates of chronic disease prevalence of all population cohorts (Perrin 2002) and it is estimated that over 90% of children born today with a chronic disease will survive beyond the age of 20 (Scal et al. 1999). Improved survival for people with chronic diseases is likely to have a cumulative effect on young people and their families in terms of social, psychological and economic pressures."**
>
> (AIHW, 2007: 36)

A consequence of improved survival rates, as these children make the transition to adulthood, is the rising financial cost of daily care, the rising cost of treatments, and the human cost of providing care. The human cost is aptly captured in Callery's (1997) assessment:

> **"Parents' financial commitment was open-ended... The organization of alternative care for siblings carried social costs including loss of privacy and autonomy in family relationships. Participation in care could be distressing and so result in personal costs."**
>
> (Callery, 1997: 746)

In an effort to reduce the call on public funds, policy changes have effectively shifted much of the care from hospitals into the community and the family home. Policy documents projected that the transference to home care would bring about improvements in the quality of care for the child (Wiseman, 1996). The growth of home care has been substantial in the UK, Canada and in Australia (Baum, 2002; Palmer & Short, 2000). On the basis of an extensive review of the literature Smith and Daughtrey (2000) assert:

> **"It has long been recognized that children should be cared for at home whenever possible. Government reports over the past 40 years have recommended the extension of community nursing services for sick children."**
>
> (Smith & Daughtrey, 2000: 813)

Home care for children with chronic conditions requires both children and parents to up-skill their health practices, coordinate care and monitor health outcomes, much of this taking place on a daily basis. However, parents face competing aspects of care, in that they must provide the necessary protective care whilst at the same time monitoring their child's / adolescent's progress to locate a suitable stage where independence and autonomy can be given.

> **"Parents are held accountable for the adherence behaviours of their teenagers with chronic illness, yet at the same time, adolescents are expected to take increasing responsibility for their own behaviours."**
>
> (Sawyer & Aroni, 2005: 405)

and

> **"Supporting adolescents with chronic illness can be especially challenging for parents and health professionals alike. In comparison with younger children, who generally acquiesce to parental requests around health, young people no longer automatically do what they are told."**
>
> (Sawyer & Aroni, 2005: 405)

Highlighting the complexity of parental attempts to promote a transition to autonomy are studies showing a difference between the emotional and behavioural functioning of young people (aged 12-24 years) with chronic illness compared to those without chronic illness (Rosina et al., 2003). A number of studies also:

> **"Suggest the existence of a subgroup of young people with chronic illness who experience more problems than their peers."**
>
> (Rosina et al, 2003)

In addition to parent child issues many young people have problems establishing a therapeutic and supportive relationship with health care providers.

> **"Young people with chronic illnesses have significant levels of dissatisfaction with the health care they receive; this has the potential to impact on their use of health care services and their health outcomes."**
>
> (Farrant & Watson, 2004: 175)

Closely linked to issues on autonomy and competence for youth coping with a chronic condition is an understanding that co morbid mental health problems affect their ability to adhere to treatments and medication regimes (Rosina et al., 2003). The co morbidity is often manifested in episodes of depression and acts of self harm.

> **"Young people with a chronic illness consistently have been found to experience significantly higher levels of emotional distress and suicidal tendencies than their counterparts (Wainwright, 1995; Kovacs, 1997; De Leo et al., 1999; Druss & Pincus, 2000)."**
>
> (Rosina et al., 2003: 140)

Extended periods of care can also have an emotional consequence for parents and other family members. It is widely accepted that there is: "A cumulative effect on children and their families in terms of social, psychological and economic pressures." (AIHW, 2005:18).

The effect on the wellbeing of families is exemplified by studies showing that chronically ill children and their families are twice as likely to experience psychological or emotional difficulties (Swanston et al., 2000; Cadman et al., 1987). A common finding within family studies is that mothers provide most care from the point of diagnosis onward (Oakley, 1976; Finch & Groves, 1983; Eiser, 1994; Englund et al., 2001; Eiser et al., 1992; Horner, 1998).

In addition, the nexus between the mother and the providers of health services is often incomplete and stressful. Swallow and Jacoby (2001a), in their investigation of mothers' experiences from time of diagnosis and along a protracted clinical pathway, identify major problems in setting up workable relationships with a raft of health professionals. Other researchers reveal a cascade of challenges for parents, including difficulty in accessing information and negotiating roles (Kirk, 2001; Coyne, 1995). Parents feel responsible and are acutely responsible for their children, and yet:

> **"They often lack knowledge, authority, and power in their dealings with the health care system and its medical care providers."**
>
> (Clarke & Fletcher, 2003: 175)

Occasionally researchers report on a father's experience of an encounter with a healthcare professional:

> **"We were advised to call the hospital when our child started wheezing. There [in the emergency unit] we met a physician who knew nothing about asthma and didn't listen to us parents. After that I lost my respect for physicians. We know more about our child than a physician who meets him once a year."**
> (Trollvik & Severinsson, 2004: 95)

Despite the nursing literature emphasising the appropriateness of 'family centred nursing', as a conceptual model of care, there is generally little systematic assessment of parents' needs and the benefits to parents; nurses also differ in their perceptions of parental roles as clients (Callery, 1997; Hopia, 2004). Chambers-Evans et al., (1999) found that although nurses believed they were using a family centred approach they were unsuccessful in promoting the health of families because they did not possess the necessary interviewing skills to elicit relevant information and focus on key issues. In addition, there were substantial "gaps in the clinicians' knowledge of families"; this made nurses question their relationships with patients and their interviewing skills (Chambers-Evans et al., 1999). From the concluding points and recommendations made by Chambers-Evans et al., (1999) it can be deduced that a gender bias exists vis a vis enhancing communication between the nurses and parents. That is, the emphasis in this study was solely on strengthening the mother and female nurse relationship.

> **"We conclude that one of the best ways for nurses to come to know family members and patients is to temporarily suspend the search for interventions and use the kind of relational and interaction strategies, characteristic of woman-to-woman talk".**
> (Chambers-Evans et al., 1999: 1425)

More recently, Shileds et al., (2007) determined, by way of a Cochrane systematic review, that there was very little quantitative evidence to show that family centred nursing approaches were effective in improving health outcomes. The researchers called for a much more stringent examination of the use of family centred care as a model for care delivery to children and families in health services.

Families are increasingly becoming the primary care givers in chronic childhood illness (Stewart et al. 1994); this phenomenon theoretically presents fathers and men within the family with opportunities to identify how they might contribute directly to the care of their child or to take on roles that free up time for their partner / spouse, so as to support their role as carer.

7.3 Searching for evidence of fathers' health practice in chronic illness care

A search for literature identifying men's health practices toward their child with chronic illness was undertaken using two approaches. The first approach searched for health practices in the context of chronic illness per se, revealing little information about fathers, other than their personal adjustment to issues associated with an ongoing health problem within the family. The second search, conducted in response to the scant information found in the first search, focused on men's health practices towards specific illnesses (asthma, diabetes, dermatitis). The illnesses chosen for the search reflected their common prevalence in young children and their troublesome sequelae into late adolescence (AIHW, 2004).

A search of the data bases Blackwell Synergy, Google scholar and Oxford journals, using key words 'child', 'chronic illness' and 'father' resulted in a small number of works leading to the conclusion that those researching families with a child with a chronic illness, more often than not, study only mothers and children. Many researchers do not include fathers because they believe they are not important.

> **"Most research has focused on mothers, fathers continue to be the underrepresented other half of the parent dyad, for as the previous studies indicate, they too have a direct bearing on the psychosocial adjustment of the child and family."**
>
> (Herrick et al, 2004: 584)

Many researchers openly admit there are limitations to their work. For example Swallow and Jacoby (2001:757), having stated that in their methodology "The experiences of children and families are the focus of this research." follow up with the comment: "The main limitations of the study were time constraints, meaning that we were unable to interview fathers." (Swallow & Jacoby, 2001:762).

Those performing literature searches have also noted the scantness of information about fathers. Schmidt et al., (2003) conducted a systematic search of the literature to locate information on how 'parents' cope with a child who has a chronic illness. Using the Medline data base from 1975 to 2001 Schmidt et al., (2003) revealed that only 9 of 391 articles found 'included an assessment of fathers'. However, the nine works identified were not referenced in Schmidt et

al.'s, (2003) publication. Only 14 studies, from Schmidt et al.'s, (2003) search, were found to have assessed children's views on self coping in combination with parents' views on coping. Where studies that use the term 'parents', do not disaggregate the data into 'mother' and 'father' the reader is left to assume that parents are homogenous in their perceptions and actions (Laws, 2003).

A lack of data on fathers' views and experiences represents a major flaw in the literature because research into gender roles and parenting clearly identifies that fathers appreciate and respond to health problems quite differently to mothers (Yeh, 2002; Svavarsdottir, 2005; Lowes et al., 2005; Knafl & Zoeller, 2000; Katz & Krulik, 1999). For example, Antshel et al., (2004) postulated that children with chronic disease may be held to different standards by either parent, relative to those who do not have this type of health problem. Applying attribution theory and sick role theory Antshel et al., (2004:622) found that mothers, by virtue of their daily proximity to the child "were more disturbed affectively by behavioural dysregulation" and fathers, who were generally in less daily contact, "were more disturbed by their child's academic difficulties". Kazar (1987) also found that fathers had more negative affective reactions to their child's academic difficulties than mothers. Antshel et al., (2004) do not consider the possibility that, if fathers took more of a caring role, the men may be more affected by behavioural problems and less concerned about academic matters. Ergo, researchers need to explore gender relations and the effects of role reversal, rather than an ideal set of maternal and paternal perceptions, attitudes and activities. Copeland and Clements (1993) recognised gendered differences in coping and sought to compare fathers' and mothers' perceptions of a child's chronic condition and the strategies they used to support themselves during critical times.

> **"Results showed that, although parental perceptions of the child's chronic condition were similar, their responses to the situation were not the same. Fathers and mothers relied on different strategies to support themselves during critical times."**
>
> (Copeland & Clements, 1993: 109)

There are also differences in support needs:

> **"Only mothers, not fathers, perceived a higher need to be in contact with parents of children in a similar situation to themselves."**
>
> (Irwin, 2004: 75S)

Occasionally within the literature there is recognition of the father's inability to express their concerns; for example Hopiaet al., (2004) recorded that:

> **"The family used non-verbal communication to express themselves. For example, a mother may communicate through facial expressions and gestures her distress at the father's reluctance to discuss feelings caused by the child's illness."**
>
> (Hopia et al., 2004: 579)

Svavarsdottir's (2005) longitudinal study of Icelandic parents' care of their child with cancer, over a two year period, shows these men devoting time to the direct support of their child and other family members, despite commitments to paid employment. The study by Svavarsdottir (2005) provided the most detailed account of men's health practices of all the literature reviewed for this chapter but was limited to summary comments such as:

> **"Fathers' *most time-consuming* caregiving tasks at these three time periods were to provide emotional support for the child with cancer, for other children in the family and for their spouse or partner."**
>
> [italics used as emphasis by Svavarsdottir, 2005]

and

> **"The *most difficult* caregiving tasks experienced by fathers were to provide emotional support for the child with cancer, to manage work outside the home and organize care for the child at the same time, and to provide emotional support for their spouse or partner. Other difficult caregiving activities reported by fathers were to …provide emotional support for other children in the family."**
>
> (Svavarsdottir, 2005: 159)
> [italics used as emphasis by Svavarsdottir, 2005]

The transition from a diagnosis and treatment of cancer to palliative care is accounted for in the Chapter 9 *Terminal illness: Care of the child with life limiting illness.*

Peck and Lillibridge's (2005) investigation of the emotional experiences of rural fathers, who lived with a chronically ill child, echo the findings of the literature search presented in this chapter.

> **"Despite the relative dearth of research regarding fathers of chronically-ill children, increasing evidence indicates that childhood illness has a powerful impact on fathers…Given that, generally, fathers have not been studied in their own right (information comes from the mother's perspective), the stereotypical picture of fathers portrayed in the literature is one of**

> **stoicism and having minimal involvement, often broadening to detachment."**
>
> (Peck & Lillibridge, 2005: 33)

Peck and Lillibridge's (2005) work did not identify any specific health practices by rural fathers. This finding suggests that the interviews with rural men as part of this thesis provide a unique set of data. In consideration of the paucity of data on fathers evidenced by Schmidt et al. (2003) there appears to be sufficient support for extending this search using specific chronic illnesses in children / adolescent.

7.4 Exemplars of chronic illness

The following exemplars of asthma, diabetes and atopic dermatitis have been chosen to describe the effects of chronic illness on parents and their health practices in support of their child because these conditions are the most prevalent among children (AIHW, 2004). Evidence of men's / fathers' health practices is sought within each of these exemplars.

7.4.1 Asthma

Asthma is a chronic disorder affecting the respiratory system and is associated with morbidity and even sudden death among children. In England and Wales combined, around 20 children die from asthma each year (Office for National Statistics, 2001). Approximately 30% of all people with asthma are children aged between 0-14 years (Al-Yaman et al., 2002). Whilst death attributed to asthma is extremely rare in children, 29% (6,653) of all child hospitalizations are for severe asthma. Boys were hospitalised at a higher rate (between 1.6-1.7 times) than girls across all age groups; no explanation was offered by Al-Yaman et al. (2002) for this sex difference.

Although asthma is the most prevalent cause of chronic childhood disability worldwide (Newacheck & Halfon, 2000) the extent of parental involvement in management of childhood asthma is difficult to aggregate because there are variations in diagnosis and / or reporting between countries (McCann et al., 2002; Suris et al., 2004). A systematic comparison of the prevalence of asthma across 56 countries and involving 463,801 children (aged 13-14 years) revealed a striking variation in the recording of symptoms (Lancet, 1998).

> **"For asthma symptoms, the highest 12-month prevalences were from centres in the UK, Australia, New Zealand, and Republic of Ireland, followed by most centres in North, Central, and South America; the lowest prevalences were from centres in several Eastern European countries, Indonesia, Greece, China, Taiwan, Uzbekistan, India, and Ethiopia."**
>
> (Lancet, 1998: 1225)

There are also variations in rates of asthma across time, as exemplified by Australian data.

> **"Asthma management rates rose from 2.4% of all problems managed in 1971 to 7.2% in 1990-91, then fell in 2000-01 to 4.6%."**
>
> (Charles et al., 2004)

As study of 4,550 adolescents in South Western Sydney, Australia, claimed:

> **"The results of this survey found an asthma prevalence among 11-15 year olds of 17.5%, being consistent with previous studies."**
>
> (Forero et al., 1996: 157)

The experiences of parents of children with asthma are linked to their understanding that asthma attacks are largely unpredictable, they affect the child's ability to breathe and can be life threatening. Further, diagnosis is often difficult because of the similarity in symptoms with other respiratory problems and triggers for asthma attacks vary between individuals. Gaining an early diagnosis of the problem, providing emotional support for the child and correct treatment are essential elements in reducing the need for hospitalisation and avoiding mortality (Gibson et al., 1995). These factors impact greatly on parental ability to work, their workload within the family and their emotional resilience. Having a child with asthma creates additional 'burdens' for parents (Lenney, 1997; Townsend et al., 1991). The emotional burden is often expressed as anger.

> **"It was found that every other parent sometimes felt angry that the child had asthma, and 14% of the mothers vs. 8% of the fathers felt angry very often."**
>
> (Dalheim-Englund et al., 2004: 393)

Several studies identify that mothers have the greatest emotional and physical strain (Englund et al., 2001; Osman et al., 2001). And some studies correlate depression in mothers with their ability to cope with the demands of caring for a child with asthma:

> **"Depressive symptoms were also associated with greater emotional distress and interference with daily activities caused by the child's asthma, along with less confidence in asthma**

> **medications, ability to control asthma symptoms, and self-efficacy to cope with acute asthma episodes."**
>
> (Bartlett et al., 2004: 229)

Whilst several studies have attempted to determine if children with asthma suffer from depression reviews of research studies show that the evidence is mixed (Vila et al., 2000; Forero et al., 1996).

It has long been recognised that asthma is a common cause of Quality of Life (QoL) impairment in young people and their parents (Gibson et al., 1995). Dalheim-Englund et al. (2004) used the Paediatric Asthma Caregiver's Quality of Life Questionnaire (PACQLQ) to survey 371 parents of children with asthma (57% mothers and 43% fathers) to determine how their lives were affected; a research question was: 'Does QoL differ between parents within the family?' Overall, the QoL was shown to be less than that of parents of children that did not have this chronic illness. Mothers' lower QoL outcomes were negatively associated with the severity of their child's asthma. Both Dalheim-Englund et al., (2004) and Horner (1998) found that fathers of younger children with asthma scored lower on QoL scales than fathers of older children. Dalheim-Englund et al., (2004) found a good amount of parental agreement on the influence of chronic illness on their QoL. Dalheim-Englund et al., (2004) conclude that although QoL studies are widely used in relation to assessing the burden of care and limitations of asthma placed on family life: "Little is known about aspects which contribute to the wellbeing of parents in their daily lives." (Dalheim-Englund, et al., 2004:394)

Wambolt et al., (1999) found that QoL was better for those parents whose child had responded to medication (steroids) compared to parents whose child did not show improvements. Horner (1998) also suggested that the quality of life of parents with older children was better; this was based on the rationale that parents of younger children need to allocate more time and resources to bring about an initial stabilisation of asthma symptoms.

Caring for a child with asthma interferes with the parents' normal activities and work / family routines. Often young children with chronic conditions attend day care because their parents work. Slack-Smith et al., (2002) surveyed 130 homes providing day care for children and found 18% had been diagnosed with asthma

and "By age 5 years, 26% of the children had had asthma diagnosed by a doctor." (Slack-Smith et al, 2002: 173).

Women often relinquish opportunities for employment so that they can better manage and monitor their child's asthma and be close at hand for potential emergencies (Smith et al., 2000). Widely published evidence suggests that mothers cannot depend on school teachers to competently care for their child with asthma because few teachers receive training about the condition, are not versed in assessment of the condition or are not assessed for competence in administration of anti asthmatic medications or treatment regimes (Gibson et al., 1995; Wong et al., 2004). Although published guidelines on asthma policies exist for Australia and New Zealand, including the use of an emergency 'first aid' kit (with metered dose inhaler for bronchus-dilating medication) there are no randomised trials assessing the effectiveness of emergency inhalers in a school setting (Reading et al, 2003).

There is considerable literature to show that child and adolescent response to chronic illness management falls well below the desired level of competency, particularly with respect to adherence to medications. The ability of a child to comprehend the nature and consequences of self administration medication regimes, based on episodic assessment, is questioned by parents and researchers alike; not only from a pedagogical perspective but also from an understanding that the experience of illness can reduce the quality of judgments made by those affected (Kuttner et al., 1990; Michaud et al., 1991).

> **"When a chronic illness is diagnosed, competence can be severely challenged because of the sustained and multiple disruptions to daily life."**
>
> (Maltby et al., 2003)

The literature just presented echoes parental concerns about safety when the child is at school (Walker & Zeman, 1992). Consequently, there have been calls for a greater synergy between parental expectations of their child self-medication and the health promoting activities within schools (Robinson, 1994).

Although there is substantial research identifying the effects on parents of having to care for a child with chronic illness, as outlined earlier in this section, there is substantially less information on their actual health practices. The actual practicing of health by parents, for a child with asthma, relates to a wide range of

activities including monitoring of peak flows (lung function) to identifing the risk of an attack, reducing exposure to triggers (lawn clippings, dust and animal dander) and the administration of medications. Quantifying parental health practices and their relationship to health outcomes has been assessed but only in relation to mothers. Steroids are commonly prescribed as a means of prophylaxis against increasing severity of asthma symptoms or attacks. For this class of drug to be effective there must be adherence to regular inhalation of the drug. It is difficult to locate any study or expert opinion that seeks to describe the role a father may have in the administration of steroids (aerosols or tablets). The following studies focus exclusively on mothers. Bender et al., (2000) determined that among North American mothers and their children they had achieved, on average, an 80% adherence to the medication regime. However, a weighing of the aerosol canisters used by the children revealed only a 69% adherence.

> **"Older children and adolescents, non-white children, and those from poorer functioning families were least adherent."**
>
> (Bender et al., 2000: 554)

Bartlett et al.'s (2004: 229) study, of inner-city children living in Baltimore, focused on the mental health status of mothers, including their ability to make judgements about asthma medication regimes and administration practices. Mothers experiencing depression were found to have:

> **"Less confidence in asthma medications, ability to control asthma symptoms, and self-efficacy to cope with acute asthma episodes."**
>
> (Bartlett et al., 2004: 229)

However,

> **"Maternal depressive symptoms were not associated with an increase in child asthma morbidity."**
>
> (Bartlett et al., 2004: 229)

In concluding, Bartlett et al. (2004) suggested that a constellation of beliefs and attitudes held by depressed mothers may significantly influence adherence to asthma medications and illness management. Although Peterson-Sweeney et al., (2003) claimed to be assessing 'Parental perceptions' of asthma medication, they interviewed 18 mothers producing only one reference to father's health practices:

> **"In most cases the father was not as involved in the care of asthma for the child but was able to fill in for the mother when needed."**

(Peterson-Sweeney et al., 2003: 121)

Similarly, Kieckhefer and Ratcliffe (2000) claimed to be studying what 'parents' say about their child's asthma using focus groups (*n*=52); there were reports of mothers' activities and views but fathers' were not mentioned.

Trollvik & Severinsson (2004) provide a rare transcript that is a potent indication of a fathers concern over the potential life threatening consequences of asthma attack. The father reported:

> **"I have never slept well since my son's first asthma attack. I wake up at the drop of a needle. I felt so anxious about him when he developed asthma, I was afraid that he would not survive an attack. It was awful, I felt like this every time he had a severe attack. Those times I remember as a nightmare. The first time he had a severe attack it was terrible, I get a pain in my stomach when I think about it. I try to forget it."**
>
> (Trollvik & Severinsson 2004: 97)

Ergo, fear for a child's life is likely to be a key precursor to men wanting to be involved in practicing health skills toward a child with asthma.

7.4.2 Diabetes

Type I diabetes affects a growing number of children and is associated with multiple risk factors including: obesity, maternal stress whilst the child is in utero, males and a diabetic parent (Hypponen et al., 2000; Harjutsalo et al., 2006). The incidence of Type I diabetes is increasing worldwide both in low and high incidence populations (Karvonen et al., 2000; Onkamo et al.; 1999). The highest incidence is found in northern Europe, with clear regional differences (Svensson et al., 2002), and in North America (Green et al., 2001). Diabetes (Type I) is the most common chronic illness of childhood in Australia (Craig et al., 2002). Children with insulin-dependent diabetes mellitus (IDDM) are at risk of long-term micro vascular and neurologic complications such as diabetic retinopathy, nephropathy, and neuropathy and these are a major source of morbidity and mortality.

It has been known for over a decade that intensive insulin therapy, guided by results from a rigorous monitoring of blood glucose levels, effectively delays the onset and progression of major complications for IDDM (New England Journal of Medicine, 1993; Journal of Pediatrics, 1994). There is concern that children in Australia and other Western countries require better management of their blood

glucose levels if they are to avoid serious complications and reduce the risk of adverse events from treatment regimes (Thomsett et al., 1999; Rosilio et al., 1998; Scottish Study Group, 2001).

> **"Many children and adolescents with Type I Diabetes have suboptimal glycaemic control, placing them at high risk of developing microvascular complications."**
>
> (Craig et al., 2002: 235)

However, attempts to achieve improved metabolic control, through more frequent doses of insulin within narrow ranges of BGL, increase the risk of a hypo-glycaemic attack that can progress to a fatal coma.

> **"Hypoglycaemia is the most common acute complication of the treatment of insulin dependent diabetes mellitus (IDDM) and its occurrence often restricts attempts to improve glycaemic control. This is particularly critical for younger patients who may be even more susceptible to severe hypoglycaemia as a result of the interaction of both physiological and behavioural factors."**
>
> (Davis et al., 1998: 111)

Paternal knowledge of the long term complications of IDDM and the possibility of a hypoglycaemic coma weigh heavily on the minds of some fathers; Mellin et al., (2004) found that:

> **"23% were nervous about their daughter experiencing low blood sugar (particularly while sleeping or driving); as one father said: 'It's almost like having a baby in the house, its like 'Go and check and see if she's breathing!'"**
>
> (Mellin et al.; 2004:225)

Mellin et al., (2004) contend that the anxiety of parents is exacerbated by providing them with, what are literally emergency 'survival skills' for their child, immediately after diagnosis.

Most adolescents will, in consideration of their emotional and developmental stage, be directly educated on medication use and appropriate diet. However, education is not a one-time event that occurs at diagnosis for the patient or the parents:

> **"Families and children need ongoing education and support as the child grows and takes on more elements of self-care. Knowledge and skills should be evaluated regularly by the diabetes educator."**
>
> (Silverstein et al., 2005:187).

Importantly, researchers do include parents and perceive them as key factors influencing better control of BGLs (Rosilio et al., 1998; Scottish Study Group,

2001. However, the literature on parental education and support focuses almost exclusively on mothers (Banion et al., 1983; Bobrow et al., 1985; Wysocki et al., 1989; Mellin et al., 2004; Sullivan-Bolyai et al., 2004b). And most recently, Lowes et al., (2005) observed that:

> **"Little is known about the experience of parents of newly diagnosed children as they cope with and adapt to their new situation."**
>
> (Lowes et al., 2005)

What is known about fathers of children with diabetes is they are concerned about the child's use of insulin and the child's ability to monitor their blood glucose level and the risk of morbidity from systematic effects of the condition (Lowes et al., 2005). Sullivan-Bolyai et al., (2004a) report that fathers fear that their child will be stigmatized for using devices to monitor and administer insulin and are concerned that the child may be bullied into letting other children activate the button that administers insulin. These examples indicate that men have substantial anxieties in relation to disease management.

The literature contains a few examples of overview statements on men's direct involvement in their child's diabetic care, for example:

> "**Fathers were actively involved in the day-to-day management and benefited from opportunities to participate in the child's care. They emphasized the importance of practicing the tasks associated with diabetes management to improve their confidence when caring for the child alone."**
>
> (Sullivan-Bolyai et al., 2004a: 316)

Fathers may also play an important role in providing long term emotional support as the physiological problems do not end with the mastering of treatment. Episodes of diabetic ketoacidosis (DKA) and hypoglycaemia, hospitalisations, and emergency department visits have been implicated as causal of adolescent depressed moods. Although Lawence et al., (2006) determined that the overall prevalence of depressed mood among youth with diabetes was: "Similar to that of published estimates of depressed mood among youth without diabetes." (Lawrence et al., 2006: 1348).

Between the first and second year after diagnosis many children exhibit emotional distress because they come to realise that the disease will not go away or improve.

> **"After an initial period of adjustment, children with IDDM have equivalent psychosocial status to children without IDDM, but by 2 years after diagnosis, they have experienced twice the amount of depression and adjustment problems as their peers. Interventions should be aimed at this critical period between 1 and 2 years post-diagnosis."**
>
> (Grey et al, 1995: 1330)

Overall, the literature contains just a few examples of men's reactions to their child's diabetes. Occasionally, these examples take the form of overview statements on men's direct involvement in their child's care but there is little in the way of descriptions of men's actual health practices or quantification of these practices.

7.4.3 Atopic dermatitis

This exemplar is intended to demonstrate that the prevalence of Atopic Dermatitis (AD) among children places parents in a position where they are required to practice health in ways that prevents ongoing exacerbations of AD. Treatment activites are particularly arduous for dual income families who have limited time with children and may require modification of employment commitments so as to take time to control the symptoms and compensate for sleep loss.

Atopic dermatitis is the most common inflammatory skin disorder in preschool children and its chronic nature is the cause of substantial morbidity in young children with a reported prevalence of 15-20% in children (Kay et al., 1994; Kemp, 1999). The prevalence has been calculated as highest in young children with 60% of affected individuals having onset in the first year of life and 85% within the first five years (Rajka, 1989). In emphasising the demands and role of the parent in treatment Thestrup-Pedersen (2002) states that:

> **"Atopic dermatitis (AD) is today the most common, chronic inflammatory skin disease among children in developed countries. Its cumulative prevalence varies from 20% in northern Europe and the USA to approximately 5% in Mediterranean countries. As a chronic disease it puts a special demand on treatment. There is no curative therapy, but competent guidance on treatment principles can control the disease in most, if not all children."**
>
> (Thestrup-Pedersen, 2002: 1)

The disability associated with AD produces significant economic burden reflected in direct medical costs associated with health service utilization, direct family care costs (e.g. transport costs), indirect costs associated with loss of productivity of

carers, and intangible costs associated with the psychological effects of the disease (Emerson et al., 200; Verboom, 2002). Kemp (2003) emphasised the cost to parents in terms of stress:

> **"The factors contributing to family stress include sleep deprivation, loss of employment, time taken for care of atopic dermatitis and financial costs. The financial costs for the family and community include medical and hospital direct costs of treatments and indirect costs from loss of employment."**
>
> (Kemp, 2003: 105)

A Victorian study (Su, 1997), estimated the mean annual, direct financial cost of care, as being Aus$330 for mild, Aus$818 for moderate and Aus$1,255 for severe eczema.

An Australian study estimated that family stress, related to the care of a child with moderate or severe AD, was significantly greater than that of care of children with insulin-dependent diabetes mellitus (Su, 1997: 195). And Moore et al., (2006) noted that sleep deprivation, anxiety and depression were often experienced by mothers as a result of attending to their child's night time comfort needs:

> **"The depression score of mothers looking after a child with eczema was twofold higher than that of mothers looking after a child with asthma."**
>
> (Moore et al., 2006: 516)

Data concerning the impact of AD on fathers and associated health practices was difficult to locate. Consequently, a search of the data base Blackwell Synergy and CINAHL was performed to locate works that mentioned or reviewed a father's involvement in their child's dermatitis. Over 808 journal articles, published between 1995 and 2005, were identified using the key words 'dermatitis' and 'father'. Abstracts from 187 articles were reviewed to determine the context in which the term father was used. The largest proportion of these articles mentioned fathers to indicate the possibility of inheriting AD from the paternal side of the family (Voor et al., 2005; Purvis et al., 2005; Sandström & Faergemann; 2004) yet other studies indicate that mothers were possible transmitters of AD (Böhme et al., 2003). None of the articles revealed information on fathers' direct involvement in care although a score of publications focused on parental issues. Gore et al., (2005) highlight that parental involvement was an important aspect of controlling AD and assert that:

> **"Information needs and preferences in treatment decision-making of parents caring for infants with atopic dermatitis (AD) are unknown, despite emphasis on quality information-giving and involvement of health-care users in treatment decisions."**
>
> (Gore et al., 2005: 938)

Analysis of 31 parent interviews by Gore et al., (2005) lead the researchers to conclude that:

> **"Parents desired verbal *and* written information. Many felt their baby's condition was not taken seriously, leading to delayed diagnosis and treatment."**
>
> (Gore et al., 2005: 939)

However, Gore et al's investigation was couched entirely in terms of assessing the information needs of the mother, despite including fathers in the sample. Gore et al., (2005), declared that:

> **"Thirty-one mothers aged 21-40 years (mean 32 years) were interviewed (two fathers were present during the interview and contributed occasionally)."**
>
> (Gore et al., 2005)

The researchers gave no explanation for the sex bias in their purposeful sampling of parents**.**

Although parental interventions for AD (day and night) have been investigated, the vast majority of studies are post hoc. Reid et al's., (1995) sleep disturbance study found that 'parents' recorded 86% of the relevant nights as disturbed, with an average of 2.7 awakenings per night; as a consequence, parents lost an average of 2.6 hours sleep per night. Successful sleep promoting interventions used by parents tend to be idiosyncratic; unfortunately Reid et al.'s (1995) data was not disaggregated from 'parent' interventions into fathers or mothers interventions. A more recent study makes only one mention of fathers, noting more paternal time spent with children.

> **"Mothers caring for children with atopic eczema lost a median of 39 min of sleep per night and fathers lost 45 min sleep per night".**
>
> (Moore et al., 2005: 514)

Moore et al., (2005) noted that, the younger the child with AD, the greater the number of mother attendances were required for care and comfort.

Thestrup-Pedersen, (2002) summarised the evidence-based knowledge that relates to the treatment of atopic eczema. The article also gave advice and opinions on prophylactic measures "as these are the focus of interest from most parents."

However, the information about fathers was confined to one case report describing:

> **"An 8-year-old boy, whose father from time to time came to collect a prescription for a potent topical steroid, which was used intermittently."**
>
> (Thestrup-Pedersen, 2002: 3)

No account was given of a father's administration of this potentially dangerous medication; there is a precaution warning the person applying the steroid ointment to avoid any contact with their skin.

Although O'Connel's (2004) literature review is aimed at considering the impact and burden major atopic diseases place on children and their families, there is only one mention of the father:

> **"The appearance of the scaly weepy skin of an infant with atopic eczema/ dermatitis may inhibit the normal touching and bonding between the child and the mother and fathers."**
>
> (O'Connel, 2004: 9)

Werner et al., (2002) found a strong positive correlation between the father's social class, as determined by level of education and income, and the prevalence of AD. However, there was no data provided on the father's health practices or contribution / lack of contribution to the child's comfort. The study also identified a positive correlation between the father's length of stay at work:

> **"Children with fathers who worked half-days or were unemployed had a significantly lower risk of AD compared with the other groups of children ($P < 0{\cdot}05$). The same effect was seen for children whose fathers did shift work ($P < 0{\cdot}01$)."**
>
> (Werner et. al., 2002:99)

The question, why underprivileged socioeconomic status was associated with a lower incidence of AD, raised by Werner et al., (2002) was scheduled for further study.

> **"The independent effects of the fathers' duration of daily work and the fathers' shift work cannot exclusively be explained by the socio-economic status. Factors of the living conditions, family interactions and child care, e.g. day nursery are associated with the duration of work."**
>
> (Werner et al., 2002: 102)

Whilst Werner et al., (2002) planned for an exploration of 'family interactions' and 'childcare arrangements', suggesting that fathers would need to be researched

further, the researchers had not openly expressed concern about a father's availability or related health practices.

Emerson et al., (2001) sought to establish the financial cost of caring for pre-school children with AD using a screening questionnaire with an 86·5% response rate (n = 1523 / 1761). The extensive use of quotations in the ensuing paragraphs is because they aptly identify a plethora of parental health practices that could potentially be performed by the father / step father. Nowhere in Emerson et al., (2001) detailing of health practices are fathers mentioned, instead the term 'parent' is used.

> **"Home environment changes comprised the purchase of bedding covers (11%, 32 of 290), cotton clothing (9%, 25 of 290), and other costs, including the purchase of antihouse-dust mite vacuum cleaners, new carpets, damp-proofing, air coolers and a humidifier (2%, seven of 290). Parents stated that they had purchased synthetic pillows and bedding covers to reduce their child's exposure to the house-dust mite. Most said that this was on recommendation of their local pharmacist, GP or friends/family."**
>
> (Emerson et al., 2001: 520)

Parents' health practices extended to the performance of extra household duties.

> **"Many parents (57%, 156 of 290) reported that they vacuumed their child's bedroom more than twice weekly; however, only 5% (16 of 290) stated that this had increased because of their child's AD. Marginal clothing and laundry costs were mainly due to the purchase of cotton vests, shirts and underwear. The frequency of washing laundry was only increased in a few families (3%, nine of 290) because of their child's AD, although 32% (93 of 290) stated that they had preferentially changed to a non-biological washing powder. This change to a non-biological washing powder seemed to be based on the perception that this type of powder was more 'skin friendly' rather than on any specific recommendation by health personnel."**
>
> (Emerson et al., 2001: 520)

Journeying to purchase medications and pharmacy products to alleviate symptoms, were also common parental tasks.

> **"OTC medicines comprised emollients (33%, 95 of 290), bath preparations (4%, 12 of 290) and dietary products (1%, four of 290), including goat milk and soya milk. Only one child was treated with 1% hydrocortisone cream obtained from a pharmacy without a prescription and in this case the child's father was a local dispensing pharmacist. Few parents (4%, 11 of 290) visited a homoeopath or an alternative practitioner; however, the relative**

> **cost of these visits was high (£1,560 in total), with one family reported to have spent £625 in the previous 12 months. Transport costs were incurred by 48% (138 of 290) of families for visits to primary care, secondary care or the pharmacist."**
>
> (Emerson et al., 2001: 520)

The time taken from work commitments and given to direct care is a clear indication of the burden incurred by parents in dual income families. Salary loss was estimated based on the number of lost working days for parents (17 days lost in total). In the previous 12 months, 5% (14 / 290) of parents had taken time off work to care for their child's AD. Private specialist consultation costs were incurred by 1% (4 of 290) of parents, and all of these were due to consultations with local dermatologists. In total, there were 10 new and follow-up private consultations costing a total of £568 (maximum individual annual cost of £180). (Emerson et al., 2001:520).

Su's (1997) study of the financial burden borne by parents made a single reference to a father's journeying to medical consultations:

> **"One father was retrenched for taking too much time off work to bring his child for medical care."**
>
> (Su, 1997: 161)

Arvola et al.'s (2000) study of 81 children in Finland who were identified as being at high risk of AD, aimed to gather information on causative factors and interventions used by 'parents' through the use two consecutive questionnaires. Within this data are aspects of parental workload. For example, there was treatment of symptoms, day and night, expressed as:

> **"Ninety per cent of parents found the care of an atopic infant more demanding than that of a healthy child. This was because of the persistence of symptoms, such as atopic eczema and pruritus, and restlessness during sleep."**
>
> (Arvola et al., 2000)

However, there was no mention of fathers or identification of who performed the tasks.

Overall the detailed search of Blackwell Synergy using the Key words 'dermatitis' and 'father' revealed 187 articles but there were no works containing information about father specific health practices. The comments by Staab et al., (2002) perhaps best indicate why this might be. Although Staab et al. (2002) studied 204 parents to determine if a structured educational program covering

medical, nutritional, and psychological issues assisted in reducing problems with AD there was no data on fathers. Staab (2002) comments that:

> **"As mothers were the primary caregivers in most families, the impact of disease was more severe for mothers than for fathers. For this reason, results are presented only from mothers."**
>
> (Staab et al., 2002:88)

More recently, Gore et al., (2005) assert that:

> **"Atopic dermatitis (AD) in childhood has increased steadily in the last four decades from a prevalence of 5% in the 1960s to a prevalence of 25% in the new millennium. However, data on parents' experiences when looking after a child, especially an infant with AD is scarce."**
>
> (Gore et al., 2005:938)

Despite this scarcity of parental data Gore et al., (2005) used purposeful sampling resulting in an over representation of mothers. Ergo, the data produced indicates that this was a study of the information needs of 'mothers' not 'parents'. In addition, there are studies focusing solely on mothers (Elliot et al., 1997) but no study focused solely on fathers. These findings indicate a gap in the literature concerning men's health practices for young children with dermatitis.

7.5 Conclusion

The literature on fathers' experiences of their child's diagnosis and treatment of chronic illness is scant; what information exists pertains mostly to their emotional responses towards the diagnosis of chronic illness and the effects on the psyche and life choices of their affected offspring (Katz & Krulik, 1999; Lillibridge, 200; Antshel et al., 2004). However, burgeoning literature on this topic reflects the increasing need for health professionals to have knowledge of both parents' needs and perceptions (Pelchat et al., 2007). The second finding from the literature search is the identification of a gap concerning the actual health practices of fathers performed towards their child with a chronic illness. Without this knowledge many researchers will continue to assume that the best understanding of parental commitment and competence in care can be gained from researching mothers (Swallow & Jacoby 2001a; Swallow & Jacoby, 2001b). This chapter has focused on chronic illness that is physical in nature; the next chapter *Mental illness* focuses on mental health problems that are most often chronic in nature.

The findings presented in this chapter support the inclusion of questions in the household survey that assess the presence of chronic illness within the family; this occurs in Section 3.3 *Health problems in your family at present*. Men's knowledge of health topics is explored in Section 3.1 *Knowledge of health and practice* and responses can be linked to chronic health issues. As chronic illness often requires pharmacological treatment, there is a section in the survey questioning parents' involvement in this form of treatment [Section 3.4 *Children and medications*].

CHAPTER EIGHT: MENTAL ILLNESS

8 Introduction

This chapter identifies the prevalence of mental health problems in children and adolescents to indicate the need for fathers to possess mental health practices. In support of this claim, health authorities have stated that parents are responsible for assessing their child's mental health status and referral to a mental health professional (MHP) if required. However, mental health literacy is not high in Australia and similar populations.

A systematic search of the literature was undertaken to locate what men do for their sons and daughters to i) promote help-seeking, ii) gain a diagnosis, iii) establish a partnership with mental health professionals, iv) assist in making informed choices on treatment options and v) provide long term emotional support. The search used the terms 'mental illness,' 'mental health problem,' and the key words 'children,' 'adolescents' and 'fathers'. Added to this was the key word 'medication' because most diagnosed child and adolescent mental health problems require prescribed medication to be delivered and monitored by parents. The electronic searches of the health care data bases CINAHL, Medline, PsychInfo, Family Health and sociological literature were supplemented by manual searches; with the time frame of 1960-2005. Where appropriate, quotations from psychologists and mental health professionals are used in this chapter to highlight the lack of literature pertaining to fathers' health practices.

As the initial literature search revealed scant information, a secondary search was undertaken to identify men's practices in response to specific diagnosable mental illness commonly emerging in children and adolescents. The specific diagnoses of depression (Ellis, 2004), anxiety disorder, attention deficit hyperactivity disorder and self harm (Burns et al., 2005) were chosen for the search on the basis of their higher prevalence in young people (Australian Institute of Health and Welfare, 2007a). Although suicide is a statistical rarity in children and adolescents (Schmidt et al., 2002) the topic was included in the literature search because of the substantial number of life years lost, the number of immediate

family members and peers affected and the strong links between acts of self-harm and suicide. The context of health service delivery, problems with diagnosis and debate over the efficacy of treatments have been identified in this chapter because they provide the context for understanding the difficulties faced by parents as they struggle to obtain some certainty in their care of a child / adolescent with a mental health problems.

8.1 Background

This section establishes that behavioural problems and formal psychiatric diagnosis are not uncommon among Australian children and adolescents. The highest prevalence of mental health disorders occurs in those aged between 16-25 years (Australian Department of Health and Ageing, 2004). The majority of serious mental disorders begin before the age of 25 years and result in a lifetime's reduction in economic productivity and quality of life (Hickie, 2007). The mental health co morbidity, caused by drug and alcohol use among young people, is a major public health problem within Australia and countries with similar social and economic structures. Many fathers are involved in mental health practices for their child as he / she moves into adulthood (Howard, 1998).

Fathers of children with mental health problems face challenges brought on by a society that does not have a level of mental health literacy adequate for the comprehension of the true nature of the illness and many fathers must negotiate with health professionals who also do not have appropriate mental health skills. A substantial number of researchers identify that health professionals' attitudes towards mental health problems are an under researched area yet the personal attributes of these professionals play a crucial role in determining the standards of care provided and subsequent health outcomes (Hadden et al., 2005; Friedman et al., 2006; Hazell et al., 1999); these points are particularly relevant to older children and young adults (Anderson & Standen, 2007). The author of this doctoral research has raised the issue that the development of empathetic attitudes towards those with mental health problems and their carers is an important challenge for health professionals (Laws, 2006) and that mental health literacy is often lacking amongst generalist nurses and other heath professionals (Laws & Rouse, 1996).

Over several decades, mental health services and partnerships between carers and mental health professionals have been reported by researchers as largely inadequate for supporting families who have a young person suffering from a psychiatric illness (Burdekin, 1993; Australian Department of Health and Aging, 2004).

> **"Little since the Burdekin Report has changed save the process of deinstitutionalisation has hastened."**
>
> (Not for Service: Experiences of injustice and despair in Mental Health care in Australia, 2005: 34)

Debates on treatment practices are prominent, often focusing on their questionable efficacy (Carr & Boyd, 2003; Vasa et al., 2006; Watanabe et al., 2007; Weisz et al., 2006). This state of play places a substantial burden on parents who have a caring responsibility thrust upon them. To date, the bulk of the literature emphasises the workload assumed by mothers in their care of a child with a behavioural problem or formal diagnosis of a mental illness.

8.2 Prevalence of mental health problems in young Australians

Determining the extent of life long mental health problems in the Australian population has been a protracted process, initially reliant on several small studies that suggested a prevalence of between 14% and 18% (Sawyer et al., 1990; Connell et al., 1982; Zubrick, et al., 1995). The first national population mental health survey of adult Australians was published in 1998 showing a prevalence of 18% (Australian Bureau of Statistics 1998). The life time probability of requiring assistance from a Mental Health Professional (MHP) is high.

> **"It is estimated that close to one in five people in Australia will be affected by a mental health problem at some stage in their lives (Commonwealth Department of Health and Aged Care & AIHW 1999), including 14-20% of children and adolescents (Zubrick et al., 1995; Sawyer et al., 2000)."**
>
> (Commonwealth Department of Health and Aged Care 2000a: 4)

Although it is estimated that three million Australians have psychological problems requiring assessment, a large portion do not seek medical help and therefore may not be represented in population data (Harrison & Britt, 2004).

The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing was the largest study of the mental health status of young people (aged 4-17 years) ever conducted in Australia and "one of the few national studies

to be conducted in the world" (Sawyer et al., 2001). This national survey found that half a million Australians (14%), aged between 4 and 17 years have serious emotional and behavioural problems (Sawyer et al., 2000). However, the true prevalence is likely to be higher as there is general reluctance among MHP to make a formal diagnosis because it may label the individual in a way that makes them vulnerable to the social stigma associated with mental health illness (Richardson, 2001). Good evidence of the hidden prevalence of illness came from a unique Finnish study, where 2,347 Finnish born boys underwent psychological assessment at age eight and again at 18 years; the later assessment occurred in conjunction with a medical examination for compulsory military service. Although 4.6% of these boys were recognized as having a psychiatric disorder, only a small minority of these adolescents had had the problem recognized within the health service (Sourander et al., 2005).

Without periodic nationally representative samples, policy makers and social planners are dependent on data collected by health services but not all children / adolescents in need of help present to a health service. The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing reported that only 25% of the children that had scored in the clinical range (in need of help) had attended a mental health service. Of those parents reporting that they needed professional help to assist with their child's behavioural problem, only 45% had attended a mental health service (Sawyer et al., 2000). Australian data suggests that a quarter of young people in need of emotional help receive it (Rey, 2001). Parents who have a child with an intellectual or physical disability often face the burden of mental health co morbidity (Feldman et al., 2004). In the U.S. there are eight million children with disabilities nationwide and two in five have a mental health problem, yet only 41.8% of those aged 6-17 years received mental health services (Witt et al., 2003). Sayal's (2006) systematic review of the literature, focusing on access to mental health services, revealed barriers involving parental perceptions of illness and difficulties in expressing concerns within the consultation process; other barriers included a lack of knowledge on where to get help and cost of service.

Australian prevalence figures for mental health problems are comparable with similar population studies in the UK (Ford et al., 2007a). It is difficult to

compare Australian prevalence studies with the North American population because there have been no national epidemiological studies of mental disorders in American children. However, the American Psychiatric Association (1992) estimates that there are upwards of 12 million American children suffering from some form of mental illness. Those proposing a national action agenda are assuming that 20% of children under 18 years have symptoms of one or more mental disorders and about half of these are seriously disturbed (Scahill, 2002; Scharer, 2005). Importantly, the presence of psychopathology in adolescence should not be regarded as normative. Ferdinand and Verhulst (1995) conducted an eight year follow up 459 young people and determined adolescent problems tended to persist into young adulthood to a moderate degree and found:

> **"High rates of withdrawal from social contacts, anxiety or depression, somatic complaints without known medical origin, social problems, attention problems, delinquent behavior, and aggressive behavior during adolescence were risk factors for specific types of psychopathology and maladjustment at 8 year follow-up."**
>
> (Ferdinand & Verhulst, 1995: 1586)

Early childhood behavioural problems often lead to a formal diagnosis in early adulthood indicating that the burden of disease associated with mental illness can be substantial and lifelong for both the individual and their parents.

8.3 Who is ultimately responsible for the mental health of children?

Having established that a substantial number of children and young people have, either a serious emotional problem or a formal diagnosis of mental illness it can be assumed that men living with children, as parent or guardian, may take part in referral of a child / adolescent to a mental health professional (MHP) for the purpose of assessment. If a diagnosis is made and treatment commenced, fathers / guardians may practice behavioural surveillance, mental health assessment, provide emotional support and medication administration for an offspring who has a behavioural disorder or mental illness. According to the United States government, the responsibility for the emotional wellbeing of a child and young persons and the care of these individuals, should mental illness strike, is ultimately the responsibility of parents and the family.

> **"Responsibilities for children's mental healthcare are dispersed across multiple systems: schools, primary care, the juvenile justice system, child welfare and substance abuse treatment. But the first system is the family, and this agenda reflects the voices of youth and family."**
>
> (United States Public Health Service, Foreward to: Report of the Surgeon General's conference on children's mental health, 2000)

When a child is discharged / separated from a US hospital, following an episode of acute mental illness, it is the parents who are expected to resume the care of that child; the parents must subsequently make plans for follow-up care, employ appropriate behavioral management practices within the home, decide on options for schooling / education and locate reliable sources of emotional support (Scharer, 2005). The Australian government does not outline parental responsibilities for on-going care but states:

> **"The parent/guardian/carer of a child or adolescent has a responsibility to obtain appropriate professional assistance if they have reason to believe that the child may have a mental health problem."**
>
> (Department of Health and Aging, 2008: 18)

This statement gives a clear indication of a parent's role in the referral of a child to a health professional; this topic is explored in section *8.10 Fathers' ability to engender help seeking.*

8.4 Burden experienced by those with mental illness

According to the Global Burden of Disease Study, the worldwide burden of disease, caused by mental health problems and mental disorders, has been seriously underestimated, (Murray & Lopez 1996). The US Report of the Surgeon General's Conference on Children's Mental Health opened by stating:

> **"The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country."**
>
> (U.S. Public Health Service, 2000)

In Australia, in 1996, mental disorders accounted for 30% of the non-fatal disease burden in Australia. (Commonwealth Department of Health and Aged Care, 2000a) and mental disorders are now the third leading cause of burden of illness after cardiovascular diseases and cancers (Mathers et al., 1999). In 2003, it was estimated that there was just over 155,500 years of 'healthy' life lost (Years Lived with Disability - YLD) because of mental disabilities in young people and

diagnosed mental disorders were the leading contributor to years of 'healthy' life lost, accounting for 61% of this non-fatal burden of disease (AIHW, 2007b).

> **"Anxiety and depression is the leading cause of burden of disease for young Australians, accounting for 17% of the male burden and 32% of the female burden."**
>
> (AIHW, 2007b: 21)

Concomitant with the potential life costs for young people are the costs and emotional burdens experienced by their carers. In a commentary on *"The mental health of young people in Australia"* Birleson et al., (2000) and Sawyer et al., (2001) highlight that child and adolescent mental health problems are an important public health problem with substantial life time burdens that impact on the quality of life of both the young people experiencing mental health problems as well as members of their immediate family.

8.5 Burden experienced by fathers and mothers

Less than a decade ago, Angold et al., (1998) contended that although paediatric chronic physical illness and adult psychiatric disorders are recognised as being substantial sources of burden for family care-takers in North American populations, little attention has been paid to parental burden resulting from children's or adolescents' psychiatric disorders (Angold et al., 1998: 75). More recently, the parental burdens associated with the care of children and young people with mental health problems have become prominent in the literature (Godress et al., 2005; Birleson et al., 2000; Caughlin & Malis, 2004). Gaining objective and measurable data has been a challenge. Both objective and subjective burdens are recorded in the literature within themes that describe, constant help seeking for their child, lack of clarity in identifying the cause(s) of the illness, exhibiting of symptoms that cause parental distress and the stigma of mental illness in the family being born by the parents (Caughlin & Malis, 2004). Ivarsson et al., (2004) validated objective parental burdens in terms of perceived problems and changes to family; for example: changes to household routines, relationships, and leisure time occurred because of the unpredictable time frames needed for care giving. Subjective burdens were viewed as emotional challenges and alterations to mental health status of family caregivers, linked to prolonged and intense feelings of guilt, feelings of loss, and anxiety. In addition, emotional

exhaustion is a burden often experienced by parents as a consequence of seeking to reconcile the appropriateness of their own management strategies.

> **"Parents talked sadly about holding down their child, restraining them, and sometimes, in frustration, hitting the child ...Parents expressed deep regret at resorting to these extreme measures, which were dissonant to their parental role and seemed to indicate how bizarre life had become."**
>
> (Delaney & Engels-Scianna, 1996: 23)

Emotional exhaustion has also been linked to the loss of friendship networks as a result of i) the child's unsociable behaviour and ii) having to allocate time to monitor the child or occupy his / her attention (Delaney & Engels-Scianna, 1996).

There is a plethora of literature identifying that parents who have a child / adolescent with schizophrenia find cohabitation emotionally stressful and burdensome. Few studies have explored gender issues related to the emotional burdens; it has been widely assumed that because mothers spend more time with the child affected by schizophrenia, that women bear a greater portion of the burden. A rare study, conducted by Davis and Schultz (1998) aimed to validate the presence of grief among Australian fathers and mothers; the work was based on the premise that:

> **"The unwitting use of female-centred understanding of parental bereavement may fail to adequately measure fathers' grief work."**
>
> (Davis & Schultz, 1998: 371)

Using 16 mother - father dyads, to explore their experiences of a children with schizophrenia, Davis and Schultz (1998) determined that both parents exhibited a substantial amount of grief over their child's impaired wellbeing; with both mothers (with higher contact hours) and fathers (with lower contact hours) experiencing similarly troublesome measures of thought-intrusion related to their child's behaviour. However, "there were no significant differences between the grief reactions of mothers and fathers" and the number of contact hours with the child had only "a minimal influence on mothers and fathers grieving" (Davis & Schultz, 1998: 374 -375). Ergo, further exploration of possible gender difference is warranted as a basis for the development of emotional support, for both fathers and mothers.

Considerable effort is also expended by parents in support of other family members. Parents worry about the physical safety of siblings and the emotional

effects of them witnessing the tensions and discord played out within the home. Parents also fear neglecting a sibling's needs by prioritising resources and their time toward the child most immediately in need of their support (Delaney & Engels-Scianna, 1996). Overall, the vast majority of literature identifying objective and subjective parental burdens do not disaggregate the data into father / mother burdens.

8.6 The stigma of mental illness

There are few records of fathers making efforts to protect their child from the stigma of mental illness but the long term consequences of such social prejudice are well noted by governments and policy makers (Hinshaw & Cicchetti, 2000). A lack of knowledge and low mental health literacy in the general population contribute greatly to a society's development of negative stereotypes of those with mental health problems. A stigma is shaped as people develop uninformed means of coping with those who show abnormal or embarrassing behaviour. The development of evidence based strategies, to reduce the stereotyping of individuals as unpredictable and dangerous, appears to be particularly important in reducing the discrimination faced by those with schizophrenia (Angermeyer & Beck, 2003). A common sense of distrust of all persons with a mental health problem can lead people to avoid socializing with, working with and living among those affected. Despite anti-discrimination legislation, discrimination extends to not employing or renting accommodation to those with mental illness. These experiences can erode an individual's personal dignity, lower their self esteem and contribute to a worsening of their mental health state. The stigma of mental illness often results in economic and social isolation and a sense of increasing hopelessness for the individual (US Dept H&HS, 1999). In addition children are often feared because they exhibit symptoms of mental illness (Pescosolido et al., 2007a).

The historical division of hospitals and health services into specific treatment centres for physical and psychological illness has contributed to a lack of knowledge and some of the stereotyping (US Dept H&HS, 1999).

> **"Despite the importance of stigma, there have been few systematic national studies of the prevalence and nature of public attitudes to mental illness."**

(Griffiths et al., 2006: 2)

In a rare cross national comparison of attitudes towards those with mental illness Griffiths et al.'s, (2006) study used vignettes to describe persons with depression; depression with suicidal ideation; early schizophrenia; and chronic schizophrenia to explore the perceptions of the Japanese and Australian public. Although there was little evidence of a difference in stigma for depression, with and without suicide for either country, negative attitudes across the range of illnesses were greater among the Japanese public. Neither Griffith et al.'s (2006) cultural work, nor similar research in German populations (Dietrich et al., 2004), offers any clear pathways for developing anti-stigma interventions aimed at reducing discrimination. Consequently, fathers across a range of cultures face similar hardship in their attempts to shield their children from the social distancing that takes place as a consequence of the stigma associated with mental illness (Pescosolido, 2007).

8.7 Drug induced mental health problems in young people

Young adults with mental health problems frequently use drugs of dependence. Drug use either predicates mental health problems (psychosis, anxiety) or people with mental health problems use non-prescription drugs (alcohol, cannabis, amphetamines) to combat symptoms of their illness. The high prevalence of co morbidity between drug use and mental health problems has long been recognized at national level (National Drug Strategic Framework 1998-99 to 2003-04; Ministerial Council on Drug Strategy, 1998; Ministerial Council on Drug Strategy, 2004). There is a strong association between drug use and mental illness for the population of youth in detention (Letters & Stathis, 2004) with some studies showing that up to 60% of detainees meet the criteria for a psychiatric illness (Roger et al., 2006; Bickel et al., 2002). Cannabis and amphetamines are strongly linked to psychosis and youth's consumption of these drugs is on the increase.

> **"There was a steep rise in the prevalence of cannabis use in Australia over the past 30 years and a corresponding decrease in the age of initiation of cannabis use."**

(Degenhardt et al., 2003: 37)

Australia is among the 'top dozen countries', in the world, for the prevalence of methamphetamine use (Fulde & Wodak, 2007). Approximately 1.8 million

Australians (9%) stated they had taken methamphetamine at some time and an estimated half a million (3.2%), aged 14 years and older, reported ongoing use of the drug (AIHW, 2004b).

The potential for high doses of cannabis to trigger a short-lived psychotic episode has been established (Degenhardt, Hall, & Lynskey, 2003) and there is good evidence to suggest that cannabis use may trigger psychosis for those with pre-existing schizophrenia or family history of schizophrenia (Degenhardt, Roxburgh & McKetin 2007; Hall 2006). A systematic review of 35 longitudinal and population based studies conducted by Moore et al. (2007) found an increased risk of a psychotic episode in individuals who had ever used cannabis and there was a higher risk among those who used cannabis more frequently (dose-response effect). Regular intake of cannabis smoke increased the risk of developing a psychotic illness later on in life by more than 40% (Moore et al., 2007).

The association between cannabis and psychosis is worrying because a longitudinal cohort study (n=2032), analysed by Coffey et al., (2002) in 1998, concludes that cannabis use appears to be normative behaviour among younger Australians with:

> **"59% reported life-time use of cannabis, 17% used at least weekly and 7% (11% males, 4% females) met criteria for cannabis dependence."**
>
> (Coffey et al., 2002: 187)

Coffey et al., (2002) concluded that a further study of cannabis dependence, as an important and distinct disorder in young adults, is required.

Amphetamine use in Australia is a major public health problem. A longitudinal Australian study followed students' use of amphetamines, from age 14-15 years through until they reached 24-25 years; revealing that at age 24 years 12% had used amphetamines in the previous year and 1-2% had used this drug at least weekly (Degenhardt, Roxburgh, McKetin, 2007). From 1999-2000 to 2003-2004, amphetamines accounted for the largest proportion of all drug-induced psychosis detected by hospital staff. Hospital separations (discharge data) denoted as drug-induced psychosis remain a concern for those aged 10-19 years. (The term 'drug-induced' is used for consistency with International Classification of Diseases ICD-10 nomenclature.) Age-specific rates among the 10-19-year age group for amphetamine-induced psychosis and cannabis-induced psychosis were 41.6-61.9

and 80.5-111.1 separations per million respectively (Degenhardt, Roxburgh, McKetin, 2007). Although the rate appears low, relative to older age groups, the life time of disability is often substantial for individuals and their carers.

Governments in several countries have created specific initiatives to inform parents of the risk of drug use and have developed strategies to assist parents in the creation of open dialogue discussions with their adolescent child on drug related topics (Kemp, 2002; DEST, 2000; Office of the National Drug Control Policy; Directgov, 2007). These initiatives, along with a growing public awareness of drug related problems, indicate that many fathers may practice health promotion within the home to deter their child / children from drug use. An analysis of fathers' role in influencing adolescent drug use / abstinence is provided in Chapter 10: *Health promotion*.

8.8 Fathers' mental health promotion practices within the family

Benevolent fathers who are free from psychopathology are able to influence their child's emotional wellbeing in ways that may be protective against their child acquiring a mental health problem (Flouri & Buchanan, 2003).

8.8.1 Fathers' mental health as a contributor to child wellbeing

There exists detailed and longstanding literature linking men's personal behavioural problems and psychopathology to high rates of mental illness and emotional distress in their biological offspring with whom they have lived (Jaffee et al., 2006; Digan et al., 2007, Low & Stocker C 2005; Timko et al., 2000; Capaldi et al., 2007; McMahon & Rounsaville, 2002; Dogan et al., 2007; Low & Stocker, 2005; Timko et al., 2002; Scaife, 2007). And although there are policy initiatives to improve the social capital of fathers it is recognised by those working with men that "some fathers they are targeting have characteristics that may not be conducive to increased involvement" with their children (Waller & Swisher, 2006). Despite the emphasis on problem behaviours of fathers it is widely recognised that:

> **"Both maternal and paternal psychopathology serves as risk factors for the development of children's and adolescents' emotional and behavioral problems."**
>
> (Phases et al 2005: 632)

Quite apart from the negative influence men may have on their child's mental health status, this section focuses on identifying positive aspects of father to child relationships that can be directly linked to an improved sense of wellbeing. Notably, there are substantial gaps in our knowledge of fathers' in-family behaviours as far back as the early 1990s. And researchers in psychology note that conceptualisations about men's parenting behaviours are sparse compared to studies of mothering (Barber et al., 2005; Amato, 1998).

> **"Conceptualisations about men's behaviours in and attitudes toward families are still sparse compared to studies of mothering and family processes more generally. This lack of emphasis on fathering is especially unfortunate given that father involvement has been shown to make a unique contribution to positive child outcomes."**
>
> (Amato, 1998: 252)

Linked to the phenomenon of sparseness, is an understanding among key researchers, that no grand unifying theory of fatherhood exists to effectively guide research on fathering behaviours; nor is there a long standing theoretical tradition of the sort that gave rise to the past 50 years of studies on infant - mother attachment (Roggman et al., 2002). With the result that: "Father involvement… has received limited attention in recent psychological research."(Cabrera et al., 2000: 127)

For many years research on children's development and wellbeing focused on the dynamics between mothers and their children (Bowley, 1982). Fathers were often assumed to be on the periphery of children's lives and so, of little direct importance to children's emotional development.

> **"This lack of emphasis on the role of fathering in child development and wellbeing is especially unfortunate given that there are several reasons why one should expect fathers to be particularly significant in children's mental health outcomes."**
>
> (Flouri & Buchanan, 2003: 64)

In view of this state of play psychologists have, over the past 10 years, produced diverse descriptions of the many roles fathers play in their child's behavioural and emotional regulation, cognitive development, peer relations, and academic achievement, (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000; Lamb, 1997, 2004; Tamis-LeMonda & Cabrera, 2002). However, no study measures the way men overtly and positively practice parental - child interactions

with the aim of promoting their child's mental health. A recent analysis of "Converging trends in family research and pediatrics" conducted in the United States (Wertlieb, 2003), denoted fathers' health risk behaviour (smoking, drinking, being overweight, exercising insufficiently, driving after drinking) as influencing their children but made no mention of any emotional support or protective activities against mental health problems. Some researchers seek to predict if emotionally supportive parenting can be transmitted through generations. However, much of this work focuses on mothers' parenting styles and what occurs in the time they spend with children (Huston & Arinson, 2005).

There is scant data on groups of men with similar socio-demographic profiles. For example, a literature search on low income men by Tamis-LeMonda et al., (2004) revealed only three studies and although this research show positive outcomes from early father-child interactions 'they did not explore patterns of influence over time.' Tamis-LeMonda et al., (2004) subsequently, reasoned that inadequate education, unstable employment, and limited resources often make it difficult for fathers on low income to: "Establish and maintain positive and emotionally supportive relationships with their children." (Tamis-LeMonda et al., 2004:1806).

The nexus between research findings and effective support strategies for fathers remains tenuous. Despite limited data on fathers, some researchers make the untenable claim that their work:

> **"Helps mental health professionals bridge scientific theories to application and practice that teach fathers how to positively influence their children's development."**
>
> (Lamb, 2004 -Web site)

8.8.2 Fathers' effects on their children's emotional wellbeing

Despite the methodological difficulties outlined above numerous studies conclude that in general, contact with fathers has a largely positive effect on a child's emotional development, sense of wellbeing and achieving important developmental milestones (Amato, 1994; Amato, 1999; Radin, 1981; Rohner & Veneziano, 2001; Flouri & Buchanan, 2002b). A father's parenting has also been positively associated with a child's positive view of self as well as being able to form close relationships outside the family (Dalton et al., 2006; Belsky et al.,

2005). The works just cited suggest that many men do practice emotional intelligence and behavioural interventions as a means of promotion of their child's wellbeing and averting mental health problems.

In a rare study of fathers, Belsky et al. (2005) used longitudinal data across three phases of development (early childhood, middle childhood, early adolescence), to determine if a history of father and mother parenting styles could achieve 'intergenerational transmission', by testing the prediction that a romantic or harsh parenting style could be replicated. The data was collected from more than 200 New Zealand men and women, and analysis repeatedly led to the finding that:

> **"We could only detect effects of childrearing history on mothering, as neither childrearing history nor romantic relationship quality predicted warm-sensitive-stimulating fathering."**
>
> (Belsky et al., 2005: 395)

Rohner and Veneziano (2001), having reviewed evidence from six categories of empirical studies showing the influence of a father's love on children's development and young adults' social, emotional, cognitive development and functioning concluded that:

> **"Father love appears to be as heavily implicated as mother love in offsprings' psychological wellbeing and health."**
>
> (Rohner & Veneziano 2001: 382)

Although Belsky et al., (2005) were not able to demonstrate the transmission of fathering style (warm-sensitive-stimulating fathering) across generations of fathers, Rohner and Veneziano's (2001) findings strongly support the idea that individual fathers have the ability to promote 'psychological wellbeing and health' into the next generation, through a loving relationship with their child.

8.8.3 Stepfathers and non-resident fathers

The literature reviewed for this section supports the assumption that biological fathers are contributors to the emotional wellbeing of children. However, the literature on effect of a male guardian / step father cohabitating with children is scant, with little focus on emotional support provided by these men.

> **"It is unknown how many children have close bonds to both a stepfather and a non-resident father or conversely how many children lack close ties to either father because prior studies have not assessed how common such patterns are in the population. Studies that focus on children's relationships either to stepfathers or non-resident fathers suggest great variability."**
>
> (King, 2006: 911)

Whilst some studies have suggested that children and adolescents in stepfather families are at higher risk of behaviour problems, there is no causal evidence between step fathers' parenting style and problem behaviour. Flouri (2008) suggests that there is a substantial probability that the child had an existing problem prior to the stepfather cohabitating. This may explain why:

> **"Stepfathers reported more total difficulties, conduct problems and hyperactivity in their children even after adjusting for involvement."**
>
> (Flouri, 2008: 152)

There is scant literature on the positive emotional effects of parent –child contact with non-resident fathers.

> **"Relatively little is known about noncustodial father–child relationships as sons and daughters enter the adult years or about the conditions that influence whether adult children and their nonresident fathers stay connected or grow apart."**
>
> (Aquilino, 2006: 929)

Whilst there are many positive gains from a child's contact with a non-resident father, not all contacts are ultimately beneficial. In a unique study, King and Sobolewski (2006) used adolescent reports of the perceived quality of child - parent contact, whereas previous studies had used only or mainly maternal responses. King and Sobolewski (2006) concluded that intensive types of involvement by non-resident fathers, typified by a warm and nurturing approach beyond mere contact, appeared especially important in prompting a child's sense of wellbeing and positive development.

8.9 Fathers' ability to engender help seeking for children

Children do not seek mental health services for themselves but rather they must rely on parents and significant others in their social environment to assess these problems and determine the need for mental health services. The ability of fathers to assess their child as being in need of care for a behavioural or mental

health problem is not revealed in the literature but fathers' health literacy is likely to be similalr to that of the general public.

Many members of the public cannot recognise specific disorders or different types of psychological distress. They differ from mental health experts in their beliefs about the causes of mental disorders and the most effective treatments. Attitudes which hinder recognition and appropriate help-seeking are common. Much of the mental health information most readily available to the public is misleading. However: "There is some evidence that mental health literacy can be improved." (Jorm, 2000: 396).

Identifying mental health problems in young children is difficult but necessary. Recent US studies reveal a prevalence of 7% to 24% for two to three year old children with social-emotional or behavioural problems (Briggs-Gowan, 2001). Ellingson's (2004) study of toddlers' (*n*=269) emotional state showed that of the parents who reported elevated problematic behaviour, few parents (17.7%) spoke to a health provider about such problems. Ellingson's (2004: 766) findings confirmed previous findings, showing that emerging: "Child behavior problems, amenable to early intervention, are often unidentified." (Ellingson, 2004: 766).

Zimmerman's (2004) analysis of the help seeking literature puts into question the limited access to treatments and other interventions for children with mental health problems.

> **"Considerable evidence exists that children's mental health problems are undertreated, with fewer than half and as few as 11% of children who screen positive for some disorder actually receiving treatment."**
>
> (Zimmerman, 2005: 1514)

Identifying a father's role in reporting the mental health problems experienced by a young child is difficult. Horwitz et al. (1998) report that there was a great deal of discrepancy between what parents identify as appropriate action, when their children (aged four to eight years) has a psychosocial problem, and what they actually do when they recognize such problems. Of the families participating in the study: "...only 40.9% actually did discuss any of these problems with a physician when a problem occurred." (Horwitz et al., 1998: 1373).

A subsequent study by Horwitz et al. (2003), sought to determine the factors that predicted parental recognition of mental health problems in young infants. This study revealed:

> **"There are considerable discrepancies between expressed parental attitudes and beliefs about psychosocial problems and actual actions about such issues."**
>
> (Horwitz et al., 2003: 1373)

Identifying a father's role in reporting the mental health problems experienced by their adolescent child is difficult. In North America, it has been estimated that although 20% of youths experience behavioural problems fewer than 25% of those with recognised problems receive any services (Horwitz, 2003). In recognition that parents find it difficult to discuss behavioural and emotional symptoms with their child's or adolescent's paediatrician, Wissow et al., (1994) studied 234 parents' interactions with 56 physicians in order to characterise 'physician to parent' communication styles. It was determined that increased maternal reporting of paediatric mental health problems could be achieved by:

> **"Asking questions about psychosocial issues, making supportive statements, and listening attentively increases disclosure of sensitive information."**
>
> (Wissow et al., 1994: 289)

However, fathers were not included in Wissow et al.'s study. A three year follow-up study by Ford et al., (2007) involving 2,461 children (5-15 years) from the 1999 British Child and Adolescent Mental Health Survey found, in "accord with the bulk of the literature", that parental influence predicted consultation with mental health services, and that:

> **"Contact with most services was predicted by three factors: the impact of psychopathology; contact with teachers or primary health care; and parents' and teachers' perceptions that the child had significant difficulties."**
>
> (Ford et al., 2007a:1)

Importantly, 'parental factors' identified in Ford et al's. (2007) work were not disaggregated into mothers' and fathers' variables; the only mention of fathers related to demographic data:

> **"Social services were more likely to be in contact with the children of younger mothers (mean age 26.1 versus 28.4 years, $F = 11.9$, $p = .0006$) and fathers who had a manual occupation."**
>
> (Ford et al., 2007a: 5)

A literature search using Google Scholar, Scoups and Blackwell Synergy using the key words ‘father’ ‘child’ ‘mental health’ and ‘referral / consultation’ revealed there is little information about men’s help seeking practices arising from concerns about their child with emotional / mental health problems; indeed there is little information on parents. Congruent with this finding are the works of other researchers on the topic. Richardson (2001) identified a gap in knowledge concerning the factors that ultimately influence and predict parental decisions to seek care from mental health services for a child in their care.

> **“We know little about how or why families make a decision to seek or not seek, or to continue or drop out of mental health treatment for their child.”**
>
> (Richardson, 2001: 29)

Zwaanswijk et al’s., (2003) search, in which 47 articles are analysed, was an extension of previous findings aimed at locating works on parental recognition of a child’s problematic behaviour and subsequent decision to consult a general practitioner or MHP. Zwaanswijk et al., (2003) conclude:

> **“Although many researchers have acted upon the request for more research in this field, to our knowledge these findings have not been systematically reviewed in a decade following Verhurst and Koot’s work [sic. 1992].”**
>
> (Zwaanswijk et al., 2003: 153)

And Zwaanswijk et al., (2003) point out that an association between the severity of the child’s psychopathology and parent referral practices remain unclear.

> **“Recent studies provide contradictory result concerning the effect of child psychopathology on problem recognition and help seeking.”**
>
> (Zwaanswijk et al., 2003: 153)

Most recently, Ganz and Tendulkar (2006) used the US “National Survey of Children with Special Health Care Needs” to study the prevalence of unmet mental health care needs among the group of 1-17 year olds and their families. Ganz and Tendulkar (2006) concluded that children, living in families with low socioeconomic status, were disproportionately reporting high rates of unmet needs, putting them at greater risk of mental health morbidity over their life span. Ganz and Tendulkar (2006) claim that their work would address “gaps and update the literature” because existing strategies, based on previous data, have failed to improve parental access to appropriate services. Ergo, broader economic and

social policies are needed to identify and connect families with requisite services (Ganz & Tendulkar, 2006). Zimmerman (2004) argues for interventions to:

> **"Sensitize parents—especially fathers—to the need to pay attention to the mental health needs of their children, in particular girls and middle children."**
>
> (Zimmerman, 2004: 1514)

This argument is based on the finding that girls are much less likely to obtain needed treatment for externalizing behaviour disorders (e.g. Attention Deficit Hyperactivity Disorder) and 'somewhat less likely' to obtain needed treatment for depression than boys.

Although the need for fathers to be more involved is well established, little has been done over a 13 year period; Phares has called for a greater research emphasis on fathers (Phares, 1992; Phares, 2005) and whilst there has been a growth in studies linking positive child development to fathering there is a continued lack of research including fathers in family based intervention for paediatric psychological problems.

> **"In 1992, Phares and Compas reviewed research on abnormal child development and found that fathers were woefully underrepresented. In a review of 577 articles on child psychopathology, they found that 48% of the studies included mothers only, 1% included fathers only, 26% included both fathers"**
>
> (Phares & Compas 2005: 632)

and

> **"The findings suggest that pediatric psychology research lags even farther behind clinical child research in including fathers in research designs and analyzing for maternal and paternal effects separately. There is also a concomitant lack of inclusion of fathers in family-based interventions in pediatric psychology."**
>
> (Phares & Compas 2005:631)

The following sections are concerned with fathers' role in diagnosis and informed choices for treatment options.

8.10 Parents' role in gaining a formal diagnosis

An informal mental health assessment by parents is often a catalyst for referral of a child to a mental health professional (MHP). However; as children do not rate their behavioral and emotional problems as highly as their parents or other adults, the discrepancy in perceptions is likely to cause difficulties for the parents

(Handwerk et al., 1999). Furthermore, discrepancies often exist among different informants' ratings of a child's psychopathology (e.g., parents, other children and teachers). Discrepancies between informants often has a negative impact on the assessment process, making it difficult to establish a clear diagnostic pathway, classify the illness and select an optimal choice of treatment (De Reyes & Kazdin, 2005). De Los et al., (2005) support this view stating:

> **"Discrepancies often exist among different informants' (e.g., parents, children, teachers) ratings of child psychopathology. Informant discrepancies have an impact on the assessment, classification, and treatment of childhood psychopathology."**
>
> (2005, De Los et al., 2005: 483)

New et al., (2002) also concluded there was a low concordance between parent and teacher ratings of child behaviour (New et al., 2002). In contrast to the studies outlined, Sourander et al., (2005) determined that:

> **"Parents, teachers and children themselves at age 8, independently predicted recognition of psychiatric disorders and perceived difficulties 10 years later."**
>
> (Sourander et al., 2005)

As Sourander et al., (2005) did not disaggregate the data on parents into father and mother variables, it is impossible to determine what proportion of mental health assessment and support was contributed by fathers.

Discrepancies between fathers' and mothers' ratings of child behaviour also have an impact on referral, especially if one parent has a mental health problem. Early work by Webster-Stratton (1988) suggests that fathers and teachers had similar perceptions of the child's behaviour problems whilst those mothers, identified as being depressed, perceived that the child was demonstrating more deviant behaviour. Webster-Stratton (1988) provides some validation of fathers' ability to make a behavioural assessment of their child, leading to a more formal assessment and diagnosis.

Overall, the literature reviewed demonstrates a lack of evidence based strategies to improve fathers' / parents' recognition of mental health problems and thus empower them to make an objective assessment of their child for the purpose of referral to a MHP. It is also difficult to locate any strategies or programmes designed specifically for fathers. Having explored the nexus between parents' referral practices and mental health services in Britain, Ford et al., (2007)

concluded that education of parents, teachers and other important adults is likely to increase the proportion of those children with impairing psychiatric disorders reaching appropriate services.

Formal diagnosis of a mental health problem in children is a complex matter and one made even more difficult to explain to fathers / parents when the medical literature carries debate on the reliability and validity of some diagnostic criteria. For example, whilst Costello et al, claim that:

> **"There are now available a broad range of interviews that generate DSM and ICD diagnoses with good reliability and validity"**
>
> (Costello et al, 2005: 972)

… the criteria in the Diagnostic Statistical Manual (DSM) and International Classification of Diseases (ICD) may not relate to the quality of the child's social functioning.

Roberts et al., (1998), having examined 52 studies that attempted to determine the overall prevalence of child and adolescent psychiatric disorders over four decades, concludes that although most studies used the Diagnostic Statistical Manual (DSMIV), several problems continue to plague diagnosis and research on child and adolescent mental disorders. Moreover, a substantial proportion of individuals who meet the criteria for diagnosis of mental illness appeared to be functioning adequately in their daily lives (Roberts, Attkinsson, & Rosenblatt, 1998; American Psychiatric Association, 2000). In addition:

> **"There is a growing concern about the validity of a diagnostic nomenclature that identifies one-fourth to one-third or more of children and adolescents as meeting the criteria for one or more clinical psychiatric disorders."**
>
> (Roberts, Attkinsson, & Rosenblatt, 1998)

The lack of clarity in diagnosis is perceived as unhelpful by fathers seeking to participate in supporting their child. A mismatch between a cogent diagnoses by Mental Health Professionals (MHPs) and parents' understanding of their child's behavioural problem is a major source of burden to parents. And fathers become sceptical when, after a series of evaluations, a variety of diagnosis and several unsuccessful strategies have been applied over time, they receive little relevant or useful information from Mental Health Professionals on how to assist them in

coping with day-to-day behavioural issues (Delaney & Engels-Scianna, 1996; Scharer, 2005).

8.11 Parents' understanding of treatment options and efficacy of interventions

The literature identifies that parental efforts frequently involve the seeking out of suitably qualified practitioners and attending a number of consultations, many of which are driven by a lack of effective treatment from a previous consultation with a counsellor, mental health professional or psychologists. Delaney & Engels-Scianna, (1996) report that:

> **"As therapies failed them, the child moved up to more intensive therapy. Throughout this process parents experienced therapies as supplying diminishing returns and half answers ...counselling did not control symptoms, and drugs that limited effectiveness."**
> (Delaney & Engels-Scianna, 1996: 19-20)

Parents are also burdened by the idea that unless hospitals and mental health services were able to find interventions to control the behaviours "now", before the child became any older, there would be consequences for the child's life chances in the future (Delaney & Engels-Scianna, 1996; Feldman, et al., 2004; Zimmerman, 2004; Ganz & Tendulkar 2006). It is estimated that 75% of Americans presenting with psychiatric problems at 21 years of age, had had mental health problems identified during childhood and received treatment (U.S. Public Health Service, 2000); this finding suggests that earlier treatments had not been effective in limiting morbidity for those with early onset of mental health problems.

Parents who have had extensive experience with therapies and an awareness of the inherent insufficiencies of the health care system are appreciative of the limited prospect of cure or behavioural modification. Early findings suggested that: "Rarely does any behavioural treatment or medication deliver what it seemingly promises." (Delaney & Engels-Scianna, 1996: 24). A review of parents' expectations of the success from treatement found:

> **"The few studies that have examined the influence of expectations on mental health help seeking for children and adolescents found that parents did not expect positive outcomes of mental health care (Faberman, 1997; Hill & Fraser, 1995; Leaf et al., 1985; Pavuluri et al., 1996; Tarico et al., 1989)."**

(Richardson, 2001: 224).

Parents' scepticism over therapies and interventions may be well founded given the recent findings of a systematic review of the proven effectiveness of mental health related interventions. Contopoulos-Ioannidis et al.'s (2005) systematic review screened 161 Cochrane and 254 Database of Abstracts of Reviews of Effectiveness systematic reviews on mental health-related interventions / treatments and found:

> **"Large trials are uncommon in mental health. Their results are usually comparable with the results of smaller studies, but major disagreements do occur."**
>
> (Contopoulos-Ioannidis et al., 2005: 578)

In addition, a gap has been identified in the evidence based practice, specific to the treatment of children diagnosed with early-onset schizophrenia.

> **"There is a dearth of intervention studies specific to the treatment of children diagnosed with early-onset schizophrenia, though this form of schizophrenia is considered to be more severe and chronic."**
>
> (Dulmus & Smyth, 2000: 59)

Debates on effectiveness of treatments and gaps in medical knowledge leave many parents feeling that they consented to their child's treatment on the basis of the opinion of the psychiatrist rather than any clear evidence of the probability of success of a treatment. Parents' scepticism over treatment effectiveness may be misinterpreted by MHPs as a questioning of their standard of practice, further eroding a collaborative approach directed toward making an informed decision about treatment options or limiting the number of treatments (Delaney & Engels-Scianna, 1996; Scharer, 2005; Hanson & Rapp (1992). An additional consideration for parents is the possibility of error and associated harm. According to Subotsky (2003), risk management is a new governance paradigm in child and adolescent mental health services as the issues involved are very different and wider than those in adult mental health services. Subotsky (2003) claims that "errors are difficult to evaluate" in child mental health because:

> **"There is considerable variation in practice between and within disciplines and outcomes are usually not immediate, nor necessarily recorded or measured. However, this same situation means that differing views can often be strongly held."**
>
> (Subostky, 2003: 319)

The issues discussed in this section indicate that supportive parents are concerned about the quality and efficacy of mental health services available to their child and as such, similar issues are likely to be raised by fathers / step fathers at interview in this doctoral research.

8.12 Fathers' experiences of their child's acute episodes of mental illness

What is known is that hospitalisation of a child, with an acute episode of mental illness, is burdensome for parents in several ways. Most parents believe that admitting their child to a mental health service, for the purpose of protection and treatment has inherent liabilities:

> **"Psychiatric hospitalization for school-age children is a time of great stress for their parents (Delaney & Engels-Scianna, 1996). Many hospitalizations are brief and centered on stabilizing the child and initiating or changing medications. The child typically returns to the family in a short time usually from 1 to 2 weeks. Parents report little change occurs in the child's behavior in such a short time (Scharer, 2002)."**
>
> (Scharer, 2005: 18)

Many parents postponed hospitalising their child because they believed they were betraying the trust of their child (Delaney & Engels-Scianna, 1996; Richardson, 2001) and subsequent to this betrayal is their child's anger towards them (Mohr & Regan-Kubinski, 2001). Associated with having their child hospitalised is the sense of guilt linked to previous misjudgements over the need for professional care. Delaney and Engels-Scianna (1996) report:

> **"Although they [sic parents] did not completely 'buy into' self-condemnation they did engage in a degree of self-accusation involving judgments of their actions or inactions. They related the following:**
>
> **"Dad: 'Because it's all my fault. You know, I may have been dumb. I did the best I could but it wasn't enough.'"**
>
> (Delaney & Engels-Scianna, 1996: 74)

The following excerpts from Mohr and Regan-Kubinski's (2001) interviews, describe one father's emotional response to leaving his child in hospital:

> **"Dad: 'Toughest thing we've ever had to do. The toughest thing'.**
>
> **Mom: 'Well, (Dad) is usually not a real—well, I don't want to say he's not emotional, because he has very deep feelings. He doesn't usually cry. But he—he has cried. I mean, he's not—and he's not**

> **ashamed of that. But he's—that night, he bawled, just bawled in the car.'**
>
> **Dad: 'Like ripping out a part of your life, and your body, your heart and just leaving it, you know? Walking away from it.' "**
>
> (Mohr & Regan-Kubinski, 2001: 74)

Many parents understood the limitations of staff's ability to understand their child as an individual.

> **"Parents did not think they had all the answers, but they understood nuances of their child's behaviour, which others often missed."**
>
> (Delaney & Engels-Scianna, 1996: 21).

How best to assist fathers adjust and assist their child with mental illness has not been part of a research agenda. Researchers have identified a gap in knowledge concerning the role of the father for a child with abnormal development, diagnosed psychopathology and treatment of emotional / behavioural problems (Lamb, 1976; Phases, 1992). There have been attempts by researchers to include fathers but there: "Continues to be a dearth of studies on the role of fathers in children's abnormal development." (Phases et al., 2005: 631; Lamb, 2004).

And some researchers continue to express surprise when fathers attend child behavioural programmes:

> **"The presence of both parents, whenever possible, is of particular importance, at least for some of the sessions, and, compared with outpatient appointments, fathers tend to attend with surprising regularity."** (Beeson et al., 2006: 339).

When fathers are researched there tends to be a bias toward identifying paternal deficits (Marsiglio, 1996). Furthermore, barriers exist when fathers seek to be involved in the treatment phase of their emotionally disturbed child (O'Brien, 1988). Whilst there have been recommendations to involve fathers in the behavioural and emotional development of their children:

> **"By involving father figures in assessing and treating children's educational, emotional or behavioral problems, school psychologists and clinicians could also encourage father involvement."**
>
> (Flouri et al., 2002: 581)

Some clinicians and researchers openly debate whether or not they should include the father in their child's therapies (Duhig et al., 2002; Lazar et al., 1991).

Whilst it is commonly assumed that a father's work commitments and other family roles preclude them from attending child psychiatric clinics these are not as important predictors of fathers' attendance as the quality of relationship between the father and his father or the father's current relationship with his spouse / partner (Walters et al., 2001). Overall, it remains clear that longstanding, stereotypical attitudes held by service providers do little to encourage men to be more actively involved in supporting and understanding of their child's psychological problems (Pharse et al., 2005; Pharse & Lopez et al., 2005; Walters, 1997).

8.13 Inadequacy of resources and support for parents

Support for men and their spouse / partner, who have a child or adolescent with an emotional problem or mental illness has been limited by a wide range of factors and consequently the morbidity and mortality among Australian's has been inadequately restrained. It is only recently that Australian governments have provided a sustainable framework and funding in support of parents who provide care and treatment for family members (The National Action Plan on Mental Health, 2006-2011). Secondly, there is now a widely acknowledged lack of measures in place to ensure that those providing mental health services meet the desirable and necessary performance standards of practice and service delivery. Consequently, as part of the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003), States and Territories have committed to the development of a national framework to monitor the performance of public mental health services. Although this framework will incorporate key performance indicators there is an acknowledgement that:

> **"The mental health sector has lagged behind developments in some other sectors, due in part to an historical lack of suitable data sets from which to build indicators but also to lack of agreement within the sector on how to apply fundamental performance measurement concepts to the mental health field."**
>
> (NMHWG, 2005:1)

Support for parents who have a child with an undiagnosed, and therefore untreated mental health problem, has been limited. Government response to this predicament has been:

> **"Improving capacity for early identification and referral to appropriate services; improving treatment services to better respond to the early onset of mental illness, particularly for children and young people."**
>
> (The National Action Plan on Mental Health, 2006: 2)

In addition, a workforce shortage of mental health professionals (MHP) at all levels, has resulted in unmet demands for mental health services across Australia. In response to the shortfall of mental health specialists, the Council of Australian Governments (COAG) has dedicated funding:

> **"To increase the mental health content in tertiary curricula through the development of mental health training modules for registered nurses."**
>
> (Council of Australian Governments [COAG])

In addition, there has been provision made for more student places at university, student scholarships and clinical training for potential health workers (allied health workers, medical students and nursing students) who would work within multi-disciplinary teams to address mental health issues (The National Action Plan on Mental Health, 2006).

8.14 Policy development in support of parents' whose child has a mental illness

In Australia, parents' ability to secure timely access to mental health services, to meet the needs of their child depends on the ability of policy and funding arrangements to deliver equitable access and universal coverage. Fathers', stepfathers' / male guardians' frustration with mental health services was an anticipated theme in the focus group and individual interviews and this projection proved true. The anticipation was based on literature identifying less than optimal policy achievements in mental health over the past two decades and consistent concerns raised over the attitudes and preparedness of staff to provide timely and appropriate services. The nexus between nursing staff, mental health professionals and fathers has never been systematically evaluated, leaving only rare and incomplete glimpses of father - staff interactions. This section outlines policy shortfalls and the attitudes and capabilities of health professionals vis a vis young people with mental health problems

Public mental health services have traditionally been isolated from other health services (Laws and Rouse, 1996) and even though policy change in Australia

since the 1990s, has aimed to create integrated levels of mental health care; no evidence has been produced to show that patients or their carers are better off. Funding increases have been allocated to community services and education but the number of in-patient psychiatric beds have been reduced (Holmes et al., 2006; Whiteford et al., 2002).

Partnerships between mainstream health (in-hospital care, GPs) and community mental health services were expected to be strengthened and thereby to offer the necessary support for out of hospital care (Callaly & Fletcher 2005). Canada and the United Kingdom have chosen to use an integrated care model similar to that in Australia but it remains a huge social experiment (Leatt et al., 2004); where this approach to resource allocation has been enacted, most countries have encountered a large number of unresolved and fundamental issues that detract from parents' satisfaction with the services provided (Beeson et al., 2006). A major problem has been an inability to show that health partnerships are working and are sustainable in the medium and long term for the UK (Dowling et al., 2004). A critical review of Australia's policy, focusing on the devolution of mental health services, concluded that the integrated model has resulted, so far, in 'a baffling array of service providers' and the general lack of coordination between them and 'GPs have a sense of being abandoned with seriously ill patients' [sic mental health patients] (Callaly & Fletcher 2005: 351). The situation just described, presents clients and their families with substantial challenges as they often experience 'difficulty navigating these systems'. Furthermore:

> **"Public mental health services ... struggle to cope with increasing demand by narrowing their focus on those with serious mental illness. People with less severe illnesses (the so-called high prevalence disorders, including substance use disorders) either receive care from general practitioners (GPs), community drug treatment services, community health counselors or other private providers, such as private psychologists, or receive no care at all."**
>
> (Callaly & Fletcher, 2005: 351)

and

> **"It has long been recognized that Australian funding and service delivery models for primary health and community care are fragmented and are often disconnected from acute and continuing care services ...are unavailable to many because of their uneven distribution across the community or because consumers cannot afford their services and because they often do not or cannot work**

> **collaboratively with the public mental health sector, for a variety of reasons."**
>
> (Callaly & Fletcher, 2005: 351)

An analysis of integrated care in a rural population in Western Australian draws similar conclusions.

> **"We identified a number of barriers to collaboration between mental health and community-based services, including poor communication, difficulties with referral and cultural differences between services. Of all these themes, the most significant was the lack of communication at individual, case management and organisational levels."**
>
> (Sweeney & Kisely 2003:209)

Similar findings have come from Canada's integrated care model with most research findings being inconclusive or negative and only a few studies showing small and limited benefits (Fleury & Mercier, 2002; Callaly & Fletcher; 2005). Evidence based policy is essential for without it:

> **"Well intentioned interventions may do more harm than good, or be ineffective and thereby a waste of public money and time..."**
>
> (Macintyre & Petticrew, 2003)

Critics of those making health policy point to inconsistencies in the standards required of clinicians, in the use of evidence based practice and the standards required of policy makers to be accountable for the outcomes of their governance (Hunter, 2001; Loughlin, 2002).

The effects of inadequate policy development have been profound in Australia and internationally. A shortage of resources and barriers to accessing timely and appropriate mental health services are wide spread phenomena in Australia, UK, USA and New Zealand (Rogers & Pilgrim, 1994; Mental Health Commission, 1998; Burdekin, 1993; Peterson et al., 2007; Humphreys, 1999). Epidemiological studies across the United States have estimated that 10% to 15% of preschool children have unmet behavioural or emotional problems (Campbell, 1995). Paediatricians have highlighted the disparity between the mental health needs and mental health service provided to young children (less than five years); yet little research has focused on how best to match the supply of services with demand from this group (New et al., 2002). Richardson (2001) has summarised the inadequacies of service provision / help seeking for young people with mental illness in the US:

> **The proportion of youth with a psychiatric diagnosis and/or significantly impaired functioning who do not receive mental health services or receive inappropriate or inadequate services ranges from 17.1% to 66% (Angold & Costello, 1995; Flisher et al., 1997; Leaf et al., 1996; Martin et al., 1996; Zahner et al., 1992); this means as many as two thirds of children who need mental health services are not receiving care or not the right care.** (Richardson, 2001: 223)

In Britain there are regional shortages:

> **"Britain may relate to a shortage of child psychiatrists and a higher percentage of children waiting more than 6 months to be seen by mental health services in the north of England."**
> (Ford et al., 2007b, pre print: online publishing May 2007)

Winefield and Harvey (1994) found that families were frequently demoralised on the realisation that help was not readily available during the early phase of their child's illness and only available once their family member's mental health had deteriorated much further. The lack of suitably trained staff to act as a point of referral in primary health care continues to be an Australian and global problem (Holmes, 2006; Abas & Broadhead, 1994). Australia is increasing reliant on mental health triage, staffed by nurses, as a model of psychiatric service provision for large populations (Sands, 2007; George & MacDonald, 2005). However, a recent report states:

> **"Mental health triage nursing was found to be a complex, stressful role that involves high levels of responsibility, clinical decision making, and multiple role functions, many of which overlap into areas of practice previously the exclusive domain of medicine, such as assessment, diagnosis, and referral."**
> (Sands, 2004: 150)

Patient referral, from general hospital staff to an acute mental health service, is often based on limited documentation; few reasons for the service request are given and the potential risk of injury, to the client and others, is rarely mentioned (Grigg et al., 2002). According to Sands (2007) problems occur because of:

> **"A paucity of established theory to inform and guide mental health triage practice and professional development."**
> (Sands, 2007)

There have also been longstanding concerns expressed over i) the lack of respect afforded individuals with mental illness by staff and ii) families' appeal for the provision of basic care with dignity (Human Rights and Equal Opportunity Commission, 1993; Human Rights and Equal Opportunity Commission 2005). Multiple reports have identified that staff may lack the necessary empathy to

engage productively with clients, with the finding that clients: "... did not consistently experience a therapeutic approach in their interactions with mental health nurses." (Rydon, 2005: 78).

Those nurses who do hold empathy for their clients, report that they are distressed over the inadequacy of resources they are provided with to enable them to meet the needs of their clients (Austin et al. 2003). And those nurses who do not have expertise in mental have reservations about the care they can realistically provide.

> **"Many nurses responsible for care feel unprepared to support mental health needs, and have negative attitudes to caring for people with mental health problems."**
>
> (Reed & Fitzgerald, 2005)

Attitudes held by health professionals towards those admitted for para-suicide have been a feature of recent studies. Several studies have shown that there is a generally negative attitude towards clients who self-harm (Anderson, 2007; Mackay & Barrowclough, 2005; McAllister & Estefan, 2002); proposed solutions to this problem include staff development programmes and improving the qualifications of those caring for young people who self harm. McAllister et al., (2002) concluded that:

> **"There is a need for continuing professional development activities to address negative attitudes and provide practical strategies to inform practice and clinical protocols."**
>
> (McAllister et al., 2002)

Huband and Tantam (2000) noted a positive association between the amount of mental health education and improvements in staff attitudes.

> **"Attitudes of clinical staff who had obtained additional qualification in counselling or psychotherapy differed significantly from those who had not."**
>
> (Huband & Tantam, 2000)

Most recently, Munro and Baker (2007) studied 140 nursing staff across a range of acute mental health settings in the UK. The overall results indicate positive attitudes but significant differences were found between qualified and unqualified staff. The development of strategies to improve staff attitudes requires ongoing attention because the greater the negative affect held by staff, the less their propensity to provide specific mental health care (Mackay & Barrowclough, 2005; Patterson et al., 2007). Recent UK policies and guidelines for staff

highlight the importance of positive attitudes towards those using mental health services (Munro & Baker, 2007).

8.15 Father's health practices towards specific mental health problems

The chapter content provided to this point has made clear that there is scant information to be found on fathers' health practices towards a child or adolescent. Consequently, a second search of the literature was conducted using key words for specific mental health problems and diagnoses. The conditions used to guide the search were:

i) Depression in childhood and adolescence
ii) Anxiety disorder
iii) Attention Deficit Hyperactivity Disorder
iv) Self-harm in young people
v) Suicide in young people

The choice of these conditions was based, either on their high prevalence or high importance among child and adolescent populations in Australia and countries with similar socioeconomic profiles; as identified in government reports (Australian Department of Health and Aging, 2004; AIHW, 2005a; AIHW 2004a).

8.16 Depression in childhood and adolescence

An Australian community survey found that 3.7% of boys and 2.1% of girls aged 6-12 years had experienced a depressive episode in the 12 month period prior to the study (Sawyer et al., 2000). The average duration of a depressive episode in young people is estimated to be nine months, with a 70% probability of relapse within five years (Birmaher et al., 1996). National studies in the United States have indicated increasing rates of depression and a shift to a younger age of onset (Burke et al., 1991; American Academy of Child and Adolescent Psychiatry, 1998) and highlighted that:

> **"It is important to note that these shifts to adolescent onset are occurring when nearly half the 31 million Americans without health insurance are aged 24 years or younger."**
>
> (Burke et al., 1991: 789)

These figures strongly suggest that cohabiting fathers / male guardians are in a position to assess for signs of childhood depression and to seek advice. However, there is scant literature identifying these mental health practices by fathers or parents, both in Australia and overseas. Garralda and Bailey (1988) believe that: "Maternal request for referral is an important determinant in many cases." (Garralda & Bailey 1988: 81).

Fröjd et al., (2007) sought to determine if the mothers, fathers, siblings, peers, teachers or boy / girl-friend had a positive influenced on help-seeking activity amongst adolescents diagnosed with a depression. The study did not link fathers to help-seeking but instead found: "Concerns of mother, peers and teacher were among the best predictors of recent help-seeking for depression." (Fröjd et al., 2007: 945).

And other researchers note:

> **"It is possible to obtain clinically useful information on adolescent depression from the child's mother. However, information on suicidal ideation was rarely endorsed by mothers, suggesting that maternal report of adolescent suicidal thoughts shows less sensitivity..."**
>
> (Rice et al., 2007:1162)

A literature search of the data bases, Blackwell Synergy, Science Direct, Scopus, PsycInfo and Google Scholar, using the key words 'father', 'parent', 'child', 'adolescent', and 'depression' could not locate any specific work that explored the fathers' role in mental health practices within the family. There were several research publications about 'parent' role in assessment of mental health problems vis a vis depression but there was scant mention of fathers by the authors; most researchers did not disaggregate the data between mothers' and fathers' variables; they simply reported on 'parents' (Rice et al., 2007; Cole & Rehm 1986; Lutz et al., 2007; Fröjd et al., 2007) and some studies specifically focused on the mother only (Rice et al., 2007; Wissow et al., 1994).

Despite increasing awareness, research exploring adolescent depression has had a relatively short history compared with adult studies (Crowe et al., 2006). Characterising what triggers depression and associations between diagnosis and cultural factors is complex with no systematic approach to researching this topic (Huang et al., 2006). Boyd et al's., (2000) study of Melbourne school children

(n= 1,299) made a comparison with previously reported prevalence rates of depression from studies worldwide; revealing a striking difference in the prevalence of anxiety and depression across different countries and cultures. This finding suggests that further research is required to determine differences and similarities between fathers from different cultures in their depression prevention strategies and assessment and referral practices for those offspring with depressive symptoms.

There are indications that many fathers are perceived as a source of emotional support for both girls and boys and this is protective against depression. The recent work by Ackard et al., (2006) clearly identifies that children can discuss problems with their father. The participants in Ackard et al's., (2006) self-reported survey questionnaire were 4,746 high school students (2,357 girls and 2,377 boys); a majority of children felt that they were cared about 'very much or quite a bit' by their father (78.6% girls, 81.8% boys). Even though a substantial proportion of girls thought they could not talk about emotional issues with their father (55.4% recorded 'not at all or a little') the majority of boys (63.4%) thought they could discuss these issues 'quite a bit or very much' with their father. Conversely, over half of the boys (51.4%) thought they were only 'somewhat able' or 'unable to talk' to their mother about problems (Ackard et al., 2006). Those children identified as experiencing depressive symptoms rated their connectedness to their parents differently for both mother and father. Van Vlierberghe et al (2007) explain this phenomenon:

> **"Youngsters who demonstrate depressive symptoms perceive their parents as more cold, instable, unreliable, and unpredictable than do non-depressed controls."**
>
> (Van Vlierberghe et al., 2007: 515).

There is a strong assumption that parents would easily recognise if their child became depressed and seek advice from their child's teacher or health professional. However, only 25% of children and young people with depression are detected and receive treatment (NIHCE, 2005; Andrews & Wilkinson, 2000). A United States study identified that, of 206 children sampled, 36% (75) never received professional help for depressive symptoms (Wu et al., 2001). The reasons offered for non-service were:

> **"In summary, our findings suggest that parental failure to recognize depressive symptoms, lack of knowledge about depression and its related treatment, and lack of adequate health insurance may all influence whether or not a child receives services as well as the type of treatment received."**
>
> (Wu et al, 2001: 194).

Goldney et al., (2001) contend that a lack of mental health literacy among parents is the largest impediment to the optimum treatment of major depression in children. There is also a profound social stigma attached to depression in children. Pescosolido, et al., (2007a) gave a measure of stigma using data from the National Stigma Study-Children (NSS-C), whereby 1,152 adult respondents were asked to record their responses to a series of vignettes. The researchers found that:

> **"Large numbers of people in the United States link children's mental health problems, particularly depression, to a potential for violence and support legally mandated treatment... Over one-third of the sample (35%) were willing to use legal means to force children with depression to see a clinician…".**
>
> (Pescosolido, et al., 2007a:619).

Children whose parent(s) have depression are at risk of developing similar psychopathology (Purper-Ouaki et al., 2002); concomitantly, parental mood disorders impede fathers' and mothers' ability to appropriately assess their child's mental health status. A follow up study of pre-school children, undertaken by New et al., (2002), serves to:

> **"Underscore the importance of evaluating parent mental health because of its central role in both the development and identification of behavioral problems in young children."**
>
> (New et al., 2002: 725).

Inter-family assessment of depression also raises issues about referral to specialist care; Angold et al's . (1987) 'proband study', consisting of 220 interviews with children who had a depressed parent, found that:

> **"Children reported more depressive symptoms than their parents reports about them and the overall pattern suggests that parents are relatively insensitive to their children's depressive symptomatology."**
>
> (Angold et al., 1987)

Beardslee et al., (2003) claim to have conducted the first and only longitudinal primary prevention study of relatively healthy children at risk for psychopathology attributable to parental mood disorder. The research demonstrates that by improving the mother and / or fathers' mental literacy and supporting an open dialogue between parent and child, there can be a long lasting protective effect on the child's / adolescent's emotional wellbeing. The interventions demonstrated "a significant reduction in risk factors and increase in protective factors in these families over a long time interval, 2½ years." (Beardslee et al., 2003: 120) and parents reported a significant positive change in child-related behaviours and attitudes, increasing over time.

8.16.1 Accessing timely and appropriate treatment for depression

A large body of research indicates that parents, from a variety of countries, have substantial problems in accessing timely and appropriate services for diagnosis and treatment of childhood depression. Diagnosis by a General Practitioner (GP) and referral to a mental health specialist is rarely a straightforward process. Two decades ago, reviews of services indicated the need for GPs to up-skill in methods of recognising common mental health problems in children and young people.

> **"General practitioner recognition of psychiatric disorder in children is limited, with wide variation between practitioners. Their assessments have moderate sensitivity and high specificity. Recognition is better in children or adolescents with more severe disturbance and in those with stressful family situations."**
>
> (Garralda & Bailey,1988).

Whilst most recent studies highlight the importance of training GPs in the diagnosis of depressive disorders (Glass, 2003; Mathet et al., 2003) there is little to suggest that GPs currently have a major role in assessment of children and adolescents or parental support (The MaGPle Research Group, including et al., 2005). Mathet et al., (2003) found that more than one out of every 10 children,

aged less than 13 years had some form of depressive disorder, and that a major depressive episode was present in 6% of the children sample (n = 155); of these an estimated 70% of diagnoses were not made during the consultation with a General Practitioner. Collaborative partnerships with other allied health professionals are seen as a means of supporting the central role of the GP in family health. However, nurses in primary health care and hospital based clinics lack literature to guide their practice vis a vis young clients with depression.

> **"There were no nursing articles that investigated adolescent depression in Australia or New Zealand according to a Cumulative Index of Nursing and Health Sciences (CINAHL) search of 'adolescent' and 'depression' from 1995 to 2005."**
>
> (Crowe et al., 2006)

Despite delays and issues surrounding the diagnosis of depression in children / adolescents it is widely recognised that early detection and treatment for depression is essential if morbidity is to be contained. Untreated depression in adolescents contributes to academic and relationship difficulties, problems with the family, alcohol and substance misuse, increased suicide rates, and can be the precursor to a lifelong burden of illness (Kates, 2005; Kramer & Garralda, 2000). Screening is designed to detect hidden illness in the general population however, there have been few efficacy and cost effectiveness studies on screening young people for depression and overall "evidence regarding the benefits of screening teenagers is lacking" (Pignone et al., 2002:765). The U.S. Preventive Services Task Force graded all evidence and concluded "the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression. This is a grade I recommendation" (USPSTF, 2002: 760).

8.16.2 Pharmacotherapy

The following discussion illustrates the complexity of the decision making pathways that require comprehension if a father is to take part in an informed consent to treatment for their child.

The Australian guidelines for evidence based treatment choices for depression are in agreement with comparable guidelines from the US and the UK (Ellis, 2004). Current guidelines for the treatment of depression suggest a combination of antidepressant medication and psychotherapy as the most effective intervention (Ellis 2004). The two psychotherapies that are endorsed by the guidelines are

cognitive behavioural therapy and interpersonal psychotherapy; both are suited to delivery by mental health professionals who have had the relevant training (Crowe & Luty 2005; Donoghue et al., 2004). The predominance of interpersonal and cognitive symptoms in adolescent depression makes these psychotherapies particularly helpful for the group experiencing mild depression (Crowe et al., 2006: 18). However, clinical guidelines do not recommend treating 'mild depression' with antidepressant medications (NICE, 2004).

Medicating for depression occurs with caution in young people. The drugs venlafaxine and the selective serotonin reuptake inhibitors (SSRI) paroxetine are specifically advised against for children yet venlafaxine and paroxetine accounted for 10% and 8% respectively, of the total antidepressants administered to children (Harrison & Britt, 2005). In the UK, Fluoxetine was the only SSRI approved for use in children with depression in 2004 (Committee on Safety of Medicines, 2004). However, accessing the site in 2007 reveals:

> **"The use of fluoxetine in children is not recommended, as safety and efficacy have not been established."**
>
> (Medicines and Healthcare products Regulatory Agency, 2007: 12)

Few fathers would understand the shifting recommendations and trends on the appropriate and safe use of these medications.

8.16.3 Prescribing trends

This section details the changes in prescribing practices over recent years in response to concerns over the efficacy and safety of some medications for use in children / adolescents with depressive illness. Following this detail there is a search of literature to identify fathers' / men's medication practices for children having pharmacological treatment for depression.

Although caution has been emphasised when prescribing any antidepressant to children, the prescribing rate of antidepressants in Australian children aged less than 18 years was 5 per 1,000 encounters and almost six times higher for those aged between 18–19 years (2.82 per 1,000 encounters) (Harrison & Britt, 2005). Despite the caution the 2.82 prescriptions per 1,000 encounters, indicates that fathers who have a child with a depressive illness are likely to be exposed to their child's medication regime. Analysis of three US data bases for prescriptions of three major psychotropic drug classes (stimulants, antidepressants, and

neuroleptics) and two leading psychotherapeutic medications (methylphenidate and clonidine) for two to four year olds revealed that: “psychotropic medications prescribed for pre-schoolers increased dramatically between 1991 and 1995” and that “increases occurred for newer less established agents” (Zito et al., 2000:1025).

There is a wide variety of prescribing practices among General Practitioners because many are wary of prescribing the recommended dose for a range of reasons. Consequently, a large proportion of patients are treated by GPs at doses that are not effective for their depression and this practice contributes to sub-optimal treatment outcomes (Kendrick, 1996; Donoghue & Tylee, 1996; Telford et al., 2002; Donoghue & Hylan, 2001).

The promise of effective treatment, implied by clinical trial efficacy rates for antidepressants, is not realised in actual clinical practice; owing to a variety of complex interactions between patient, provider and health-system characteristics. Although this situation gradually improved in primary care and other out-patient clinic settings throughout the 1990s, treatment remains sub-optimal in most health care delivery systems (Mendlewicz, 2001: S1). More recent work shows that: “Reliable estimates of GP prescribing of antidepressants to children in Australia are needed.” (Harrison & Britt, 2005: 92).

Whilst contemporary guidelines are more detailed and evidence based, there remain multiple key concerns expressed by medical experts and medical researchers with respect to the quality of evidence on which to base their practice for children and adolescents with depression (Kendrick, 1996).

> **“There is a striking paucity of safe and effective treatments for pediatric depression, and major attention to this problem is needed.”**
>
> (Vasa et al., 2006: 1021).

Michael and Crowley (2002), having performed a meta - analysis of drug treatements for depression, and found that overall “the vast majority of pharmacological interventions were not effective in treating depressed children and adolescents” (Michael & Crowley, 2002:247) but qualified this by adding that selective serotonin reuptake inhibitors (SSRIs) are efficacious, and “Will likely play an increased role in the management of affective illness in youngsters.” (Michael & Crowley, 2002: 247).

Contrary to Michael and Crowley's (2002) conclusion, Gunnell and Ashby (2004) state that selective serotonin reuptake inhibitors and tricyclic antidepressants account for over 90% of antidepressant prescribing in Britain and have been shown to benefit adults but: "The effectiveness of any antidepressants in childhood and adolescence is less clear." (Gunnell & Ashby, 2004: 34).

This statement is supported by Whittington et al's., (2004) findings from a systematic review of published Randomised Control Trials (RCTS) and non published RCTS and based on the lack of transparency between risk and benefits of serotonin reuptake inhibitors (SSRIs). Whittington et al's., (2004) findings make it difficult to claim, with any certainty, that SSRIs are a safe form of treatment for depression in children. Furthermore, Hansen et al., (2005) note that comparative analysis of the effectives between types of second-generation antidepressants, in the treatment of major depressive disorders, has not been evaluated and existing data might be biased, given that:

> **"About 96% of comparative trials were sponsored by or had at least 1 author affiliated with a pharmaceutical company"**
>
> (Hansen et al., 2005:415).

Hansen et al (2005) conclude their work with the statement that: "Choosing the agent that is most appropriate for a given patient is difficult." (Hansen et al., 2005: 415)

It is unlikely that fathers are aware of prescribing trends and the issues that surround them. A search of the literature using the words 'fathers', 'medication', 'child', 'adolescent', 'depression' and 'mental', in the data bases Blackwell Synergy, Google scholar SCOPUS and Psycinfo revealed no specific works identifying fathers' participation in medication management of depression or mood disorders in children. Schock et al., (2002), in reviewing research literature on the role of the father and their participation in the treatment of a child with mood disorder, do highlight that:

> **"Linkage between father characteristics and more clinically focused variables have received scant attention."**
>
> (Schock et al., 2002: 230)

and

> **"Fathers are seen as lacking critical information, and this lack of awareness may result in fathers being both less accepting of their child's problem and less informed about how to help the child when he or she is symptomatic."**
>
> (Schock et al., 2002:231)

Schock et al., (2002) recommended fathers be provided with knowledge of their child's disorder, as well as being educated on how to increase their skill level in dealing with mood disorder symptoms but these recommendations fell short of making the link between changes in symptoms and the use of medications. Instead, Schock et al., (2002) focused on the non-drug treatment, even though many children do receive medication for mood problems and depression.

8.16.4 Associations between anti-depressant medications and suicide

Classes of antidepressant treatments are defined by their mechanism of action. Commonly prescribed classes of antidepressants in primary care are selective serotonin reuptake inhibitors (SSRI) and tricyclics. These drugs are not without risk and the medical literature is loaded with debate about the possible link between SSRI suicides among users (Gunnell & Ashby, 2004; Mc Henry, 2006; Vasa et al., 2006) and adverse events reported in depressed children and adolescents taking SSRI compared with the placebo group in RCTs (Goldney, 2005; Rey & Dudley, 2005; Jick et al., 2004; Isacsson et al., 2005). These reports have prompted regulatory bodies in the United States, the United Kingdom, and Europe to issue warnings urging clinicians to monitor suicide risk and adverse effects carefully when prescribing antidepressants to youth (Mann et al., 2005; U.S. Food and Drug Administration, 2006). Juxtaposed to the risk associated with taking antidepressants are concerns over the effects on suicidal ideation linked to inadequacy of antidepressant treatment (Oquendo et al., 1999).

> **"Such concerns need to be weighed against the risk of untreated depression because suicide is the third leading cause of death in youth and more than 90% of suicides in depressed youth are untreated at the time of death."**
>
> (Mann et al., 2005: 2068)

Moreover, a decision to recommend the use of these drugs is based mostly on published data, even though unpublished data may have different findings; this does not represent best practice because all the evidence is not considered. On this point Whittington et al., (2004) contend: "Greater openness and transparency

with respect to all intervention studies is needed." (Whittington et al., 2004: 1335).

Fathers are likely to have concerns over the widely publicised probable association between the use of antidepressants and suicide (Hall et al., 2000). This assumption is supported by the finding that approximately a quarter of Australian adults believe that antidepressants would be harmful for a person who is depressed and suicidal (Jorm et al., 2005).

> **"Surveys of the public in several countries have found that negative attitudes towards antidepressants are common. However, there has been little research into the factors associated with these attitudes."**
>
> (Jorm et al., 2005:2)

And regulatory bodies continue to investigate the possible association between certain anti-depressant drugs and suicides among young people.

> **"The recent deliberations by the U.S. Food and Drug Administration (FDA) regarding the relationship between antidepressants and suicidality in children have incited debates about the safety of these medications for the treatment of pediatric depression."**
>
> (Vasa et al., 2006: 1021)

Many fathers are likely to hold concerns over the undesirable side effects associated with antidepressant medications. Pescosolido and Perry et al., (2007) surveyed public knowledge of treatments for mental illness using interview data collected from 1,393 non-institutionalised individuals, as part of the National Stigma Study: Children; the researchers found that 66% believed drug treatment delayed solving 'real' behaviour-related problems and most (68%) believed that psychiatric medications hindered development (68%). Based on qualitative data gathered from a doorstep survey of over 2,000 people in the United Kingdom, Priest et al., (1996) concludes that the lay public appear to be generally sympathetic to those with depression but most (85%) were against the use of antidepressants, believing counselling to be more effective. The large majority of those surveyed (78%) regarded antidepressants as addictive with only 16% indicating that they should be given to depressed people (Priest et al., 1996). The public's reservations on the effectiveness and safety of antidepressant drugs for young people are similar to those held by clinicians, as evidenced by the findings that:

> **"Rigorous evidence for the efficacy of treatments for depression in young people is scarce. To make matters worse, few trials separate out data from children and adolescents. This is important because children may have a different response to treatment than adolescents and adults."**
>
> (Hazell, 2002: 229)

and

> **"The literature indicates that although both psychotherapy and pharmacotherapy have been found to be beneficial for depressive disorders, children do not seem to respond to antidepressants as well as adults do."**
>
> (Wu et al, 2001: 194)

Most recent literature continues to highlight that children respond differently to antidepressive medication than adults do, with concerning side effects (Bylund & Reed, 2007). Fathers are likely to be disappointed when they are presented with evidence of the limitations, extending to lack of efficacy, of most drug treatments (Badamgarav et al., 2003).

8.16.5 A non-drug form of treatment is psychotherapy

Many parents are faced with the need to make an informed consent when evaluating the known cost and benefits of psychotherapy for depression in their child and / or adolescents. However, evidence of efficacy for psychotherapy is sparse or conflicting (Badamgarav et al., 2003; Carr & Boyd, 2003). A recent Meta-analysis by Watanabe et al., (2007), used data from all relevant randomized-controlled trials to produce the finding that none of the studies reported adverse effects from the treatment or cost-effectiveness of outcomes; this was a concerning omission by researchers. In addition efficacy of the treatment was determined to be limited:

> **"Psychotherapies appear to help depressed youths for the short term, but are no longer significantly favourable at 6-month follow-up."**
>
> (Watanabe et al., 2007: 84)

A systematic review of six randomised trials, comparing the efficacy of Cognitive Behavioural Therapy (CBT) was undertaken by Harrington et al. (1998); it was concluded that CBT "may be of benefit" to children and adolescents experiencing a depressive disorder of moderate severity however, without large randomised control trials, this recommendation could not be extended to include the treatment

of severe depression in young people. A recent meta-analysis by Weisz et al., (2006) exploring the effects of youth psychotherapy also concluded that:

> **"Youth depression treatments appear to produce effects that are significant but modest in their strength, breadth, and durability."**
> (Weisz et al., 2006: 132).

The most recent review by Sims et al., (2007) concludes:

> **"Evidence for the effectiveness of these preventive interventions in real-world settings is needed, including cost effectiveness as well as research on the dissemination of evidence-based interventions within community and practice settings."**
> (Sims et al., 2007: 451).

Some reviewers are content to report that effective treatment can only be gained through a combination of exercise, social support and self-help using CTB (Christensen et al., 2004).

There is growing evidence that shows that fathers and non-resident fathers are willing and able to engage in family therapies intended to support the emotional wellbeing of their child and correct adolescent behavioural and mental health problems (Walters et al., 2001; O'Brien, 1988; Phares et al., 2005). However, there is a great need to educate men on the limitations of treatments and the best ways to improve their participation in support of a child with depression; to date there are no works that quantify men's participation in drug and non-drug treatments or identify their practice in assessing their child's symptoms as a trigger to referral to a Mental Health Professional.

8.17 Anxiety disorder

Anxiety among children and youth is common within normative populations (non-war zones) with global prevalence ranging from 5-20% (Aschenbrand et al., 2005); the Australians' prevalence is within this range (Boyd et al., 2000).

Genetic influences, behavioural inhibition, and parent-child interactions play significant and interactive roles in the development and maintenance of Social Anxiety Disorder (SAD). The problem of dysfunction anxiety currently has the nomenclature of "social phobia" in the DSM-IV and is defined as a:

> **"…marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The avoidance,**

> **anxious anticipation, or distress in the feared social or performance situation(s), interferes significantly with the person's normal routine."**
>
> (American Psychiatric Association, 2000: 456)

Children and youth experiencing SAD find the symptoms overwhelming and distressing, affecting their social competence, academic work, peer relations and often family relations. Childhood anxiety has been associated with parenting styles characterized by i) limited or inconsistent expressions of care and warmth ii) extreme displays of overprotection and control, and iii) issues associated with maternal-child attachment. Elizabeth et al., (2006) investigated literature that sought to make links between parent-child interactions and whilst there were some traits linked to controlling behaviour of the mother, similar but scant findings were related to the father:

> **"Such findings are broadly supportive of the proposition that parent-child interaction can have a major influence on social development and childhood anxiety disorders such SAD."**
>
> (Elizabeth et al., 2006)

There was scant mention of fathers and no details on their appreciation of their role in evoking anxiety or health practices directed toward treating anxiety in Elizabeth et al's., (2006) work. More recently, Bögels & Phares (2007) clearly identified a gap in knowledge linking fathers to the anxiety prevention and treatments.

> **"Fathers have been neglected in investigations of the development, prevention, and treatment of anxiety and anxiety disorders in children and adolescents."**
>
> (Bögels & Phares, 2007: e journal)

Dadds et al., (1999) trialed a schools-based course for 128 Queensland children who were identified, by a screening tool, as having an anxiety disorder. The data was collected at 12 and 24 months with analysis revealing that parental anxiety predicted poor initial responses to an intervention programme. Although a systematic review of a number of Australian schools anxiety intervention programmes produced positive results the researchers concluded:

> **"Universal approaches appear to produce short - to mid-term small to moderate reductions in anxiety and depression in schools.**
>
> (Neil & Christensen, 2007: 305-307)

and

> **"Even well established programs require further evaluation to establish readiness for broad dissemination."**
>
> (Neil & Christensen, 2007: 305-307)

Treatment and prevention programmes were discussed by Neil & Christensen (2007) in terms of their limited findings on fathers' involvement in the treatment of child / adolescent anxiety problems.

8.18 Attention Deficit Hyperactivity Disorder

Issues around the diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children have been prominent in the medical and psychosocial literature over the past decade. Attention Deficit Hyperactivity Disorder is a mental disorder characterised by problems in maintaining attention and/or problems with impulsive behaviours; ADHD is most commonly diagnosed in early childhood. A complete symptomatic description of ADHD can be sourced at American Psychiatric Association (1994: 79–85). Descriptions of symptoms, assisting in diagnosis are obtained directly from the child, the parents and teachers (Rappley, 2005). Most fathers would have the opportunity to assess their child's behaviour and seek help for their child as ADHD symptoms are omnipresent.

If ADHD is not diagnosed and treated appropriately the disorder is likely to have a negative effect on the child's life chances as symptomatic behaviours effect academic work and social interactions with peers and authority figures (Eisenberg & Schneider, 2007; McLeod, 2007; Ross, 2007, Rimmerman et al., 2005; Diamantopoulou et al., 2005). Those children diagnosed and treated for ADHA have substantial risks of co-morbidity. Although impact of ADHD is not uniform Klassen et al., (2004) found children with more symptoms of ADHD had worse psychosocial Health Related Quality of Life.

The prevalence of attention deficit hyperactivity disorder (ADHD) differs between countries. In the US approximately 3% to 7% of school-age children meet the criteria for ADHD (Sciutto & Eisenberg, 2007: 106). The subjective nature of evaluating appropriate / inappropriate behaviour contributes to concern that ADHD is over diagnosed (Rappley, 2005). In most countries, the majority of children with attention deficit/hyperactivity disorder (ADHD) are undiagnosed

(Sayal et al., 2006). Although the public perception is that this level of prevalence is attributable to over-diagnosis, recent prevalence studies and research into factors affecting diagnostic accuracy examined by Sciutto and Eisenberg (2007) resulted in the finding:

> **"There does not appear to be sufficient justification for the conclusion that ADHD is systematically over diagnosed. Yet, this conclusion is generally not reflected in public perceptions or media coverage of ADHD."**
>
> (Sciutto & Eisenberg, 2007: 106)

Impacting on the psyche of fathers and mothers is their attempts to cope with a child's behavioural problems on a daily basis, a lack of clear service pathways to obtain diagnosis, the social stigma attached to the diagnosis and lack of parent support to assist them in correcting behavioural problems (Bussing et al., 2003a; Sayal et al., 2006). There are also gaps between parents' symptom recognition and clear indications of the need to seek help, resulting in a substantial proportion of children with unmet needs (Bussing et al., 2003b).

In the United Kingdom:

> **"A major barrier to accessing specialist services is the limited recognition of disorders by general practitioners."**
>
> (Sayal et al., 2006: 744)

A UK study by Sayal et al., (2006) found that although 80% of parents of children diagnosed with ADHD recognised the child had problems, many sought help on the basis of the parental burden rather than child factors. Most parents stopped at consulting education-based professionals and made limited presentations of the problem behaviours to primary health care services and even less to health specialists. An Australian study of 389 children with ADHD (Sawyer et al., 2004) had similar findings:

> **"Factors other than children's ADHD symptomatology have a significant relationship with service attendance."**
>
> (Sawyer et al., 2004: 1355)

Among the 389 children, 20% had attended only school-based services, 39% had attended only health services and 41% had attended both health and school-based services. Importantly, 69% of parents attending health services wanted additional help. Foy and Earls (2006) suggest barriers occur at multiple levels in relation to diagnosis and treatment patterns linked to poverty, gender and race. In

the US half of the physicians (50.1%) reported that insurers limit coverage for assessment and treatment of ADHD and this is a financial barrier for some parents (Rushton et al., 2004).

A literature search was conducted on the assumption that fathers are aware of i) ADHD symptoms, ii) the need for referral to a MHP and ii) the medications used to treat ADHD and the issues that surround them. A search of the literature, using the words 'fathers' and 'ADHD' expanding to 'child, adolescent, diagnosis', medication was carried out in the data bases Blackwell Synergy, Google scholar SCOPUS and Psycinfo. The search revealed no specific works identifying a father's participation in medication management of ADHD. The vast majority of the literature identified was concerned with fathers' coping strategies (Johnson, 1996) rather than any well informed health practice to improve the child's mental health status.

Podolski and Nigg (2001) study focused on parental coping and reported that:

> **"Most studies focused exclusively on mothers, with relative neglect of the impact on fathers."**

and

> **"Unlike most prior studies, we included fathers as well as mothers."**
>
> (Podolski et al., 2001: 504, 510)

In Podolski and Nigg's (2001) study, both fathers and mothers rated the severity of ADHD behaviour as distressing to their parenting role. However, maternal role-specific distress was related to both 'oppositional child behaviours' and child 'inattention – disorganization' but father distress was predominantly accounted for by the child's 'oppositional or aggressive' behaviours. Girls with ADHD tended to elicit more parental distress than boys.

> **"For fathers, parenting role distress was associated uniquely with child oppositional or aggressive behaviors but not with ADHD symptom severity."**
>
> (Podolski & Nigg, 2001: 503)

Consequently, it was not surprising to find that the most pertinent health practice employed by fathers was to withdraw from oppositional conflict: "For fathers, positive reframing was also the most notable coping strategy." (Podolski & Nigg, 2001: 510).

Podolski and Nigg (2001) recommend that further study is warranted with larger sample sizes to test whether mothers and fathers exhibit different coping strategies in relation to parenting distress.

The Multimodal Treatment Study of ADHD (2004) found that medication management yielded greater reductions in parent and teacher-reported ADHD symptoms even though parent and teacher satisfaction measures favoured psychosocial treatment.

Although assessment of education needs and special needs classes are promoted as assisting chidren with ADAH:

> **"Behavioural therapy is not routinely recommended as first-line treatment for uncomplicated ADHD in children."**
>
> (Rappley, 2005: 169)

Treatment for ADHD remains predominantly pharmaceutical because there is strong evidence to show that stimulant medication mediates the symptoms of inattention, impulsivity, and hyperactivity in young children. Nearly a decade ago it was estimated that nearly five million school-age children, living in North America, were prescribed stimulant medication for ADHD (Diller, 1998). From the findings of the literature search outlined above it can be stated that no works could be located to describe the medication practices of parents / fathers for ADHD even though common side effects include appetite suppression, stomach ache, and headache; these side effects are troublesome and eventually lead to a discontinuation of the medication in 1-4% of children (Rappley, 2005).

A substantial challenge for fathers and mothers is to locate support for their child as they move into adolescence.

> **"Adolescents with ADHD are now leaving children's services often with no readily identifiable adult service to support them, which presents problems as local pharmacy regulations often preclude the prescription of stimulant drugs by general practitioners (GPs)."**
>
> (Nutt et al., 2007: 10)

In recent years, UK and Australian health services have proven inadequate in meeting the needs of children with ADHD and those youths in transition away from children's services (Nutt eta l., 2007; Sawyer et al., 2004).

8.19 Self harm in young people

Deliberate self-harm and para sucicide is common and is costly in terms of both individual distress and service provision (Royal Australian and New Zealand College of Psychiatrists, 2004; Bille-Brahe et al., 1997). United States data show that mental disorders are diagnosed in roughly one half (56.0%) of emergency department visits by young people (aged 7 to 24 years) following an episode of deliberate self-harm (Olfson et al., 2005). Varying definitions of Deliberate Self-Harm (DSH) have made it difficult to determine the true prevalence and prevent useful comparisons between studies (De Leo & Heller, 2004). Although most GPs may experience the death of a patient through suicide once every five years, an average of six patients on a GP's list will deliberately self-harm each year (Phaff & Almeida, 2005). In an Australian community study, 6.6% of university students claimed they had performed at least one act of self-harm in the 12 month period before the survey (Schweitzer et al., 1995).

Data identifying the number of attendances at accident and emergency departments is not a good indicator of prevalence of DSH as many youths choose not to attend these facilities. A UK study across 41 schools involving 6,020 pupil questionnaires, for students aged 15 and 16 years, revealed that although 6.9% (398) participants reported an act of deliberate self-harm (in the 12 months prior to the study), only 12.6% of episodes had resulted in presentation to hospital (Hawton et al., 2004). A previous study by Hawton et al., (2002) using a similar method and population to that of Hawton et al., (2004) recorded self harm in 506 (8.6%) of the student sample. In an Australian study, consisting of 3,757 year 10 and year 11 students, De Leo and Heller (2004) determined that of the 317 (8.4%) recording DSH, only 10.3% of these presenting to hospital for treatment. De Leo and Heller (2004) concluded that:

> **"...it appears that investigations of DSH based on monitoring studies of adolescents severely under-report the extent of the problem."**
>
> (De Leo & Heller, 2004: 143)

A search of the literature was conducted using the key words 'father' or 'parent*', 'child' or 'adolescent' and 'self-harm' in the data bases Blackwell Synergy, Google scholar and SCOPUS. The search findings revealed that although some researchers recorded parents' observations of their child's depression and suicidal

ideation / deliberate self harm (Starling et al., 2004; Tulloch et al., 1997) this work did not extend to recording any specific paternal health practices employed to reduce suicidal ideation or DSH.

The cause of self-harm is most often linked to causes of suicidal ideation and gender, Starling et al., found:

> **"Both young women and their parents showed twice the odds of young men or their parents to report self harm."**
>
> (Starling et al., 2004: 734)

Tulloch et al., (1997) examined the association between parents' communication style and self-harm among 14-19 year old Australian adolescents, using a control study of 52 youths (36 females, 16 males) who presented to the accident and emergency department of a general hospital with a self-inflicted injury. The absence of a family confidant was very strongly associated with the act of self-harm and was most prominent among those who had an internal locus of control. Ergo, impairment of communication between adolescents and their parents could be the origins of self-harm. Many parents record a sense of guilt and shame that their child has been desperate enough to take such action and not turn to them for aid or advice (Mc Donald et al., 2007).

It is difficult to locate evidence for clinical interventions that effectively reduce a repetition of deliberate self-harm (DSH) in adolescents and young adults. Following a critical review of three RCTs, four clinical control trials and three quasi-experimental studies Burns et al., (2005) concluded that:

> **"The evidence base for treatments designed to reduce the repetition of self-harm in adolescents and young adults is very limited... Expensive interventions such as intensive aftercare offer no clear benefit over routine aftercare."**
>
> (Burns et al., 2005: 121)

Overall, there were few indications in the literature of the role and practices of parents seeking to reduce the risk of para-suicide or expunge suicidal thoughts and self harm. This perhaps reflects the very complex nature of adolescent emotional problems with several key researchers recommending assessment in early school years and school based interventions (Haavisto et al., 2005; Hawton et al., 2002). The emphasis on schools may also reflect findings that part of the

reason for self-harm lies in early life child-parent discord, family difficulties and depression (Tulloch et al., 1997; McLaughlin et al. 1996, Schock et al., 2002).

8.20 Suicide in young people

Suicide is relatively rare in childhood and becomes more frequent in early adolescence (Fairweather et al., 2007; Pelkonen, Mirjami; Marttunen, Mauri, 2003). Despite the continued statistical rarity of these suicides (Schmidt et al., 2002) the years of life lost are substantial and for every single suicide multiple lives are affected (Australian Bureau of Statics, 2003). It has been estimated that up to six people are directly affected by an individual's suicide (Maple, 2005). In one generation (25 years), at least 120 million people globally, will have been close to a person who has suicided (De Leo et al., 2001). Their experiences include a sense of bereavement, guilt, stigma (for families and communities) and intense psychological unease. Parental and family bereavement, caused by suicide, is not well understood because many of those affected remain isolated and private in their grief (Maple, 2005). Even those on the periphery of a suicide may be affected in that knowledge of someone else's suicidal behaviour significantly increases the risk of similar acts (De Leo et al., 2005; Schmidt et al., 2002).

Suicide is one of the leading causes of death among young persons of both sexes yet:

> **"Very little is known worldwide about the causes of death and suicide rates among young people aged 15-19."**
>
> (Wasserman et al., 2005: 114)

And suicide data is still not available within many countries (Wasserman et al., 2005: 114). Furthermore, the recordings of 'other violent deaths' (OVD) may be a repository for hiding culturally unacceptable suicides in belief systems such as Islam (Pritchard & Amanullah, 2006). The recordings by coroners, of 'undetermined deaths', is problematic among white, Anglo populations because it is suspected this category is indicative of a hidden and higher prevalence of suicide.

According to the latest World Health Organization (WHO) Mortality Database, available from 90 countries, global suicide rates among adolescents aged between

15 and 19 years were 7.4/100,000. Suicide rates were higher in males (10.5) than in females (4.1) (Wasserman et al., 2005: 114). Suicide rates and trends differ between countries:

> **"Suicide rates were upwards in Ireland, Italy, Spain, the UK, Cuba, Australia and New Zealand. Substantial rises were observed in a few countries (Ireland, Cuba, Mexico, Australia and New Zealand) for young males."**
>
> (Levi et al., 2003: 341)

In 2002 the United States recorded 264 child and adolescent (ages 5-14 years) suicides, making this the fifth leading cause of death for the age group (Gibbons et al., 2006). An assessment of suicide in children and adolescents in England and Wales 1970-1998 concluded:

> **"Among children and adolescents, the only group to have shown an increase in official suicide rate since 1970 has been males aged 15-19 years. This increase is still evident when one examines the changes in undetermined and accidental rates during 1970-1998 and indeed the actual increase in suicide may be greater than the official suicide statistics indicate."**
>
> (McClure, 2001:469)

A review of Australian suicide trends 1964-1997 reported:

> **"Australian suicide rates for males 15-24 years and 25-34 years rose from 1964-1997. Comparable rates for females showed no significant change."**
>
> (Canto, 1999: 137)

McKelvey et al.'s, (1998) pilot study, sought to determine the prevalence rates of psychological distress and suicidal ideation among 15-24-year-old patients presenting to five Australian general practices. The patients (*n*=69) had relatively high levels of psychological distress and suicidal ideation. Of most concern were those presenting with medical complaints (87.5% of the sample). A subsequent Australia wide study, involving 247 GPs, with 3,242 participants (15-24-year-old) supported the earlier claim that:

> **"Despite presenting with primarily medical complaints, almost half of young people presenting to primary care physicians had high levels of psychological distress and almost a quarter had high levels of suicidal ideation."**
>
> (McKelvey et al., 2001: 550)

Assessment of child and youth suicidal ideation by fathers and mothers is poorly recorded with many anecdotes relating to a feeling of total surprise. Some studies show a link to depressive illness but a significant minority (31%) of young

depressed suicide victims were depressed less than three months prior to death (Brent et al., 1993). Suicide may be preceded by attempts at suicide; Bridge et al., (2006) found the risk of repetitious attempts is highest in the first three to six months after a suicide attempt but remains substantially elevated from the general population for at least two years. Little literature explains the experiences of parents as they become aware of these attempts; perhaps because the matter is extremely sensitive and there is substantial introspection as parents seek to determine if the cause of their child's distress has to do with them.

> **"Early childhood abuse and neglect appear to contribute to the familial transmission of suicidal behavior by compounding genetic vulnerability."**
>
> (Brent & Mann, 2006: 2721)

and

> **"...findings are insufficient to permit accurate prediction of who will commit suicide, but they do suggest that impulsive aggression, neurocognitive difficulties, and family adversity might be considered potential targets for treatment in persons who have attempted suicide."**
>
> (Brent & Mann, 2006: 2721)

Fathers and mothers cannot assume that GPs will be able to identify suicidal ideation despite the use of Australian GP workshops enhancing recognition: "Higher recognition rates do not necessarily lead to changes in patient management." (Pfaff et al., 2001:222).

Meta analysis of the literature, including randomized as well as open clinical trials, suggests that treatment by medication is effective for those with a diagnosed depression.

> **"Risks of completed and attempted suicide were consistently lower, by approximately 80%, during treatment of bipolar and other major affective disorder patients with lithium for an average of 18 months."**
>
> (Baldessarini et al., 2006: 625)

A literature search of the data bases, Blackwell Synergy, Science Direct, Scopus, PsycInfo and Google Scholar, using the key words 'father', 'parent', 'suicide attempt child', 'adolescent', 'prevention' could not identify any specific works that explored the fathers, role in mental health practices orientated towards assessing for suicidal ideation or interventions for prevention.

An Australian study (Starling et al., 2004), collected retrospective data using clinic records at a university-affiliated adolescent psychiatry service; the aim of the study was to determine if there were changes in prevalence of psychological disturbance (anxiety and depression) in the children, over the period they were receiving treatment from their parents.

> **"The parents in this study showed an increasing awareness of self-harm and suicidal ideation in their children, with increasing year of birth. There was no evidence for an increasing awareness of anxiety/depression."**
>
> (Starling et al., 2004: 736)

Although Starling et al's. (2004), study recorded parents' awareness of self-harm and their youth's talk of killing themselves there was no mention of any mental health practices / strategies employed to reduce the risk or assess the risk of suicide. There was evidence that males talked very little about killing themselves.

> **"Male adolescents were less likely to talk about killing themselves (OR = 0.63) and parents were less likely to report suicidal ideation in their male children (OR = 0.47)."**
>
> (Starling et al., 2004: 735)

For many fathers and mothers there is no warning; it is estimated that 40% of suicide completers under the age of 16 do not appear to have a diagnosable psychiatric disorder (Bridge et al., 2006). Adolescents with no mental health disorder more often communicated suicidal thoughts for the first time, just before they suicide. Communication of suicidal intent and discipline problems and difficulties with the law are among the few clinical warning signs (Marttunen et al., 1998). It was concluded that the process (means, time and place) leading to suicide seems to be relatively short among those male adolescents with no diagnosable psychiatric disorder (Marttunen et al., 1998). Overall there is scant literature on the role and effectiveness of parental interventions.

8.21 Conclusion

This chapter has established, from prevalence data across a range of mental health illnesses, that mental health issues centred on caring for children and youth present a substantial workload for parents and mental health professionals.

The literature indicates that parents are often unable to determine if their child requires referral to a mental health professional. Those parents caring for a child /

adolescent with a diagnosed mental health problem are often unable to make informed decisions about the most effective drug or non-drug treatments because of a lack of evidence based practice.

The scantness of data on men's health practices is partly explained by key researchers noting methodological problems, a researcher bias toward reporting mothers' health practices and a failure to disaggregate data on 'parents' into father / mother variables. The literature search revealed works identifying that not all men are equipped to take part in help-seeking, diagnosis, treatments and ongoing surveillance of their child's mental health status.

Despite the limitations of the literature and a lack of systematic research exploring the capabilities and actual mental health practices of fathers, there is sufficient evidence to indicate that many men care deeply about their sons and daughters behavioural and mental health problems. And there is overarching evidence to show that fathers' mental health prompting activities (subliminal or active strategies) have a positive influence on many children's sense of self-worth and sense of resilience, resulting in a protective effect against mental health problems later in life.

The findings presented in this chapter support the inclusion of questions in the household survey, that record the presence of mental health problems within the family; this occurs in Section 3.3 *Health problems in your family at present*; Q3.3.7 *Has a doctor told a family member they have a mental health problem?* The information on mental health problems recorded by the survey can be linked to actual health practice questions (example: Q 2.3.1 *Who usually looks after a sick child*? Q3.5.10 *Who usually gives medicines to the children in your family?*).

Questions that identify specific health practices towards children with a diagnosed mental illness were not included in the survey because of the sensitive nature of the problems and a decision was made by the researcher that these practices could be better explored using a qualitative method (individual interviews). The contents of this chapter provided a preparatory background for the researcher to explore the topic "mental health" within the focus group discussions.

CHAPTER NINE: TERMINAL ILLNESS

9 Introduction

This chapter presents the findings of a systematic search of the literature aimed at identifying fathers' health practices directed towards assisting their child with a life limiting illness (LLI). The purpose of this chapter is two-fold: i) to identify the opportunities afforded men in their attempts to contribute to their child's quality of life during a life limiting illness, and ii) to describe men's actual health practices in support of their child during the final stage of a terminal illness (the process of dying). Literature exploring parents' experiences of caring for a child with cancer is not included in this chapter unless the content refers to the process of dying (non – survivors of cancer).

An initial literature search sought to identify men's health practices using the general term 'terminal illness' and the key words 'child' 'adolescents' and 'fathers'. Added to this were the key words 'life limiting' 'life threatening'. The electronic searches of the health care data bases CINAHL, Medline, PsychInfo, Family Health and sociological literature were supplemented by manual searches; with the time frame of 1960-2005.

In 2004/2005 a literature search exploring fathers' role in the care of the terminally ill child was published by the author of this doctoral study. In that publication (Laws, 2004/2005), several statements by key researchers (quotations) were used to support the claim that substantial gaps existed in the research of fathers' contribution to the care of the gravely ill child. This chapter is based on that initial search (see Appendix 8) supplemented by a search of more recent literature.

9.1 Background

The incidence of cancer and terminal illness in young people is small relative to other age groups in the general population but the personal care provided by parents is often substantial and their long-term efforts to prolong survival and

optimise quality of life often have a profound effect on parents' wellbeing (Valdimarsdóttir, 2007). Terminal illness in the paediatric and adolescent population has many origins. A major precursor to terminal illness is paediatric and adolescent cancer. It is estimated that each year in the U.S. 2,300 children and adolescents die of cancer making this "the most common cause of disease-related mortality for children 1-19 years of age." (Ries, 1999: iii).

Improvements in survival have presented parents with longer periods of concern over the potential for adverse medical events, side effects of multiple modes of treatment and the child's contemplation of what it means to be diagnosed with a potentially life threatening illness. Researching parents' experiences and efforts to provide care during the survivor phase and at the time of reoccurrence of cancer has only recently become a focus of research (Patterson et al., 2004; Terracicni et al., 2001: 815; Sterken, 1996). Consequently, little is known about the contributions of fathers in the support of their child who potentially faces a life limiting illness.

Whilst mothers are reported to be the main carers and the nexus between the family and providers of health services (Jones & Urban, 2003; Black, 1998) data on the contributions made by fathers are rare (Sterken, 1996; Holm et al., 2003; McGrath & Huff, 2003a). Although Patterson et al., (2004) purport to be exploring the lived experience of parents in coping with their child's cancer, using a sample of 58% mothers and 42% fathers, there was a disproportionate emphasis on mothers, with seven verbatim comments by mothers and only three from fathers; there were no declarations by the researchers suggesting that women were better informants in the study. Brody and Simmons (2007) conducted in-depth interviews with eight fathers whose children had received treatment for cancer to 'explore the resources that helped fathers' but reached the limited conclusion that: 'further studies were warranted' to understand how fathers cope. Psychological studies sampling fathers in large numbers, often did not arrive at a generalisation as there was often a lack of congruency between findings within a single study. This led researchers to make conjectures about what the data might mean (Hoekstra-Weebers et al., 2001; Wijnberg-Williams, 2006).

Even when fathers are sampled and categorised as 'primary caregivers' for a child with cancer the researchers (Bonner et al., 2007) focus on the psychosocial

functioning of the father rather than the psychology of caring through active participation in emotional care giving. Out of the 67 articles reviewed by Vrijmoet-Wiersma et al., (2008) only one study focused on fathers alone and that study was conducted in Taiwan. Bonner et al., (2007) are openly critical about the lack of father research published in psychology journals, noting:

> **"…editorial attention, with numerous opinion pieces in journals such as *Pediatrics* (Pruett, 1998) and the *Journal of Pediatric Psychology* (Seagull, 2000) calling for the inclusion of fathers as an emerging and vital need in the field."**
>
> (Bonner et al., 2007: 851)

Absent from the psychology literature is data providing insight into why some fathers engage in health practices for their terminally ill child and others do not. A recent study by Edwards et al., (2008) revealed that a willingness to participate in care did not differ between fathers and mothers. And from the time of diagnosis, fathers and mothers held a similar understanding of the child's prognosis, with 58% of couples agreed on the goal of cure (Edwards et al., 2008).

9.2 Incidence of cancer in young people

In the US, over 12,400 people under the age of 20 years receive a diagnosis of cancer each year (Ries, 1999). In Australia, 603 individuals, aged between 0-14 were diagnosed with cancer in 2001; leukaemia and brain cancer accounted for 57% of all cancers diagnosed in this population (Australian Institute of Health and Welfare, 2005). The major cause of death for children aged 0-14 years was external causes (e.g. road traffic accidents) accounting for 36% of mortality followed by cancer at 19% (ABS, 2006).

Survival rates for children with cancer have continued to improve over the past 20 years; five year survival rates are approaching 80% and a growing number of children now survive into adulthood (Smith & Hare, 2004; Patterson et al., 2004; Ware & Raval, 2007). European data show that increases in survival times are real and are not attributable to lead-time bias arising from improvements in screening and diagnostic procedures; this phenomenon is evidenced by Terracini et al., (2001) who state:

> **"A regression analysis of incidence, mortality and survival rates during 1978-1989 over the whole EUROCARE database strongly indicates that the prognostic improvements over time are real and cannot be attributed to changes in diagnostic procedures."**
>
> (Terracini et al., 2001: 810)

And this is supported by international data giving absolute numbers of survivors:

> **"Extrapolation of prudent estimates from Italy and the UK indicate that in Europe the number of adolescents and young adults who have overcome a cancer in childhood is in the order of at least 100,000."**
>
> (Terracicni et al., 2001: 815)

A major implication of improved survivorship is the expansion of a life span, giving fathers an increased opportunity to be pragmatically engaged in health practices that are supportive of their child's / adolescent's health and wellbeing. The move from institutional care to home care for these children is likely to position fathers with better access to their child on a daily basis. Goldman (1996) prescribes that:

> **"When a child is to be cared for at home, the parents and the sick child themselves should take an active part in planning a practical and acceptable regimen of care."**
>
> (Goldman, 1996: 16)

Challenges facing fathers include, the long-term consequences of treatments (surgery, chemotherapy and radiotherapy), the results of adverse medical interventions, experiences of painful procedures; all of which are associated with higher risk of psychopathology developing in the child (Sloper, 2000; Patterson et al., 2004). Despite the litany of potential problems, researchers highlight that:

> **"Population-based studies on the quality of life of long-term survivors after childhood cancer have been limited."**
>
> (Terracicni et al., 2001: 815)

This observation was recently reiterated by Paterson et al., (2004) who state that the cure phase of a child's recovery has:

> **"Only recently begun to emerge as a primary focus of clinical research, including studies of health-related quality of life among survivors."**
>
> (Paterson et al., 2004: 390)

An impediment to data collection is the number of children who survive but are lost to follow up (Parkes et al., 2007). The scantness of data for this phase of a

child's recovery, combined with a research emphasis on maternal caring, means that little is known about fathers' tangible efforts aimed at assisting their child.

9.3 Fathers' emotional burden

An exploration of fathers' health practice toward a child with a life limiting illness (LLI) or in a terminal phase of illness needs to establish the context in which these men practice health. The most salient context to consider is fathers' emotional reactions and adjustment to diagnosis and key events along the care pathway.

Researchers have sought to compare stress between mother and fathers. A comprehensive review of the literature conducted by Bonner et al., (2007) revealed that over the past decade, 23 studies were undertaken to explore parents' experiences of childhood cancer patients and compare fathers' and mothers' adjustment. The majority of these studies found that fathers' reports of adjustment were similar to those of mothers'. However, Bonner (2007) could only postulate, from a single study recoding men as the *primary medical* caregivers and *non-primary medical caregivers* (Frank et al., 2001), that men most proximal to care giving experience higher levels of stress than men not involved in care.

Numerous researchers have found an association between caring practices of fathers and mothers and the prevalence of psychopathology in these parents (Frank et al., 2001; Matt, 2006; Greening & Stoppelbei, 2007; Kazak et al., 1997). Brown et al., (1993) determined that 34% of mothers (n=21) met DSM-III-R criteria (American Psychological Association, 1994) for at least one psychiatric disorder. Several researchers found a difference in predictors of affective responses between mothers and fathers; achievement-related attributions and perceived social support were associated with positive affective responses for fathers (Frank et al., 2001; Kazak et al., 2004). However, the stress reported by some fathers approached that of post-traumatic stress disorder (PTSD).

Much of the research into parents' experiences has focused on assessing if criteria is met for post-traumatic stress disorder (PTSD) and post-traumatic stress symptomatology (PTSS), as defined by the Diagnostic Statistical Manual of Mental Disorders, 3-4th edition (DSM-III & IV); (American Psychological

Association, 1994). Matt (2006), having performed a systematic review, concluded that the applicability of PTSD, used both conceptually and diagnostically, to cancer-related emotional responses remains poorly articulated within the literature. A range of research methods has been employed to determine the psychological effects on 'parents' using PTSD criteria with many researchers openly declaring limitations to their work. Kazak et al., (2004) found moderate to severe PTSS was reported for 44% of mothers, 35% of fathers (*n*=146 mothers, and 103 fathers) and nearly 20% of families had at least one parent with PTSD at the time of the survey. Some studies do not show a relationship between parental stress and PTSS. Jurbergs et al., (2007) having sampled 258 (84%) mothers, 42 (13.7%) fathers, and five (1.6%) other guardians, found that parents of long-term survivors reported significantly lower levels of PTSS than did controls. However, Jurbergs et al., (2007) states that there were several subgroups of parents affected by PTSD:

> **"Time since diagnosis, child treatment status, and relapse history are significant determinants of parent PTSS. Only parents of children who experienced a relapse appear to be at increased risk of PTSD."**
>
> (Jurbergs et al., 2007: 1)

In the future, it will be vital that evidence-based interventions be developed to address emerging issues associated with caring for survivors; better support for both parents would assist in reducing their risk of experiencing collateral psychological morbidity (Kazak et al., 2007).

9.4 Fathers promoting their child's wellbeing

For the child / adolescent, prolonged discomfort from symptoms related to terminal illness and feelings of helplessness diminish their emotional resilience and they become at risk of developing stress related mental health problems (PTSD, depression) (Kersun & Shemesh, 2007). A meta analysis of the effects of psychological interventions in paediatric oncology to overcome psychological distress and adjustment problems, conducted by Pai et al., (2007), concluded that psychological interventions in the paediatric oncology setting 'show promise' in decreasing distress and improving the adjustment but "…may have minimal effects for child outcomes." (Pai et al., 2007: 978).

An important health practice performed by fathers is the provision of emotional support and advocating for their child's quality of life (Jones & Neil-Urban, 2003). However, the literature suggests that fathers may be impeded in performing this support because of personal distress. Robinson et al.'s, study sought to identify factors that influence the association between parent distress and child distress among families of children with cancer. Using a control group of parents the researchers were able to show that …

> **"Significant associations were found between parent and child distress… Children whose parents were distressed were more likely to be distressed themselves."**
>
> (Robinson et al., 2007: 400)

Although researchers identify sources of stress for parents and children (Sloper, 2001; Dahlquist et al., 1996) there is little evidence to show that psychologists, who aim to support parents, are able to provide evidence based strategies that are effective in reducing distress and meet outcome targets. According to Kazak (2005), a lack of measurable outcomes occurs because the majority of paediatric oncology publications report, not on an assessment of the effectiveness of supportive interventions, but on the results of descriptive and correlation research. The following statement summarises Kazak's (2005) findings:

> **"The largest area of work in pediatric oncology has examined the psychological reactions of patients and parents during the course of active cancer treatment. This work provides ample evidence of challenges faced by children and families but has returned inconclusive data with regard to potential intervention targets."**
>
> (Kazak, 2005: 30)

Against this background Kazak (2005) makes comment on the lack of literature concerning effects supportive interventions from fathers:

> **"Most psychological research in pediatric oncology includes either patients alone or patients and mothers, with persistent lack of attention to fathers…"**
>
> (Kazak, 2005: 30)

Most recently, Vrijmoet-Wiersma et al., (2008) located 67 studies spanning 10 years as part of a systematic search for literature exploring parental stress and management practices. The principle findings from Vrijmoet-Wiersma et al (2008) were:

> **"The inclusion of predominantly white parents and the assessment of either mothers alone or parents as a couple causes bias and generalization problems."**
>
> (Vrijmoet-Wiersma et al., 2008: 7)

and

> **"One time, cross-sectional surveys were employed in the majority of studies." However, "in almost all articles the necessity of longitudinal designs is argued."**
>
> (Vrijmoet-Wiersma et al., 2008: 7)

A major barrier for researchers was locating an appropriate time to make an assessment of parents' mental state and coping.

> **"Clinical practice has shown that assessment within 4 weeks after diagnosis is difficult, because parents are often too overwhelmed to take the time to fill in questionnaires… The end of treatment brings new challenges for parents and longer term follow-up is necessary to keep track of the parents who still report high-stress levels."**
>
> (Vrijmoet-Wiersma et al., 2008: 8)

The conclusion by Vrijmoet-Wiersma et al., (2008) left little doubt that what research had been undertaken was about monitoring parental stress and unlikely to yield any evidence that could be used to provide interventions to reduce distress experienced by parents. Consequently, distress in fathers is likely to continue, impeding their ability to affect a reduction in distress in the child they are caring for. Kazak et al., (2007) also acknowledge past limitations in effective support for parents and proposed a blue print for practice, stating:

> **"The dissemination of evidence-based psychosocial practice in pediatric oncology remains a large and challenging goal. The proposed blueprint may facilitate collaborative work to help assure that children with cancer and their families have access to evidence-based care."**
>
> (Kazak et al., 2007: 1099)

This section suggests that men may have many unresolved emotional issues from having cared for or not cared for their child who has a life limiting illness.

9.5 Evidence of fathers' health practices at home and in hospital

Holm et al.'s (2003) study of fathers and mothers of children with LLI carries a crucial request from them to all health professionals.

> **"…parents want nurses and other medical professionals to help socialize them into actively participating in their children's medical care."**
>
> (Holm et al., 2003: 312)

Over a decade ago researchers concurred that little was known about fathers and their role in caring for a child with a life limiting illness (LLI). Sterken (1996) described the uncertainty experienced by fathers and their coping behaviours toward the diagnosis of child cancer and observed of the literature that:

> **"Limited research has been conducted regarding the father's relationship with the chronically ill child, particularly the child with cancer."**
>
> Sterken (1996: 81)

Similarly, Brown and Barbarin (1996) contended that:

> **"While existing research yields much about mothers, the needs, concerns and experiences of fathers are rarely studied and are not well understood."**
>
> (Brown & Barbarin, 1996: 55)

Jones and Neil-Urban (2003) provide more recent evidence and comments to show that little additional research on fathers of children with LLI has emerged and summarise findings with the statement:

> **"…in terms of research; relatively little has focused on fathers as providers of care. Whether this reflects the reality of family care giving (i.e., fathers may assume a minor or secondary care-giving role compared to mothers) or the focus of existing research is unclear. This focus is in part due to the fact that mothers are presumed to be the primary family care-giver."**
>
> (Jones & Neil-Urban, 2003: 42)

For this doctoral thesis, a literature search was conducted to locate works that describe and / or quantify men's health practice toward a child with a terminal illness. The search took place within the data bases Blackwell Synergy (1982-2005), Google Scholar (1993-2005), PsycINFO (1985-2005) and Oxford Journals (1986-2005), augmented by hard copy methods. The search was guided by the key words 'father', 'child', 'terminal illness' 'cancer', 'palliative care'. The search ended when the information collected was believed to have provided a sufficient basis for constructing a synthesis of contemporary knowledge. Given the scantness of literature found in a previous literature search (Laws, 2004 / 2005) the results from this contemporary search are highlighted as a set of statements made by key researchers. The search findings are presented in the

upcoming section 9.6 *Fathers' physical health practices* for paternal care both in-hospital and at home.

9.6 Fathers' physical health practices

In the in-hospital care situation men's health practices are likely to be limited to emotional support for their child, providing distraction and entertainment as well as assisting the child with activities of daily living (feeding, toileting and comfort care). In the opening comment by Holm et al., (2003), in their recent work on identifying gaps in the literature relative to parental participation in care, the researchers' state:

> **"Few research studies have addressed the ways parents participate in their child's medical care, particularly in relation to the cancer experience."**
>
> (Holm et al., 2003: 301)

and

> **"Although studies have addressed parent behaviour during specific, well defined procedures that are part of cancer treatment, research has not focused on parents' descriptions of ways they participate more broadly in the entire process of their children's medical care, beginning with their search for diagnosis and extending through the completion of treatment."**
>
> (Holm et al., 2003: 302)

Although Holm et al. (2003) provide rich qualitative data there are few excerpts from their interviews with fathers and these pertain to only one task, the gathering of information about the illness and treatments (e.g. internet use and questioning the medical profession). Jones and Neil-Urban (2003) also recorded that fathers actively search for information on diagnosis and subsequent treatments by using the internet, books and interviews with medical personnel. Ware and Raval, (2007) produced a rare study aiming to gain an understanding of fathers' experiences of having cared for a child with a life-limiting illness (LLI); a phenomenological analysis was undertaken following individual interviews with fathers (*n*=8). Ware and Raval (2007) make the following criticism of previous studies:

> **"Studies have failed to address how fathers experience having a child with a LLI (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005; Hunt, 2003). Outcome variables seem to have been chosen prior to exploring how men themselves actually think about their**

> **experience. Thus we seldom learn of the 'common and unique' nature of men's experiences."**
>
> (Ware & Raval, 2007: 551)

Ware and Raval (2007) explained that their sample was small (*n*=8) because of the sensitive nature of the topic. Hunt et al., (2006) have also made comment on the sensitive nature of the topic, stating that:

> **"Recruitment of participants was much more difficult than anticipated… The sample is thus likely to be heavily biased towards men who are prepared to talk about emotional and psychological aspects of childhood LLI."**
>
> (Ware & Raval, 2007: 551)

None of the themes generated in Ware and Raval's (2007) study directly referred to men's actual health practices but there were clear indications, from the men, of their doing important tasks. For example, the men had made women's emotional work possible by recognising that there is a gender division of labour around the expression of emotions. That is, men at interview felt they needed to remain stoic so as to be able to give support to their wife when she expressed emotion.

> **"How I coped with it was a typical male, the female broke down in tears and someone had to be strong to support the other."**
>
> (Ware & Raval, 2007: 557)

The stoicism displayed by men can be interpreted as self-sacrificing, because Ware and Raval (2007) noted that:

> **"The perceived need to mask their true feelings from others, and indeed from themselves, was generally thought to be an unhelpful mechanism. As one man put it; 'I was screwed up about it but someone had to hold it together for everyone else.' "**
>
> (Ware & Raval, 2007: 557)

Jones and Neil-Urban (2003) also reported the same theme when stating:

> **"Many fathers reported hiding their emotions from their wives in order to protect them. Over time, they realized this was not an effective strategy; it left both to suffer their grief alone."**
>
> (Jones & Neil-Urban 2003: 55)

Assessing medical competence was particularly important to fathers; most fathers behaved as the child's advocate, based on their understanding that doctors were not infallible. For example, fathers intervened when they believed that medical interventions were inappropriate; men's notion of what was inappropriate came from an up-skilling in their health literacy on the internet, and this enabled them

to participate directly in decision making about treatment options (Jones & Neil-Urban, 2003).

> **"Accurate diagnosis was often difficult to obtain because medical resources were limited. Fathers left their 'home communities' to find resources that could provide a definitive diagnosis."**
>
> (Jones & Neil-Urban, 2003: 55)

In another example of men contributing indirectly to their child's health, the men made women's physical caring possible. Some men focused their efforts on generating income, making themselves feel useful and releasing their spouse / partner from financial concerns. This point was emphasised by Ware and Raval (2007) using a father's own words:

> **"'We had this automatic division of labour and responsibility. [Wife] was going to see to his physical needs and his care and I was just going to make sure I brought home the bacon."**
>
> (Ware & Raval, 2007: 556).

The cost of care is often a burden for fathers as Patterson et al. report:

> **"One father said about his son: 'He's worried that we have to sell our house and our trucks to keep him up with his medication and stuff.' "**
>
> (Patterson et al., 2004: 396)

Evidence of men's health practices by way of studies specific to direct care is sparse. Referring to men's ability to support their child during medical procedures and treatments McGrath and Huff stated that:

> **"There has been a modicum of work published on the father's perspective and even less on father's hospital experience, particularly in relation to their involvement with invasive treatment procedure."**
>
> (McGrath & Huff, 2003 b: 9)

Pain relief is an important component of home care for those children experiencing symptoms from terminal illness or in the phase of palliative care. Whilst Jalmsell et al., (2006) found that fathers were equally as adept at identifying a range of troublesome symptoms there was no data on interventions / health practices used by fathers to resolve the symptoms. No study could be located in this search of the literature to determine the health practice of administering analgesia by parents. However, numerous authors highlight a correlation been parental distress, caused by their child suffering from intractable pain and a lack of literature supporting appropriate pain management practices within the home (Frager, 1996; Liben and Martinson, 1996; Collins, 1998).

There are well documented barriers to men being actively and competently engaged in the direct care of their child. With support services in general directed toward women, it is not uncommon for fathers to report that they were given insufficient information and support following the delivery of the diagnosis and consequently they experienced an acute emotional shock (Ware & Raval, 2007: 559). Parents report a deluge of appointments after the diagnosis; most consulting times are restricted to normal business hours making it difficult for employed men to attend. Ware and Raval (2007: 558) note that unnecessarily long waiting times and duplication of services are caused by poor communication between service providers and parents, and this adds to frustration by wasting parents' time.

Concerns about the ability of health care workers to provide continuity of care for parents when their child is transferred from a health service to home care, have been prominent in the literature (Farrell & Sutherland, 1998). Specifically, an assessment of how well equipped nurses and other allied health professionals are to support parents in advancing their nursing skills, the mastery of complex equipment and safe administration of medications (by a whole range of routes) is, according to Farrell and Sutherland (1998), 'yet to be determined'. As much of the home care provided by parents occurs during the palliative phase, the following section *Palliative Care*, is used to describe that care.

9.7 Palliative care

In the US the vast majority of paediatric end-of-life care and death occurs in an acute care hospital / paediatric intensive care unit with two thirds of death resulting from withdrawal of life-sustaining treatment or mechanical ventilation (Meyer et al., 2006). A study of Canadian families suggests that a successful home-based care programme exists in support of parents (Kopecky et al., 1997) but programmes such as this are rare. An assessment of UK services by Hannan (2007) suggested that palliative home care is possible provided all eventualities are planned; there has been no assessment of the effectiveness of this planning. Most Australian children with terminal illness continue to receive palliative care in-hospital in the lead up to their death. There has been a gradual increase for the care of the dying child to be provided in specially designated hospices and this is

supported by the following points. Few parents want care at home; one set of parents explained that home was for raising children and not a place to remember their dying (Mallinson & Jones, 2000). Furthermore, paediatric and adolescent palliative care is a difficult and challenging field (Freyer et al., 2006) and whilst a large proportion of children will have acceptable relief from pain and distress, many do not (Collins et al., 2005; Friedrichsdorf & Kang, 2007). Consequently, parents remain apprehensive about the ability to oversee their management of their child's pain and:

> **"The burden of symptoms for the child with cancer during the palliative phase and their parents is high."**
>
> (Theunissen, et al., 2007: 160)

The end of life phase for adults and the provision of palliative care for this population is better understood and carried out than it is for the child / adolescenct (Davies et al., 2008; Mallinson & Jones, 2000; Liben, 1996). Overall, palliative care remains relatively underdeveloped in the paediatric setting mainly because absolute numbers of children within individual care settings is small, making research difficult (Hyson & Sawyer, 2001: Goldman, 1996). There is no systematic training for pediatricians in residency (Khaneja & Milrod, 1998) and Hilden (2001) reports:

> **"Pediatric oncologists reported a lack of formal courses in pediatric palliative care, a strikingly high reliance on trial and error in learning to care for dying children, and a need for strong role models in this area."**
>
> (Hilden et al., 2001: 205)

Wolfe et al., (2000) concluded that little is known about the symptoms and suffering at the end of life in children with cancer whilst:

> **"High-quality palliative care is now an expected standard at the end of life."**
>
> (Wolfe et al., 2000: 326)

vis a vis adults:

> **"It is not known whether the care of children with cancer meets this standard."**
>
> (Wolfe et al., 2000: 326)

Monterosso and Kristjanson's (2008) study of 24 Australian parents, across five Australian tertiary paediatric oncology centres, concluded that most parents construed palliative care as a negative event. According to parents:

> **"The concept of palliative care was perceived to be misunderstood by key health professionals involved in the care of the child and family."**
>
> (Monterosso & Kristjanson, 2008:59)

In an earlier study Monterosso and Kristjanson (2007) concluded that both parents and health professionals did not fully understand the concept of palliative care.

> **"Analysis indicated the concept of palliative care is poorly understood by health professionals and by parents."**
>
> (Monterosso & Kristjanson, 2007: 689)

The need for palliative care arises when initial treatments for cancer fail or there is a relapse. And although it is rarely doubted that a relapse is stressful for parents, information on their experience is, according to Hinds et al., (1996) scant:

> **"It is surprising how little data are available to support the observation that the occurrence of a relapse (first or subsequent) is an extremely stressful time for patients and families."**
>
> (Hinds et al., 1996: 148)

A commonly recommended strategy, aimed at reducing the long-term psychological morbidity of parents, is to improve the communication skills of health professionals working in the paediatric intensive care unit and those delivering palliative care (Meert et al., 2008; Monterosso & Kristjanson, 2008, Meyer et al., 2006; Wijngaards-de et al., 2005; Valdimarsdóttir et al., 2007). A US study by Contro et al., (2004) interviewed family members (*n*=68) of 44 deceased children for their experiences. The study revealed several areas of concern around staff to family communications, describing the style of communication as 'confusing, inadequate or uncaring.' Meert et al., (2008) interviewed 56 parents of 48 children who had died in a Paediatric Intensive Care Unit (PICU) within 3-12 months prior to commencement of this US study. Parents held issues with the way that false hope was communicated by the physician or the manner in which bad news was conveyed to them. Areas for improvements were i) the affect (e.g. body language) used by the physician, ii) the need for lay terminology and iii) a matching of the pace with which information was delivered to the parents' ability to comprehend meaning and its implication for care. Health professionals also report being hindered in their role; a US study of nursing staff (*n*=117) and physicians (*n*=81), identified four main barriers to their providing the level of care they aimed for; these were:

> **"Uncertain prognosis (55% of respondents), family not ready to acknowledge incurable condition (51% of respondents), language barriers (47% of respondents), time constraints (47% of respondents) and discrepancies in treatment goals between staff members and family members."**
>
> (Davies et al., 2008: 282)

The need for honest communication has been highlighted in most palliative care studies (Monterosso & Kristjanson (2008). Despite similar and long standing findings that communication between health professionals and parents is suboptimal there have, according to Meyer et al., (2006), been few attempts to test interventions aimed at improving communication. Meyers et al's (2006) review of the literature lead them to conclude that:

> **"There has been little empirical inquiry of parent perspectives to improve the quality of end-of-life care and communication."**
>
> (Meyer, 2006: 649)

Whilst Meyer et al's., (2006) study aimed to describe communication from the parents' perspective and included 36 mothers (64%) and 20 fathers (36%) the qualitative data presented was not separated into father and mother comments.

An important factor in reducing psychological morbidity among fathers is to provide them with timely information about proposed curative treatment towards the end of life and the child's fatal prognosis, with the aim of increasing intellectual awareness of the child's impending death. Valdimarsdóttir et al., (2007) found that fathers with short time frames for developing emotional awareness had a more than doubled risk of depression, over eight times greater risk of absence from employment and an almost four times greater risk of medication use for psychological problems compared with that of fathers who had a longer time.

None of the literature, when reviewed in its entirety, was concerned with the health practices fathers carried out for their terminally ill child. Congruent with this finding is the opening comment by Holm et al., (2003), in their recent work on identifying gaps in the literature relative to parental participation in care; the researchers state:

> **"Few research studies have addressed the ways parents participate in their child's medical care, particularly in relation to the cancer experience."**
>
> (Holm et al., 2003: 301)

Researchers often have difficulty obtaining data from fathers and consequently focus on mothers. Kirsch and Brandt (2002), in a pilot study containing data from fathers of school aged children vis a vis a family member with cancer state:

> **"Collecting data from fathers has been an ongoing problem for researchers interested in developing a comprehensive view…"**
>
> (Kirsch & Brandt, 2002: 73)

Jones and Neil-Urban (2003), as a prelude to a secondary analysis of their data similarly state:

> **"Caring for a child with cancer is a demanding experience for both parents, yet most research focuses on mothers."**
>
> (Jones & Neil-Urban, 2003: 41)

Hayout and Krulik (1999) using a phenomenological approach studied 11 Israel families over two and a half years, openly declaring a bias towards collecting data from mothers, stating:

> **"This article presents partial findings from a study that examined the process experienced by parents (mainly mothers)** [original emphasis within the abstract] **of an adolescent child with terminal cancer."**
>
> (Hayout & Krulik, 1999: 71)

Much of the nursing literature concedes that more needs to be done to understand and support parents, inclusive of fathers, in their quest to provide an appropriate standard of care for children with terminal illness (Laws, 2004/2005).

9.8 Conclusion

This chapter is premised on the notion that fathers' of terminally ill children will want to optimise the quality of life for their son or daughter by contributing directly to their care; this premise is supported by the findings of Holm et al., (2003) and Edwards et al., (2008). Although many men are involved in care-giving there is little literature that identifies their activities (Brown & Barbarin, 1996; Sterken, 1996). Overall, there has been a modicum of work published on the father's perspective of caring; even less on the father's hospital experience of caring for their terminally ill child (Mc Grath & Huff; 2003b). Consequently, men who provide care are likely to have unrecognised and unmet needs (Jones & Neil-Urban, 2003). To support fathers in the carrying out of health practices there needs to be an identification of the issues and barriers they face (Pelchat et al., 2007). The review of the literature, as presented in this chapter, indicated that

little has progressed since a similar review by the author of this doctoral thesis (Laws, 2004/2005).

One of the major barriers to men practicing health towards their terminally ill child is the lack of psychological support for fathers. Paediatric cancer is a stressful event for parents because of the threat of death and a sense of helplessness experienced when uncontrollable events emerge (Patterson, Holm, & Gurney, 2004). Caring for a child in the terminal stage of illness also increases parental psychological stress and the risk of psychopathology. Psychological stress (PTSD and PTSS) reduces a father's capacity to provide direct physical and emotional support for their child and be supportive of their spouse / partner. Support for fathers is less than optimal because research in psychology has been limited to describing men's emotional experiences and adjustment with no attention paid to trialing the effectiveness of supportive interventions (Bonner et al., 2007; Kazak et al., 2005). Kazak (2007) concludes that evidence-based assessment, intervention and psychosocial care, in paediatric oncology, are urgently needed to provide comprehensive services to the child and family.

CHAPTER TEN:
INJURY AND ACCIDENT PREVENTION

10 Introduction

Unintentional injury is the leading cause of death for children and adolescents between the ages of one and 18 in Australia, the UK, Europe, and United States (AIHW, 2005b; Sethi et al, 2008; Centres for Disease Control and Prevention, 2009). Child injury is described by national public health organisations as being preventable (National Institute for Occupational Safety and Health, 2009; Towner et al., 2001; Townwer, 2002; AIHW, 2006b, National Centre for Injury Prevention and Control, 2000).

This chapter presents the findings of several systematic searches of the literature to provide information about fathers' health practices, directed at preventing unintentional injury in children within the family. Details of the searches are presented within each section. The aims of the chapter are to identify if fathers perceived they had a role in injury prevention [see section: 11.2 *Fathers' perceptions of injury prevention*] and to determine how researchers had included men in the study of parents' injury prevention practices [see section: 11.3 *Researching fathers' injury prevention practices*]. The only data located relating specifically to fathers is presented in section 11.4 *Fathers' injury prevention practices.* Given the paucity of literature on fathers, the literature search was extended to include fathers' surveillance of their children's safety within and outside the home [see section 11.5 *Fathers' injury prevention by surveillance*]. Finally there is an identification of fathers' role in injury prevention to determine if they are prepared to practice health (first aid) when injuries do occur [see section: 11.6 *Fathers' treatment practices for injuries*].

10.1 Overview of injuries and accidental deaths

Accidents in children are linked to a mismatch between physical ability and the task, their willingness to robustly explore new environments and a poor recognition of dangerous situations. As minor childhood injuries are managed predominantly by parents, carers or the child, most are not recorded by medical services. Morrongiello et al, (2006) draw attention to the size of the problem, stating:

> **"Estimates indicate that one of four children experience a medically attended injury each year in the United States (Scheidt et al., 1995) and that direct and indirect costs because of injuries total at least $174 billion per year (National Safety Council, 1991)."**
>
> (Morrongiello et al, 2006: 529)

In 2003, approximately 20% of the Australian population was aged 0-14 years (4 million); between 2002 and 2003, there were 65,651 hospitalisations for injury for children aged 1-4 years. Falls were the most common injury with a rate of 628.1 per 100,000 children, followed by pedal cycle accidents (98.1 per 100,000 children) and accidental poisonings (80.8 per 100,000 children) (Australian Institute of Health and Welfare, 2005; ABS, 2005a).

Recording the severity of injury is difficult and varies with the force and mechanism of injury (collision with a blunt object, fall, thermal burn, chemical burn, Motor Vehicle Accident) (Fiissel et al., 2005; Young et al., 2005a). A major injury is considered to be one requiring medical treatment without which healing would be delayed. Young et al., (2005a) determine the need for a definition stating:

> **"Injury severity in children obviously forms a continuum, with no precise definition of what distinguishes a major from a minor injury. For the purpose of this article, a minor injury is one that could reasonably be expected to heal with minimal medical intervention. Clearly, it is essential to recognise such injuries and exclude 'major' injuries."**
>
> (Young et al., 2005: 558)

A wide range of accidents result in child deaths and these are recorded by respective Australian state authorities (NSW Child Death Review Team, 2008; Victorian Child Death Review Committee, 2008; Child Death Review Committee

Western Australia, 2007). Boss et al., (1995) identify the size of the problem in stating:

> **"Preventable accidents were the highest single cause of death for children aged 1-14 years in 1992, at 49.3% of male deaths in this age group and 37.6% of female deaths. They were also the highest single cause of death for young people between the ages of 5-15 years."**
>
> (Boss et al. 1995: 102)

Nearly a decade on from Boss et al's., (1995) data, injury remained the leading cause of death among Australian children aged 0-14 years; between 2001 and 2003 there were 815 deaths. The most common external causes of death were transport accidents (2.7 per 100,000 children), followed by drowning (1.2 per 100,000 children) and assaults (0.6 per 100,000 children). (Australian Institute of Health and Welfare, 2005).

The typical causes of childhood injury vary according to their developmental stage and sex. For the period 1999-2003 Australian boys were consistently more likely to have died in transport accidents than girls across all child age groups; with the difference greatest among 10-14 year olds (150 boys compared with 77 girls). Over the same period more than twice as many boys as girls drowned (193 boys; 93 girls). Although the number of child deaths is small, they often have a life changing impact on the parents, siblings and those within the family's social network.

Many deaths occur in the child's residence (Nagaraja et al., 2005) and nearly 90% of all child injuries occur in or around the home (Morrongiello et al., 2006a; Dowsell et al., 1996). Surveillance of children in the family environment is ultimately the responsibility of the parents but public health organisations cannot agree on the age at which parental supervision might be reduced or no longer required (Porter et al., 2007). Most researchers continue to study and report on the surveillance characteristics of mothers only. However, Morrongiello et al., (2004) key researchers in the area, determined that:

> **"We have a limited understanding of what parents actually do in their home to manage injury risk to young children and how efficacious their strategies are."**
>
> (Morrongiello et al., 2004: 114)

And few studies have examined the proposal that, lapses in parental supervision is the most important factor contributing to an increase in injury rates (Morrongiello et al., 2006a).

There has been a long history of research effort seeking to determine if an association exists between a family's Social Economic Status (SES) and the risk of child injury (Langely et al., 1983). Whilst death rates and injury have fallen in all social classes in the UK; they fell less steeply in the lower classes (IV and V) between 1981 and 1991 (Roberts & Power, 1996). Canadian researchers also identify a similar social gradient in children presenting to hospitals for emergency injury treatment. McDonald et al., (2003) identified that a reduction in childhood injuries has been slow in the US; suggesting that:

> **"Increased attention for finding effective prevention and education strategies is warranted as injuries continue to be significant contributors to childhood morbidity and mortality."**
>
> (McDonald et al., 2003: 129)

These findings indicate the need for targeted injury prevention efforts among children from economically disadvantaged populations. However, Evans and Kohli (1997) acknowledged that parental knowledge and safe keeping behaviour by parents, from low SES families, cannot be a single predictor of higher rates of child injury in this group; their research leads them to conclude:

> **"The findings do not suggest that differences in the injury experience of children from more and less affluent backgrounds are due to differences in parental attitude, knowledge, or practice of home safety measures. Thus, the study does not support the selective targeting of families from less affluent areas with educational interventions."**
>
> (Evans & Kohli, 1995: 29)

A review of Canadian research by Soubhi (2004) showed that study results linking injury rates to SES of neighbourhoods consistently varied according to research design. And although LeBlanc (2006) and collaborators show very good evidence of an association between the amount of hazards in a home and injury risk among young children:

> **"The association is neither strong enough nor straightforward enough to translate into an immediate intervention."**
>
> (Howard, 2006: 900)

Faelker et al., (2000) state that whilst many other researchers have identified links the:

> **"Exact requirements of the optimal prevention approach remain elusive."**
>
> (Faelker et al., 2000: 203)

Dowsell et al., (1996) performed a systematic review of the world literature, to provide information about the most effective forms of health promotion interventions, aimed at reducing childhood (0-14 years) unintentional injuries, concluding that the study design of evaluations in injury prevention needs to be improved so that more reliable evidence can be obtained. To reiterate:

> **"Better information is needed on process, so that successful strategies can be replicated elsewhere."**
>
> (Dowsell et al., 1996:140)

A large systematic review by Dowsell and Towner (2002), constructed to identify the effectiveness of interventions for unintentional injury in children from socially deprived areas, identified mothers as key players but there was no mention of fathers as having any role. A growing number of researchers have explored the role of parents' injury prevention strategies but there is scant literature using the term fathers.

10.2 Fathers perceptions of injury prevention

Several large studies have shown that a majority of adults believe a wide range of unintentional injuries are preventable; however parental beliefs on how to prevent childhood injuries vary widely (Girasek, 2001). Vincenten et al's., (2005) study across 14 European countries, using omnibus surveys and telephone surveys of parents (*n*=2088), showed that 95% of parents reported that they personally take measures to avoid accidental injury to their children and:

> **"Three-quarters of parents agreed that child injuries can be avoided. It was concluded that parents want to be better informed about the causes of child accidents and about actions they and society can take to reduce injury-related risks to children."**
>
> (Vincenten et al., 2005: 183)

None of Vincenten et al.'s, (2005) published data differentiated between father and mother responses to injury prevention; by reporting on 'parents' responses to the survey the researchers left the reader with no specific information on fathers'

beliefs or injury prevention practices. Bennet-Murphy's (2001) US study of teenage mothers (*n*=17), with at least one child younger than three years, produced findings that contrast sharply with that of Vincenten et al., (2005), for example:

> **"Not one mother spontaneously mentioned injury prevention as an important part of the 'job' of mothering… 27% believed injuries were unavoidable, and another 33% believed that injuries were the result of stable child characteristics."**
>
> (Bennet Murphy et al., 2001: 179)

Over a decade ago Peterson et al., (1995) drew attention to the lack of knowledge on how parents socialise their children into positive and safe health behaviours by stating:

> **"…there has been a call for increased research on the socialization of children's health behaviors (e.g., Tinsley, 1992), an area that has remained under-explored."**
>
> (Peterson et al., 1995: 224)

In addition, few studies attempt to determine the relationship between parental global attitudes concerning child injury and their prevention efforts. Langley and Silva (1982) found no relationship between parents' beliefs that injuries in general could be prevented and their child's injury history. And there has yet to be a clear demonstration of the link between parental attitudes and preventive behaviour (Matheny, 1988; Peterson et al., 1990: 179).

A search of the literature using the key words 'father' and 'perceptions / concern' about 'child' 'injury' using the data bases PsychInfo, Embase, SAGE (social sciences) Medline, CINAHL and Google scholar revealed very few works. A key finding from the literature was an understanding that a father's assessment of a child's risk taking behaviour and the guidance provided during risk taking activities are fundamental to understanding a child's socialisation in injury avoidance. According to Hagan and Kuebli (2008):

> **"Only one other study to date has examined fathers' socialization of children's physical risk taking."**
>
> (Hagan & Kuebli, 2008:12)

The study by Morrongiello and Dawber (1999) had found that fathers encouraged their sons, more than their daughters, to engage in physical risk taking but there was no difference between mothers' and fathers' monitoring of the children whilst teaching physical tasks or in free play sessions. Hagan and Kuebli (2008)

examined parental responses to their preschool child's actual risk taking by employing a semi-naturalistic setting; preschoolers (*n*=80) performed two motor skills activities that posed potential threat to physical safety if proper parental supervision was not present. The behaviour and verbal communication between parent and child were recorded by video recordings. Hagan and Kuebli (2008) found that:

> **"Fathers' perceptions of children's everyday risk were significantly correlated to children's actual level of risk taken on the obstacle course. In contrast, there was no significant correlation between mothers' perceptions of everyday risk taking and actual risk taken on the obstacle course."**
>
> (Hagan & Kuebli, 2008: 12)

And fathers of daughters tended to monitor their child's movement and ability more than fathers of sons.

Both Morrongiello and Dawber's (1999) and Hagan and Kuebli (2008) findings support the notion that fathers play an important role in the socialization of children's risk taking and are important gender socializing agents, in that:

> **"It was fathers, not mothers, who differentially monitored their sons and daughters during risky situations."**
>
> (Hagan & Kuebli, 2008:12)

Ishak et al., (2007) note that despite fathers' critical role in guiding an infant's motor skill acquisition, researchers know little about parents' expectations of their infants and susceptibility to mishaps. Ishak et al., (2007) examined how mothers and fathers expectations of their infant's crawling ability affected parenting choices between risk taking (challenges) and ensuring safety; the findings were reduced to researcher speculation as:

> **"Parents were inconsistent when their responses were classified as oriented toward safety versus challenge, vacillating between the two from trial to trial."**
>
> (Ishak et al., 2007:67)

Lewis et al's., (2004) study explored parental attitudes regarding the developmental benefits of minor injuries in early childhood. Data was collected using an Injury Attitudes Questionnaire (IAQ) from 159 couples (88% dual income households) and 23 single mother families; the descriptive data, presented as tables, gave responses for both mothers and fathers. The findings showed that 'on average', parents did not endorse the idea that minor injuries gave

developmental benefits but 22% of parents did believe there were benefits. However, the exact relationship between parents' gender and injury beliefs was unclear. There was only a weak association indicating that fathers held stronger beliefs about the value of learning from injuries compared with mothers. The research did not seek to identify if parental beliefs relate to actual injury rates in early childhood.

10.3 Researching fathers' injury prevention practices

The vast majority of studies seeking to establish a link between parental beliefs on risk minimisation focus only on mothers (Zolotor et al., 2008; Russell & Champion, 1996; Morrongiello et al., 2006a; Morrongiello et al., 2006b; Gärling & Gärling, 1993; Morrongiello et al., 1998; Morrongiello & Hogg, 2004; Morrongiello & Dawber, 2000; Morrongiello & Dawber; 1998, Bennet, 2001; Russell & Champion, 1996; Wortel, & de Geus, 1993; Garling & Garling, 1993; Garling & Garling, 1995; Glik et al., 1991) or declare they are studying parents' but really mean mothers, as the word father is not mentioned in their publications (Porter et al., 2007; Boles & Roberts, 2008; Morrongiello et al., 2004; Peterson et al., 1990; Ueland & Kraft, 1996; Schwebel & Bounds, 2003). A smaller number of studies do include fathers in data collection but do not separate data into findings for fathers / mothers (Morrongiello & House, 2004; Boles et al., 2005).

Boles and Roberts' (2008: 834) investigation of links between parental distraction and child injury rates declare that "Participating parents were most often the mother (85%)" and provide no details on fathers (15% of the sample). Kendrick et al's (2005) study of the effectiveness of home safety behaviours among parents received 82 completed questionnaires from fathers (23.2% of the sample) but did not report specifically on fathers' home safety behaviours. Recently, researchers have openly declared that they precluded fathers from their studies because they believed them to be unreliable informants for the recording of child injury prevention practices within the home. For example:

> **"We initially planned to have a second parent who independently completed some diary forms, but based on poor participation by fathers in other research, we decided against this because we feared it would indeed lead to a nonrepresentative sample of participants."**
>
> (Morrongiello et al., 2006a: 537)

Yet the lack of information about fathers' injury prevention practices has been commented on by key researchers in the area, with Schwebel and Brezausek (2004) reporting:

> **"One notable limitation of previous research is that almost all studies focused on the role of mothers in childhood injury prevention, and it is unclear whether fathers might serve the same protective role."**
>
> (Schwebel & Brezausek, 2004: 19)

Porter et al.'s, (2007) study investigating 'parent opinions' about the appropriate ages at which adult supervision is unnecessary for bathing, street crossing, and bicycling reported mothers' opinions only.

10.4 Fathers' injury prevention practices

Green and Hart (1998) identified focus group discussions as a useful way of accessing children's knowledge about injury risks; from their analysis of 16 focus groups on the topic they reported on only one identifier of a father's instruction to his son about injury prevention and safety. The father's instructions were:

> **"Jason: and my dad, and he tells me not to pick up any buggy things or don't touch dogs without asking the owner and don't take anything. If a stranger says, 'd'you want my sweets?' say 'NO'—if it's one of your friends you can say 'yes'."**
>
> (Green & Hart, 1998: 17)

Only one study could be located that was specifically designed to record fathers' injury prevention practices. Schwebel and Brezausek (2004) conducted a prospective longitudinal study to predict injury risk in 181 toddlers aged between 6 months and 36 months. The hypothesis; fathers' parenting would contribute to the safety of children after controlling for the role of child, mother, and father individual differences (i.e., child gender and temperament, mother and father personality, and work related gains and strains on family life) was tested using data from fathers. There was no hypothesis concerning the intensity of a father's parenting activities and reduced risk of injury; instead the researchers chose to report that men's involvement in domestic duties correlated with their increased involvement with the child. However, a father's participation in internal and external household chores was associated with a slightly increased risk of injuries in children aged 12 to 36 months. The strongest positive predictor of injury was an association between fathers' perceived gains to the quality of family life

arising from his employment efforts. Schwebel and Brezausek's (2004) results provide modest support for the suggestion that fathers play a similar role to that of mothers in reducing the risk of injury but neither paternal nor maternal involvement with children served a highly protective role for toddler injury in this study.

Whilst Schwebel (2007) recently published a section of work linking parenting quality and style to the effects of childhood injury risk information on fathers; the researchers noted that previous information was scant and forecast the release of new data, which was shown in the latest publication as being 'in press' (Schwebel & Brezausek, 2008 in press).

10.5 Father s' injury prevention by surveillance

Fathers are involved in surveillance of children but quantitative and qualitative data to evidence this health practice is sparse. Although Morrongiello et al., (2006a) sampled only mothers (*n*=40) and discussed responses gained from children in the sample (*n*=18 girls and *n*=22 boys) the researchers noted, from mother and child responses, that 'Dad' was responsible for surveillance for 15% of the time for young children and 19% of the time for older children.

In 2004 Morrongiello, Ondejko, and Littlejohn, reported that 'emerging evidence' has shown that closer parental supervision provides a protective role and is linked with fewer child injuries but in a later publication Morrongiello and McCourt (2006) state that there remains 'considerable speculation' about the relation between supervision and young children's risk of injury. No study identifies that fathers' supervision or lack of supervision influences their child's injury rates. However, Bishai et al.'s, (2008) study, aimed at determining if grandparents' supervision was protective of injury and contained some adjunctive information about fathers. The researchers reported for cases of medically attended injuries that:

> **"In situations in which the father watched the child while the mother worked, there was no statistically significant difference in the odds for injury."**
>
> (Bishai et al., 2008: 984)

and

> **"Odds were increased for children who lived where fathers did not co-reside."**
>
> (Bishai et al., 2008: 980)

These findings support the notion that a father's presence is protective against child injury.

10.6 Fathers' treatment practices for injuries

The following statement, from Schwebel and Brezausek (2004), infers that there is a difference between mothers' and fathers' assessment of injuries and the need for interventions or referral to health professionals for treatment…

> **"Parents use differing thresholds to determine whether or not to seek professional medical assistance, and therefore measures of injuries requiring professional medical attention are influenced not just by the extent of the child's injury but also by the threshold that parents use to decide whether to seek professional medical attention."**
>
> (Schwebel & Brezausek, 2004: 26)

A search of the literature, using the key words 'child' 'injury' 'treatment' and 'father', within the data bases PsychInfo, Embase, SAGE (social sciences) Medline, CINAHL and Google Scholar did not reveal any literature on a father's interactions with children following an injury. However, Peterson et al., (1995) specifically identify mothers' injury intervention practices. Using 1,000 child injury events by diary, the data revealed that 80.1% of injuries received no parent-initiated remediation, 14% received only a lecture, and less than 3% of injuries were followed by parental action. Children reported that 96.1% of their injuries were followed by no intervention and recalled lectures from parents after only 1.2% of injuries. Kendrick and Marsh (1999) conducted a postal survey of parents (*n*=2,152) to determine their first aid knowledge and confidence in injury treatment practices across a range of common childhood injuries. Mothers represented 91% of respondents and the reporting of data was restricted to maternal responses. Consequently, no information was given on the first aid skills and confidence of fathers.

Researchers are concerned about the sensitive nature of questioning parents on the factors contributing to child injuries. Scheidt et al (2000) sought to determine if parents were actually troubled by researcher's questions about their child's injuries and how they were sustained. The injured child's mother was interviewed

most frequently (82%), followed by the child's father (11%). The study concluded that:

> **"Parents are generally not threatened or offended by research questions that probe into the circumstances of injuries to their children."**
>
> (Scheidt et al., 2000: 54)

However, the researchers did not identify fathers' responses separate to mothers, leaving the reader with data on 'parents' opinions only. Scheidt et al.'s (2000) main findings were supported by those researchers monitoring UK health visitor reports, with the added comment that 12.5% of parents considered that participation in the study had actually improved the relationship with the health interviewer (Ramsay et al., 2000).

10.7 Fathers' promotion of personal safety for their child's social environment

The issues surrounding children's civic safety and the identification of potential dangers in the course of their daily lives remain prominent in social policy development in the UK and are well recorded by researchers (Roberts et al., 1995; Valentine and McKendrick, 1997; Dixey, 1999; Hood, 1996). Wyness (1994) included fathers (22 parenting couples with teenage children) in a study of child safety outside the home. Qualitative data presented in the form of excerpts from open ended interviews with fathers revealed that these men held strong concerns over their sons' and daughters' safety and provided clear boundaries on:

a) times for returning home,

b) contingencies if the child was late home, and

c) what types of friends they should associate with.

The two quantitative tables presented in Wyness's (1994) study also contained a summary of fathers' responses but was limited in scope and detail. The inclusion of all family members voices (children, father and mother), as found in Wyness's data collection, is a rarity in this type of research. Other studies of safety outside the family home have focused on only mothers (Dixey, 1999) children and mothers (Kelly et al., 1997), or children's perception of personal safety (Harden, 2000; Harden & Backett-Milburn). Recently, Backett-Milburn and Harden

(2004) made an empirical contribution to the sociological discussion of risk by presenting an analysis of the family context and everyday negotiations around public risk and civic safety. Backett-Milburn and Harden's (2004) article focused on four Scottish families, drawn from a larger qualitative study, to determine how risk-related behaviours and anxieties are being created and recreated in families on a daily basis. Backett-Milburn and Harden (2004) found that many risk-related issues had to be faced and renegotiated on a regular basis with fathers and children drawing both on their biographical experiences and shared knowledge of local stories to determine appropriate risk-averse behaviours and risk-taking boundaries. A key finding was that the discussions on risks were fluid, contingent and contextual. Consequently, definitions of risks and how to deal with them…

> **"Were regularly contested between fathers and children both verbally and through behavioural contradictions and challenges".**
>
> (Backett-Milburn & Harden, 2004: 446)

The value of Backett-Milburn and Harden's (2004) work is that their study had included fathers and the analysis had, for the first time, established that fathers were key players in setting the boundaries intended to minimise their child's risk of injury by others in social settings outside the family.

10.8 Conclusion

Despite a systematic search for literature to locate the health practices of fathers, aimed at reducing the risk and incidence of unintended injury in children, only scant information could be found across more than a decade of research. The absence of information on fathers' injury prevention activities within the home has not been fully explained by researchers but there is a common assumption that the greater amounts of time spent by mothers, in the proximity of children within the home, justifies an ongoing focus on maternal accident and risk reduction. Key information on fathers' concerns about older children's personal safety came from Wyness (1994) and Backett-Milburn, and Harden (2004) who distinctly described these men setting rules and boundaries for their child's socialising outside the home. Schwebel and Brezausek's (2004: 26) study of toddlers made tentative steps towards understanding a father's role in injury prevention but contained no specific data on these men's actual prevention practices.

Researchers and commentators discussing the merits of parental education aimed at improving safety practices within the home, continue to emphasise the role of the mother; this approach fails to account for an increasing number of families headed by single fathers and an increasing amount of time fathers spend with their children (Chalasani, 2006; Bianchi, et al., 2006) (See chapter *Fatherhood* – Section: 4.2.2 Changes to families and fatherhood). The rising trend for dual income families also suggests that mothers are spending less time in direct supervision of their children; this is particularly the case for working mothers who utilise paid childcare to cover their time spent in employment.

Identification of a knowledge gap for fathers' health practices toward children with injury and for injury prevention provides support for the construction of survey questions that measure such practices. The household survey; Section 2.4 *Typical activities performed for sick children*, includes specific questions about the treatment of childhood injuries; Q 2.4.8 *Bandaging a sprain*, Q 2.4.9 *Treating a burn or scold*, Q 2.4.10 *Treating a sting or bite*. The Section 2.5 *Health promotion* captures health practices commonly performed to reduce the risk of injury; Q 2.5.2 *Making sure seat belts or restraints are worn*, Q 2.5.3 *Keeping medicines and poisons locked away* and Q 2.5.4 *Surveillance of children near fires /stoves*. The section: 3.3 *Health problems in your family at present* allows the respondent to record the occurrence of a recent child injury [Q3.3.2 *A recent injury (e.g. burn. laceration, broken bone, sprain)*].

CHAPTER ELEVEN: HEALTH PROMOTION

11 Introduction

This chapter seeks to identify the health promoting activities practiced by fathers towards their child. Chapter Four of this thesis, "*Fatherhood*" outlined the role of the father in protecting and nurturing their child and is therefore closely linked to the health promoting activities discussed in this chapter. Key public health researchers recognise the family as an important resource for promoting health (Litman, 1994; Ferrer et al., 2005) and whilst mothers and expectant mothers have been heavily featured in investigative and intervention studies (Kar et al., 1999) little work has been directed toward identifying the ways that fathers can contribute to their child's health using health promotion practices (Garfield & Isacco, 2006; Redmond et al., 2004; Spoth & Redmond, 2000).

A systematic search of the literature was conducted to identify the health promotion practices performed by fathers. The key words used in the search were; 'father / parent', 'health promotion' and 'child / adolescent'. The search took place within the data bases Medline, CINAHL, Sage publications, Oxford journals, Google scholar and Embase (Allied and Complementary Medicine). The search revealed that fathers had an important role in promoting the health of their child. [See upcoming section 11.1 *Health promotion: a core paternal responsibility*]. Although several studies identified the potential for greater father involvement in the monitoring of their infant's and child's health status, men's use of Well Child Visits has been limited [See upcoming section 11.2 *Screening infants and young children*]. A lack of literature outlining fathers' engagement in health promotion activities for older children and adolescents indicated that a more refined literature search was required. The framework for a second literature search was based on exploring three major and preventable health concerns as identified by the Australian Institute of Health and Welfare (AIHW, 2005); these included, children's initiation to and use of alcohol [see section 11.3: *Fathers' influence on alcohol initiation in children*] other drugs [see section, 11.4: *Fathers' influence on use of illicit drugs*] and tobacco [see section 11.5.2:

Fathers' smoking habits influencing children's smoking habits]. Adjunct to children's use of tobacco was an investigation of men's attempts to reduce their child's exposure to Environmental Tobacco Smoke [see section 11.5 *Fathers attempts to reduce their child's exposure to smoke*].

The second literature search revealed that fathers were able to promote their child's / adolescent's health by modifying their smoking habits. Fathers also played a key role in approving or disapproving of behaviours (smoking tobacco, drug use and alcohol consumption) known to contribute to illness, disease and premature death. However, trials measuring the effects of interventions aimed at modifying parental behaviours known to be harmful to children (e.g. Environmental Tobacco Smoke) were reported as gains for mothers and a substantial lack of responsiveness from fathers.

11.1 Health promotion: a core paternal responsibility

The term health promotion, when used in public health and health professional literature is applied to a wide range of activities, the purpose of which is to avert illness, accidents and injury (WHO, 2000). Women have been credited with succeeding in promoting health through keen leadership and affirmative action (Kar et al., 1999) and much of the family's health promotional work continues to be performed by mothers (Second International Conference on Health Promotion, 1998). Researchers seeking to identify how best to predict fathers' involvement in their child's health have noted that:

> **"… to date, little research has evaluated the extent of a father's involvement in his child's preventive health care and which factors influence that involvement."**
>
> (Moore & Kotelchuck, 2004: 574)

The family's role in upholding health promotion practices acts as a key element in controlling disease and promoting social health. Over a decade ago sociologists recognised that:

> **"The family constitutes perhaps the most important social context within which illness occurs and is resolved. It consequently serves as a primary unit in health and medical care."**
>
> (Litman, 1994: 495)

Contemporary public health analysts continue to call for improved health promotion practices within the family because a large number of life style related

illnesses begin in childhood (Ferrer et al., 2005). However, fathers and mothers continue to be poor role models for their children by exhibiting a wide range of poor health behaviours; this phenomenon has been widely publicised in the United States. Wertlieb (2003) reports that the National Centre for Health Statistics (United States) found that 40% of fathers and 30% of mothers engaged in one or more behaviours know to carry a health risk (smoking, drinking, driving after drinking, being overweight, exercising less than recommended guidelines). Worryingly, less than 50% of all parents practiced at least three of the five 'good health habits' (eating breakfast, snacking rarely, participating in sport or other exercise, experiencing adequate sleep, using a seat belt when driving) (Wertlieb, 2003). Help-seeking was also poor, with 55% of fathers and 74% of mothers not visiting a doctor or clinical to have a health-check over the two year period prior to the survey (Wertlieb, 2003).

In response to the poor health practices exhibited by parents, a key report titled "*Setting an Example: The Health, Medical Care, and Health-Related Behavior of American Parents"* concludes by …

> **"… calling on parents to set a better example of healthy behavior for their children. It also calls on the public health community to find more effective strategies for encouraging parents to engage in healthful behaviors. Parents have the strongest motivation of any group of adults to change their behavior and preserve their health: they have children to raise."**
>
> (Zill, 1999: 4)

And health professionals have recognised the need to formally state, by way of a health charter that: "A child's health begins with the health of his parents." (Green, 1994: iii).

Most recently, Ahmann (2006) highlighted the logic of incorporating fathers into nurses' health promotion practices, stating:

> **"Although mothers are generally more likely than fathers to be involved with their child's health care needs, incorporating fathers is important as well. Some research suggests that factors interfering with paternal involvement include work conflicts and greater convenience for mothers accompanying the child to health care visits. One factor fathers have identified as a positive motivator is a health care provider's specific invitation or encouragement to attend the child's appointments. Fathers and mothers may cope differently with a child's illness or disability, and the type of support each parent needs may vary. Health care**

> **providers can increase their own awareness of paternal concerns and needs to best encourage paternal involvement."**
>
> (Ahmann, 2006:88)

The presence of a father's benevolent support can enhance a child's health status from the time of birth. A review by Dunkel-Schetter et al., (2001) of over 200 studies, seeking to establish the determinants of adverse birth outcomes, found support from the infant's father and / or other family members, predicted a higher birth weight, as well as other positive birth related outcomes (Wertlieb, 2003).

Studies on the health effects of having a father resident in the family home from childhood to adolescence are very scant and not consistent. The negative health and developmental effects associated with growing up without a father in the home, the absent father, was discussed in Chapter 5 *Fatherhood*. However, having a father reside in the family home is not always linked to improvements in a child's health. In Chapter 5 it was noted that child health could be improved if a father, who perpetrated antisocial behaviour, was removed from the family home. Relatively little health research has examined the long-term impact on a child's health as a result of separation from the biological father, caused by marital divorce. According to Tucker et al., (1997) the best evidence of health outcomes comes from the Terman Life Cycle Study, tracking children aged approximately 11 years in 1921 (*n*=1528) until 1991. The Terman study showed an association between the child's experience of divorce and a higher risk of premature mortality for boys (throughout the life span) with a weak but not statistically significant association for girls (Tucher et al., 1997). Ergo, the literature to date shows that a father's benevolent presence has the potential for elevating the health status of a child.

11.2 Fathers' role in attending health screening for infants and young children

Screening infants and children for potential health problems has remained largely the role of health professionals practicing in maternal and child health services and schools (Gunn et al., 1996; Goldfield et al., 2003). A father's role in participating in child health appointments has been constrained by their employment times with most health clinics being open in general business hours. Service times were developed to afford relatively greater convenience for mothers

and most continue with this practice because mothers are the parent most likely to accompany their child to a health visit (Ahmann, 2006). Garfield and Isacco (2006) postulate that gender equity and labour market reforms have expanded the potential for fathers to play an important role in their child's health and development, however few researchers have studied fathers' health surveillance strategies or utilisation of clinics that provide health checks for infants and children. Factors other than employment status play a role in constraining fathers' attendance; a review of the literature leads Garfield and Isacco (2006) to conclude:

> **"Father involvement in health care has been studied little, especially among nonmarried, minority fathers."**
>
> (Garfield & Isacco, 2006: 637)

Garfield and Isacco (2006) studied 32 US fathers, resident in the family home, as a means of exploring the men's involvement in and satisfaction with Well Child Visits (WCVs). The qualitative data revealed men's lack of confidence in their parental role per se and barriers within the health care system deterring many men from participating. The main contributors to fathers' positive appraisal of the WCV clinics were their inclusive interactions with the physician, improvements in personal health literacy by way of receiving clear explanations of health issues and processes and having their questions taken seriously. Whilst some men had a sense of receiving good quality care, some men felt that they were, 'viewed with suspicion by staff', judged as having a weaker bond with the child and received poorer quality information than that afforded mothers. Garfield and Isacco (2006) study identifies positive aspects of father involvement but there were no detailed accounts of men's actual health practices at the WCV or evidence of these men initiating ongoing health practices within the home.

In an earlier study of fathers' self-reported attendance at WCV's, Moore and Kotelchuck (2004) had sampled 104 English-speaking urban fathers who were parenting children younger than seven years. The data from a self-reported questionnaire revealed 89% of the fathers had attended at least 1 WCV, more than half (53%) had attended more than one WCV and 40% recommended further scheduled visits. Higher attendance was positively associated with older fathers, a father's presence at the birth, parenting more than one child and US health insurance coverage. Moore and Kotelchuck (2004) suggested the implementation

of universal health insurance and medical practitioners targeting of younger fathers and those with older children, would assist in more fathers actively promoting child health through the use of WCVs. Further to this, paediatricians are specifically seeking to engage more with fathers as partners in child health promotion (Coleman & Garfield, 2004).

Given the paucity of health promotion studies identifying the activities of fathers, the literature search was extended to include reports of fathers' health promotion practices in relation to three major health issues facing young children and adults. Smoking and early use of alcohol and illict drugs contribute to a higher risk of illness and disease across the life span and have been directly linked to earlier mortality. The literature suggests that fathers can play an important role in preventing an initiation to alcohol and other drugs, and the effects of smoking.

11.3 Fathers' influence on alcohol initiation in children

The normality of alcohol use in Australia is evident from consumption data; on average, Australians annually consume 7.8 litres per capita, compared with the United States at 6.7 litres, Canada at 6.6 litres, and the United Kingdom at 8.4 litres (AIHW 2003). Alcohol abuse / misuse in adolescents is widespread and approaching an epidemic in Australia, New Zealand, Britain and America; strong public health concern is expressed over binge drinking among adolescents of both sexes (Pidd et al., 2006; Collins et al., 2002; Department of Health, 2003). Although health literacy regarding the negative health effects from long term alcohol misuse is adequate among adult populations (Caetano and Cunrandi, 2002). Hayes et al., (2004) contend that Australian parents' understanding of the parameters for guiding alcohol initiation and safer patterns for teenage drinking remains limited.

> **"For many parents, knowing the 'right age' to permit their adolescents to consume alcohol, or indeed if they should permit alcohol consumption at all, was a critical question that they felt ill equipped to answer."**
>
> (Hayes et al., 2004: xi)

The current recommendations are to delay the onset of drinking before the age of 16 years, a strategy developed for reducing dangerous and long term consumption levels into adulthood (Hayes et al., 2004: xi).

Fathers' influence on their children's consumption of alcohol is difficult to determine because most parents are unaware of or underestimate their child's alcohol consumption. Many fathers have poor knowledge of the pathways to abuse and find it difficult to identify addictive behaviours in their children. Overall, the protective influences that Australian parents exert remain unclear because there is:

> **"Very little Australian research and very few intervention programs with proven success."**
>
> (Hayes et al., 2004: v)

In response to this state-of-play, the Australian Government Department of Health and Ageing commissioned the report, *Parenting Influences on Adolescent Alcohol Use*. The report by Hayes et al, (2004) presented finding from a literature review of 26 cross-sectional and 30 longitudinal studies. In total, 14 cross-sectional studies, and 17 longitudinal studies reported positive associations between parental monitoring and a reduction in adolescent alcohol consumption. The report did include comment on studies that differentiated between fathers and mothers influence on alcohol use; Beck et al. (2003) had found the likelihood that adolescents had obtained alcohol without a parent's knowledge or had consumed alcohol in the previous three months decreased when adolescents reported that their father's opinion was important to them (odds ratio .55, and odds ratio .50 respectively). In addition Hayes (2004) had observed a general consensus among researchers regarding the positive effects of fathers and mothers monitoring their child's alcohol use:

> **"Adolescents who are poorly monitored begin alcohol consumption at an earlier age, they tend to drink more, and are more likely to develop heavier drinking patterns…also… poorly monitored adolescents are more likely to associate with 'deviant' peers."**
>
> (Hayes et al., 2004: 31)

However, the linkage between an adolescents propensity to drink alcohol the fathers and / or mothers consumption, has not been widely investigated.

An association has been found between family structure and the use of alcohol among teenagers. A cross-cultural study over 11 European countries found that children from intact families had lower frequency of heavy drinking in comparison with those living with a single father, single mother or blended families (Bjarnason et al., 2002). Longitudinal studies suggest that family

breakdown is an independent risk factor in adolescent alcohol use (Fergusson et al., 1995; Coffey et al., 2000). Hayes et al.'s, (2004) search for similar Australian studies concluded with the comment: "…no Australian studies on family composition were found". (Hayes et al., 2004: 52).

The few studies that have explored the utility of alcohol intervention programmes for parents indicate that social and psychological factors modify the outcomes in different ways for mothers and fathers. For example, Rueter et al. (1999) found that mothers who experienced marital difficulties and demonstrated poorer parenting skills showed the greatest improvements from a structured intervention programme aimed at reducing teenage drinking; whilst fathers experiencing personal adversity (e.g. financial concerns) rated the intervention program as less effective. Although there is limited research on the topic, the evidence presented here suggests that fathers' health promotional practices, around initiation of drinking and modifying their child's consumption of alcohol, are managed mostly by paternal attitudes and attributes (fathers as models).

11.4 Fathers' influence on adolescents' illicit drug use or abstinence

Fathers' ability to deter their child from experimentation with illicit drugs is an important health practice that takes many forms. A search of the literature was conducted using the key words 'father' or 'parent', 'child' or 'adolescent', 'drug' and 'prevention'. The search was conducted in the data bases Blackwell Synergy, Google scholar and SCOPUS. Three groups of literature were identified.

The first group of literature pertained to the patterning and type of drugs used by the father with some evidence that paternal drug use increases the probability of their offspring exhibiting similar consumption patterns and types of drugs, both licit and illicit (Resnick et al., 1997; Johnson et al., 1984; Hoffmann & Su, 1998). In consideration of the association between parent and child drug use, Li et al., (2000) recommend:

> **"Parent substance use should be addressed in adolescent substance use prevention programs, and that continuing non-use by parents should be reinforced."**
>
> (Li et al, 2002: 1537)

Although rehabilitation programs have been based on an understanding that fathers who achieve abstinence can act as a positive example for offspring who use drugs, research evaluating this association could not be located.

The second group of literature made general reference to the influence of parenting styles. Although there has been extensive research supporting use of the Health Belief Model (HBM), in the study of protective and preventive health behaviours in adults, Spoth and Redmond (2000) contend that only few studies focus on family-skills and family engagement strategies to reduce drug use in children. In a later publication Redmond et al. (2004) reassert this finding stating:

> **"The application of these constructs to preventive efforts undertaken by parents on behalf of their children is relatively rare (Peterson, Farmer, & Kashani, 1990; Spoth & Redmond, 2000)."**
> (Redmond et al., 2004: 224)

Despite Rermond et al's (2004) claims of few studies the author of this thesis located several important works linking parenting style to a reduction in drug initiation and habits in offspring; Baumrind (1991), Coombs et al., (1991) and Caughlin & Malis (2004) all identify family values and belief systems as important indicators of drug avoidance in adolescents. These ideas are supported in an early US study by Gfroerer and De la Rosa (1993) who concluded:

> **"Parents' attitudes and use of licit and illicit drugs were found to play an important role in their children's drug use behavior."**
> (Gfroerer, & De la Rosa, 1993: 87)

More recently Miller-Day (2002) study of parent communication styles with children produced the findings:

> **"The results suggested that parental antidrug messages were part of the ongoing discourse of family life rather than structured in an isolated 'drug talk', as is advocated in contemporary media."**
> (Miller-Day 2002: 604)

In addition, Teichman and Kefir (2000) found positive and significant relationships between perceived parental attitudes of rejection and acceptance of drug use and adolescent attitudes toward intention to use psychoactive substances; with the finding that:

> **"On most parameters, the father's influence was significant, whereas the effect of the mother did not reach significance."**
> (Teichman & Kefir, 2000: 193)

A study by Pinto and Queely, (2003) claimed to be searching for links between parenting styles and children's drug use for a mutual aid group activity but the data and analysis exclusively refers to mothers; fathers did not receive a single mention despite being included in the sample.

The third type of literature sought to evaluate parents' perceived utility gained from special programmes designed to enhance parental effectiveness in preventing drug use among adolescent family members. Cohen and Rice (1995) used a control group and a parent-targeted drug prevention intervention to determine the effect of encouraging parents to intervene when risk factors, such as tobacco and alcohol use, were detected in their child. The study found that "parent participation was poor" but as a general theme:

> **"Maintaining high rapport and a respectful parent-child relationship did protect against adolescent substance use. Future parent-targeted prevention programs should target protective factors, rather than trying to control risk factors."**
>
> (Cohen & Rice, 1995: 159)

Overall, there was scant literature found on the role of fathers and their use of parental programmes designed to minimise the risk of their child using illicit substances (cannabis, amphetamines). Importantly several studies directly de-emphasised the role of the father. Kosterman et al's (2001) study tested the effects of parent-training sessions on parenting practices using content specifically designed to maximise Drug Free Years (DFY) for adolescents. A sample of 209 rural families was divided into a control group and an intervention group. The data showed that effects of training were "most pronounced among mothers". Kosterman et al's (2001) findings on parent gender were congruent with that of Redmond et al's., (2004) review of the research literature:

> **"Studies examining parent gender effects have shown that mothers are more likely to participate in, and apply information from, parenting programs than are fathers (Rickwood & Braithwaite, 1994; Slipp, Ellis, & Kressel, 1974; Spoth, Redmond, Hockaday, & Shin, 1996; Stanton & Todd, 1981)."**
>
> (Redmond et al., 2004: 227)

Redmond et al., (2004) examined the efficacy of family and youth preventive programmes for substance abuse as well as the factors influencing parental participation in such interventions. Of the 1,260 parents completing the telephone interview, 92% (1,156) provided complete data on all study measures;

mothers comprised 73% of the sample. Redmond et al., (2004) explored parental perceptions of:

a) their child's susceptibility to future substance,
b) their ability to prevent such problems, and
c) benefits of family-skills programs designed to prevent adolescent problems.

Redmond et al. (2004) reported findings as:

> **"While mothers felt that their children were more susceptible to teen substance use problems and viewed family-focused prevention programs as more beneficial than did fathers, they also perceived themselves as having higher levels of efficacy to prevent those problems."**
>
> (Redmond et al., 2004: 237)

Disturbingly, Redmond et al., (2004) findings, based only on perceptions such as 'Mothers perceived themselves to be more efficacious than did fathers', are used to justify a further emphasis on the mother's role in preventing drug use and inclusion in future programmes.

> **"The finding that mothers perceive family-skills programs to be more beneficial than fathers, taken in conjunction with previous research indicating that mothers are more likely to participate in, and apply information from, parenting programs than are fathers (Rickwood & Braithwaite, 1994; Slipp, Ellis, & Kressel, 1974; Stanton & Todd, 1981), suggests that recruitment efforts be directed toward mothers whenever possible."**
>
> (Redmond et al., 2004: 238-239)

Whilst mothers perceived themselves to be more efficacious than did fathers, no evidence was produced to show that mothers were anymore effective in succeeding in getting their children to refrain from drug and alcohol use. Redmond et al., (2004) also gave caution on the generalisability of their findings due to the culturally homogeneous nature of the rural area (two parent family, nearly all white). To improve father participation in studies Redmond et al., (2004) suggested secondary recruitment strategies for fathers accompanied by:

> **"Information directly relevant to fathers (e.g., information concerning the role of fathers in the prosocial development of their children)."**
>
> (Redmond et al., 2004: 239)

Redmond et al's., (2004) recommendation suggests that the researchers had not used information directly relevant to fathers in their initial recruitment strategy.

Fathers are likely to be further marginalised by findings that show they are already marginalised. Miller-Day's study (2002) incorporating interviews with youths focusing on parent – adolescent conversations about illicit drugs found that 'fewer than half' had ever broached the subject with a parent and those that did, had a gender preference for maternal conversations:

> **"Significantly more adolescents felt closest to and preferred talking with their mothers about risky topics than to other family members."**
>
> (Miller-Day 2002: 604)

This finding was used in support of additional resources and research focus on mothers.

> **"This article...discusses implications for targeting mothers as prevention agents."**
>
> (Miller-Day 2002: 604)

The finding by Miller-Day (2002) is somewhat countered by the effectiveness of cross gendered fathering identified in Brook et al's., (1984) study of paternal - daughter relationships exploring the variables of daughters' use of marijuana. Brook et al.'s, study showed that:

> **"... the father is more likely to act as an ameliorator with his daughter than with his son in reducing marijuana risk factors."**
>
> (Brook et al., 1984: 1032)

In addition, a qualitative study (*n=3*) by Bry et al. (1986) found that decreases in adolescent boys' drug use and school failure were accompanied by increases in reports of positive interactions with their fathers.

11.5 Fathers' attempts to reduce their child's exposure to smoke

Smoking is the third leading cause of preventable morbidity and mortality in Australia and countries with similar social and economic systems (Pattenden et al., 2006; Freund et al., 1993; US Department of Health and Human Services, 1989). In addition, exposure to Environmental Tobacco Smoke (ETS) has been estimated to be the third leading cause of preventable death (Glantz & Parmley, 1991). The majority of smokers are of child bearing age and consequently as many as 50% of children world wide may be exposed to ETS (Lister & Jorm, 1989; WHO, 1999b; Jarvis, 1999). In the United States of America, 30-60% of children, less than five years of age, are regularly exposed to tobacco smoke in

their homes. Exposure of children to ETS is linked to respiratory infections, ear disease, asthma, and sudden infant death (Hovell et al., 2000; Cook et al., 1997; Cook et al., 1999; Pattenden et al., 2006; Nelson, 2001; Willatt, 1986; Keskinoglu, 2007; Shiva et al., 2003; Witorsch & Witorsch, 2000). Exposure to passive smoking has been responsible for approximately 150,000–300,000 US cases of bronchitis or pneumonia in infants aged less than 18 months (Environmental Protection Agency, 1992). Health economists have estimated that approximately 9% of the total direct medical costs in the first year of a child's life can be attributed to the effects of passive smoking (Leung et al., 2003).

Identifying parents that have a tobacco dependency and smoke around their children is a key concern for paediatric health workers, particularly where children have a respiratory condition (Winkelstein et al., 1997; Gergen et al., 1998). Ergo, a father's decision to smoke or not to smoke near their child represents a key health promotion practice.

11.5.1 Fathers' alteration in smoking habits

Several systematic reviews have focused on the ability of intervention programs to change the smoking habits of parents / fathers. Gehrman and Hovell (2003), conducted a critical review of 19 empirical studies published between 1987 and 2002; concluding that more rigorous study designs, along with ETS interventions of greater intensity and duration, would be necessary if promising results were to be achieved. The report identified three studies mentioning fathers but Gehrman and Hovell (2003) chose to comment on only Murray and Morrison (1993) study of asthmatic children and parental health promotion. Gehrman and Hovell (2003) claimed Murray and Morrison's (1993) study was of value because:

> **"In particular, the study detected effects in fathers, who often are not included in measures or outcomes of ETS studies."**
>
> (Gehrman and Hovell, 2003: 296)

However, the rigor of the study was low because of its quasi experimental design; in addition fathers comprised only 10% of the sample (*n*=807 parents).

Priest et al.'s (2008) systematic review of family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke was limited to interventions using controlled trials, with or without random allocation. Only one study targeted fathers; Zhang (1993) focused on elementary

school children's ability to encourage their fathers to quit smoking. Zhang (1993) achieved a reduction in fathers' reported smoking rates in the intervention group and no change in the control group eight months after a school-based intervention (children wrote letters to their fathers urging them to quit). Although Priest et al. (2008) cite a study by Chan (2006) as focusing on fathers, the research actually focuses on Hong Kong mothers' actions to protect sick children from ETS produced by fathers. The study showed that nurses' interventions were successful in motivating mothers to request that the father smoke away from their child, limit smoking or quit smoking altogether.

Despite a plethora of interventions there is little evidence that fathers are curtailing their smoking around children. Jarvis et al., (2000) concluded, from a review of the literature that:

> **"There is little evidence that parents who smoke have achieved meaningful reductions in their children's exposure through limiting when and where they smoke. Complete cessation remains the only option that can be firmly endorsed, not only for parents' own health but also for their children's."**
>
> (Jarvis et al., 2000: 345)

A recent study of mothers (Robinson & Kirkcaldy, 2009) identified that when the father of the child was reluctant to give up smoking, mothers also resolved to keep on with the habit. One mother summarised her feelings in terms of unfairness between her and her partner, stating:

> **"My husband used to go on saying 'just try and stop smoking' but he was smoking and I said well you're just as bad. And I just used to think why is he going on at me? He's just as bad. If he had packed in then maybe I would have tried harder. FG5."**
>
> (Robinson & Kirkcaldy, 2009: 15)

Conversely, fathers' negative attitude toward maternal smoking and knowledge of the effects on the unborn child have been linked to mothers' improved ability to cease smoking (Bottorff et al., 2006; Balckburn et al., 2005). Attempts to prevent new mothers relapsing into pre - pregnancy patterns of smoking have met with limited success, with approximately two thirds of new mothers resuming smoking within months of the intervention ending (Wilson et al., 2001). Whilst SES and smoking are linked, there is an absence of national data on the socio-demographic profile of fathers who smoke (at the time of the birth of their child) making it

difficult to determine just how representative of a population any intervention study might be (Balckburn et al., 2005).

Irvine et al (1999) studied the effects of a health information leaflet outlining effects of smoking around a child with asthma. Analysis was based on 213 families in the intervention group and 222 families in the control group; the study showed that informing parents of the harmful effects of passive smoking was ineffective in persuading them to reduce the exposure of their children to tobacco smoke, with 98% of parents in both groups continuing to smoke around their child one year after follow-up. Irvine et al. (1999) did not disaggregate the data into fathers / mothers, reporting only on parents.

The Journal of the American Medical Association (2007:170) reported on the effectiveness of voluntary "smoke free home rules for Second-hand Smoke" (SHS) around children; noting "Substantial sociodemographic disparities exist with regard to SHS exposure in the home", with no information on maternal or fathers adherence to these rules. Spencer et al., (2005) reported on the effects of home smoking bans on toddlers (18-30 months) ETS exposure, showing a slight reduction in the child's (*n*=301) bio markers for ETS (cotinine: creatinine ratios - CCR). The cause of this reduction could not be attributed to the mothers' or fathers' / partners' reduction in smoking around the child because the researchers had determined that mothers would be proximal to the child for most of the time, consequently the vast majority of data (> 95%) was collected from mothers only. Wilson et al's., (2001) study attempting to link smoking with CCR of children with asthma also encountered methodological problems such as small samples and an inability to separate the ETS effects caused by either mothers and fathers/ grandfathers / other carers.

Blackburn et al., (2005) identified that smoking rates vary internationally; the small number of studies from North America, United Kingdom, Italy and Scandinavia recording fathers' smoking status suggest that 50–80% of children in smoking households lived with a father who smokes. Blackburn et al., (2005) studied smoking behaviour change among UK fathers of new infants (*n*=286). The self-report measures of tobacco consumption and attempts to change smoking behaviour show 785 attempted to stop smoking (in the home) and 605 had achieved this. However, the final results revealed:

> **"Findings suggest that during the early months after the birth of baby, only four in ten fathers who were smoking when their babies were born smoked fewer cigarettes than they did before their baby's birth."**
>
> (Blackburn et al., 2005: 524)

For those men in manual occupations, the odds of not attempting or not achieving not smoking in the home were twice those of fathers in a non-manual occupation (Blackburn et al., 2005).

Whilst substantial benefits to children would arise if parents stopped smoking after birth (Strachan & Cook, 1997), overall there has been little evidence to show that fathers routinely protect their infants / children from the effects of ETS in the home. What evidence does exist suggests that not smoking in the home is a more likely occurrence than quitting smoking for fathers (Blackburn et al., 2005; Robinson & Kirkcaldy, 2009). This brings into question the role models fathers establish for their children; continuing smoking outside the home may offer protection against ETS but the child may initiate smoking as a teenager because they have observed their parent has an acceptable habit.

11.5.2 Father' smoking habits influencing children smoking habits

Considerable public health effort has been made toward preventing initiation of smoking in adolescence and identifying the processes underlying smoking initiation (Hoey & Miller, 2006; Lynch & Bonnie, 1994). Parental smoking and associated attitudes toward smoking are key factors associated with their children's initiating smoking. Conversely, the premise that antismoking ground rules, negative parental attitudes toward smoking and monitoring of children are effective against smoking initiation is widely supported in the literature (Simons-Morton, 2002). However, Chassin et al., (2005) suggest there are difficulties in synthesising data for multiple studies because of the variety of methodologies employed and who was asked to pass on opinions (mothers discussing fathers, children discussing the impact of parental smoking, parents discussing monitoring of children). For example:

> **"The information about father's smoking in childhood came in most cases from the mother, and later information about parent smoking came from the study participants themselves."**
>
> (Mc Gee, et al., 2006: 1200)

McGee et al., (2006) claim to have aimed to extend earlier work by examining three aspects of parental smoking behaviours in childhood and linking this to tobacco smoking and smoking cessation during early adulthood. The earlier work referred to by McGee (2006) was that of Stanton et al., (1989) and …"That analysis was carried out separately for mothers and fathers." (McGee, 2006:1194). However, McGee et al., (2006) did not provide an analysis of fathers.

A large US cross sectional study (*n*=37,244 students) found parental smoking and less parental concern about smoking were strongly independently associated with youths' current smoking. Each of these behaviours acted synergistically to exacerbate the likelihood of smoking in their children. Conversely, the prevalence of current smoking was lowest among youths who reported their parents did not smoke and had the highest level of concern about smoking (Kalesan et al., 2006). Although Kalesan et al. included data on fathers they did not provide a differential analysis on the influences of fathers on their child's taking up smoking.

Chassin et al., (2005) interviewed 382 adolescents (age 10–17 years) and their parents in a longitudinal study design to determine parenting style and smoking-practices as predictors of adolescent smoking onset. Although Chassin et al., (2005) highlight that …

> **"Smoking-specific discussion was assessed with four items each about mother and father.**
>
> (Chassin et al., 2005: 337)

the discussion section made not one reference to 'father', relying instead on general statements about 'general parenting style; a possible reason for this can be found in the researcher's declaration that only mothers' reports were used for between study comparisons:

> **"To compare our findings with those of previous studies and to maintain the largest sample size, mothers' reports were used as the measure of parent report, except for the small number of cases (3.5%) in which only fathers' reports ..."**
>
> (Chassin et al., 2005:337)

and

> **"Because adolescents' perceptions of their mothers and fathers were highly correlated (*r* =.69 for behavioral control and .48 for acceptance), they were averaged into measures of perceived parental behavioral control and acceptance."**

(Chassin et al., 2005:336)

Most recently Gilman et al., (2009), whilst exploring comparative effects of parental smoking and nicotine dependence on intergenerational transmission of the habit determined a …"Gender-specificity of parental smoking effects on adolescent initiation."(Gilman et al., 2009: 275).

The study of 564 adolescents, aged 12 to 17, revealed the effects of parental smoking on offspring initiation smoking differed by sex (χ^2 4.5; *P* = .034), indicating a stronger effect of fathers' smoking on boys than girls. Adolescents who lived with fathers who smoked were more than three times as likely to initiate smoking; in contrast, there was no effect on initiation risk for offspring whose father smoked but was non-resident.

Farkas (1999), a researcher referenced by most of the authors cited in this section, conducted a cross-sectional study of 4,502 adolescents, aged 15–17 years who lived in a two-parent household. Farkas (1999) found that adolescents with older fathers were less likely to become smokers and those boys who achieved cessation from smoking were more likely to have fathers that were better educated. In addition fathers were just as likely as mothers to quit smoking and more fathers quit smoking than mothers following the birth of their child (77.7 $\pm$ 2.8% for mothers and 81.1 $\pm$ 2.1% for fathers). In a large Dutch study of 2,206 adolescent, Bokland et al., (2004) found 55.1% of fathers had quit before the birth of their child (*n*=379) and 63.9% of mothers had quit before the birth of their child (*n*=440). The study by Bokland et al., (2004) is important because detailed demographic data was collected for the purpose of examining the role of both the father and the mother. Bokland et al., (2004) criticised Farkas et al., (1999) stating the researchers: "Did not differentiate between fathers and mothers concerning quitting behaviour." (Bokland et al., 2004: 336).

Bokland et al., clarified this general point with the example:

> **"Our study shows that quitting by the father has a stronger effect on adolescent ever smoking in the case the partner was a never or former smoker."**
>
> (Bokland et al., 2004: 336)

Additional findings from Bokland et al., (2004) were; if the father stopped smoking before his child reached the age of seven, the likelihood that the child would become a smoker as an adolescent was significantly lower than if the father

stopped when his child was between seven and 14 years old; this relationship was also established for mothers who stoped smoking before their child reached seven years. However, adolescent whose parents had stopped smoking before the child had reached seven years were still more likely to take up smoking than were children of fathers who never smoked. In conclusion:

> **"Not only should prevention be targeted to the mother but also to the father, because this study clearly demonstrates the importance of cessation by the father. Nevertheless, in the Netherlands, primary prevention efforts focus mainly on the adolescent rather than on the parents."**
>
> (Bokland et al., 2004: 367)

In a more recent study, Otten (2007) selected 6,377 students, only those children that lived in families with both a mother and a father, to examine the role of parents' current and former smoking habits as predictors of adolescent smoking. Although multiple data were collected on fathers the discussion section of this study did not provide any comment on an association between fathers' smoking / not smoking and their child's smoking status. And the finding that children in single parent families were more likely to smoke than those in dual parent families was not accompanied by any comment on possible differences between fathers as single parents (smokers / non /smoker) or mothers as single parents (smokers / non /smoker).

11.6 Conclusion

The literature supports the notion that fathers have a key role to play in using health promotional interventions and monitoring their children with a view to reducing the risk of illness, disease and premature mortality. Although there is a need for fathers to be involved with their children's health needs from an early age, there is scant literature to shown that men are attending clinics that screen for health and developmental problems.

The use of alcohol and others drugs has reached epidemic proportions in many Western countries and whilst studies identify that parents' disapproval plays a key role in their children's choice of initiating substance use, there is little to suggest that all fathers are interested in formal informational programs. Few researchers have called for studies into what might attract fathers toward gaining a deeper

understanding of issues and how they could best implement health promotional activities to deter their children from use of these substances.

Parental smoking habits are an important predictor of smoking initiation among adolescents and successful cessation from smoking by parents does reduce the likelihood of children initiating smoking. However, there has been little work to determine how best to influence fathers to quit smoking. Mothers tend to be the focus of studies because of the harmful effects of maternal smoking on the unborn child and their close daily proximity to their infants and young children. Whilst fathers have been targeted for their smoking habits within the home there has been no general statement on appropriate interventions leading to better outcomes. Nevertheless, fathers have the potential to promote their child's health by not smoking, quitting smoking before the child reaches seven years and smoking outside the house. There are several successful health promotional strategies exhibited by fathers but only touched upon by researchers. Firstly, many fathers do quit smoking because they have children or do not expose their child to ETS. Secondly, children do pay attention to fathers anti-smoking comments but only if the father is a non smoker; fathers that smoke and inform their children not to smoke have very little influence on deterring their child from smoking. Thirdly, fathers also play a key role in monitoring their child's smoking / non smoking status; with higher educated and non-manual workers linked to higher rates of children not smoking.

The findings from this chapter supported the construction of questions for focus group discussion and the household survey. Although the topics of alcohol and tobacco use were not included in the household survey, the questionnaire: Section 3.1 *Knowledge of health and health practice*, identifies respondents' knowledge of health promotion topics that can be applied to childhood [Q3.1.5 *balanced diet*, Q3.1.9 *common childhood illnesses*, Q3.1.10 *type of immunisation* and Q3.1.12 *personal hygiene*].

CHAPTER TWELVE:
QUALITATIVE ANALYSIS

12 Introduction

Analysis of data for focus group discussions and interviews occurred in two stages; a descriptive analysis is presented first, followed by a thematic analysis.

According to Cote-Arsenault & Morrison-Beed (1999: 282) data analysis in qualitative research that uses focus groups is 'on-going'. Qualitative data analysis begins in the planning stage when a review of the literature is used to support the development of semi structured interview questions. In this thesis, the chapters titled '*Masculinity', 'Gender division of labour'* and *'Fatherhood'* provided a theoretical basis for interpreting men's role within the family.

During the focus group the moderator of the focus group used a reflexive process to analyse the data; whereby responses from men were used to create extensions to the semi structured questions, probing their experiences and nuances to gain a 'thick' description (Denzin & Lincoln, 2000). Krueger (1997a) asserts that within the group and between group analyses are essential and must be undertaken by a researcher who was present at the group sessions.

> **"Data analysis is ongoing and occurs during the planning stages, focus groups, and debriefing sessions to identify general impressions and overriding themes and patterns. During this time, modification and refinement of questions occurs prior to the next focus group."**
>
> (Cote-Arsenault & Morrison-Beed, 1999: 282)

In preparation for the final analysis it was understood that there is no deterministic approach to the analysis of qualitative data (Smithson, 2000); descriptive analysis and thematic analysis are appropriate when little is known about the topic.

12.1 The write-up

The researcher must choose a style and language that best fit their research purposes, methods, and data (Knafl & Howard, 1984). The study was designed to both identify the actual health practices of men and describe men's views on doing health practices as a father / guardian, within the context of the family and wider society. The write up of data analysis occurred in two frames. In frame one, descriptive analysis of the corpus of material identified the actual health practices and was written- up with minimal analytic or interpretive intrusions from the researcher.

> **"Qualitative descriptive study is a method of choice when straight descriptions of phenomena are desired."**
>
> (Sandelowski 2000: 334)

and

> **"Researchers who conduct qualitative descriptive studies stay closer to their data and the surface of words and events than researchers conducting grounded theory, phenomenological, ethnographic, or narrative studies…There is nothing trivial or easy about getting the facts, and the meanings participants give to those facts, right and then conveying them in a coherent and useful manner."**
>
> (Sandelowski 2000: 336)

In frame two, thematic analysis of men's views on doing health practices are represented in ways that:

> **"Economically and faithfully captured common and idiosyncratic themes in the interview data."**
>
> (Sandelowski, 1998: 377)

The men's words are paraphrased or quoted to illustrate these views (Sandelowski, 1998: 377). This follows Chenail's (1995) idea that:

> **"The data, which have been painfully collected, should 'be the star' in the relationship."**
>
> (Chenail, 1995: no pages)

The task of this researcher is to ensure that the reader hears these men, with minimal voice-overs and recombinations of data, and to reduce the volume of data, but amplify the men's voices. There is no attempt to provide a grounded theory as much of the literature reviewed in preceding chapters provided adequate description of masculinity, fatherhood and the gender division of labour

surrounding parenting and provision of child health care within and outside the home.

12.2 Frame one: Descriptive analysis

The corpus of verbatim material was read in order to identify men's role within the family and their health practices vis a vis their children's health. The data was clustered under semi-structured interview questions developed from the critical review of literature and categories that emerged from the interviews. In accord with Sandelowski's (2000: 338) guidance the qualitative descriptive analysis in this study is reflexive and interactive, as the researcher modified the treatment of data to accommodate new data and new insights about those data.

Participants are identified as numbers to provide an audit trail within this study; should excerpts of the verbatim transcript be reproduced for publication this data identification method may be removed to protect anonymity.

12.2.1. Division of labour: childcare

A fundamental division of labour within a family is characterised by who spends most of the time with their child and why. A more refined understanding of the workload can be appreciated when each parent identifies what is their childcare time.

Interview question: **Did your wife / partner work after the children came along?**

Father #5 ***"A lot Yeah!, a lot*** **[emphasis on the words 'a lot']*...the money we had went on the farm, we had a car and a ute [a ute is a car where the rear seat is replaced by a loading bay] and we had to run them, and the household."***

Later in the discussion Father #5 stated

Father#5 ***"We have always been able to work a little bit harder and a little bit longer than other people."***

This man's wife had two – three employment schedules in one week and the following interview exchange highlights his flexibility in child caring.

Probe question:	**How did that work out for childcare?**
Father #5	***"We were very much a tag team*, [referring to wife's part time work in the evenings] *it didn't matter if she was there [or not] because the children got her during the day and me after work finished."***
Probe question:	**You were there at night and after your work finished?**
	***"Yeah!"* (Yes)**
Probe question:	**And if the children were sick, your wife wasn't there, you took over?**
	"Yep!"
Probe question:	**Did you get instructions on how to care for the sick children when you got home?**
	"Yep!"
Probe question:	**Does that mean that it didn't matter which parent was at home?**
Father #5	***"Yeah!"* (Yes) [some minutes later in the discussion father #5 returns to the topic of child care, to delineate a role stating]**
	"I still avoided changing a dirty nappy, like the plague if I could. With XXX [*his first son*] we just didn't have the money for the disposables, I think, yea! They got used if we went out somewhere."
Father #12	**"*I'll have to admit XX* [wife] *has done* [pauses to rephrase comment] *well right from the start, with changing nappies etc., 90% of changing - like when they were babies. And … XX* [wife] *wasn't doing any work so that was her sole role… I'd like to think that I did more of the nappies but XX* [wife] *tells me that I didn't."***

12.2.2. Division of labour: health practices

Numerous comments made by men indicate that children's health problems are women's work; they are commensurate with literature exploring masculinity and a social division of labour based on normative male and female roles. To the men at interview this gender role convention appeared natural as well as universal among families. The convention was also underpinned by the knowledge that their forefathers and mothers had held with this convention.

Interview question: Who normally gives medications to the children?

The administration of medication to children by parents normally involves three indicators, either the child has symptoms associated with an acute illness / injury (fever, diahorrea, discomfort) or the child has an illness that can be cured by medication (head lice, bacterial infection) or there is an illness that is ongoing (asthma, dermatitis) that requires medications to prevent worsening of the condition. All men at interview were aware that a child in their family had been taking medication in the past month or was taking medication at the time of the focus group / individual interview.

The administration of medications by the correct route, prescribed dose and specified time are key elements in the appropriate treatment of most childhood illness. Observing for their desired effects, as well as adverse effects is an important practice. Most men rarely, if ever, attended medical appointments with their children and therefore they had no first hand information from the doctor on the purpose of the medication prescribed or how the drug should be safely and effectively administered. Lack of knowledge about drugs' administration and their actions meant that some men were hesitant to give medications and others used inappropriate measures.

Probe question: **If one of your children needed medication as a result of seeing the doctor, who would give the medication?**

Father #AC ***"XX* [wife] *would do that, Panadol and that sort of thing I don't like giving that to kids."***

Probe question: **Do you have a dislike for that kind of thing?**

Father #AC ***"I'd rather not give them anything if we could."***

Another father immediately adds:

Father #2 ***"I have had to give Panadol syrup in the syringe but I would rather XX* [the child's mother*] do that. I don't like getting up in the middle of the night and doing that; I wouldn't be sure about giving the right dose; I'd be worried about giving too much."***

Interview question: Did you feel comfortable in getting the dose right?

Father #5 ***"Probably, in a lot of cases, instead of getting out the measuring glass, a teaspoon is about 10mls and so I'd use that. In a lot of cases they just got tea spoons, they have always been very good about taking it."***

In another group discussion the responses were more positive regarding this health practice.

Father #12 ***"Yes definitely, oh all that sort of thing, cough mixture or …"*** **[the participant can't find the word to express in more detail and moves on to talk about general childcare]**

Probe question: What type of medications did you give?

Father #5 ***"Flavoured antibiotic…that sort of thing."***

Probe question: Did you ever get any information from pharmacists?

Father #12 ***"Er! Yes pharmacists are renowned for giving out information, their um… sometimes I think that they think that they know more than the doctor does."***

Interview question: Who normally cares for the sick child in your family?

Most men explained their lesser involvement in the care of sick children by inferring their spouse / partner was better educated on the topic and possessed superior nursing skills. Seen as complementary to this normative social role for women was men's prioritisation of work commitments.

Father # 8 ***"XX*** **[wife]** ***works in the health industry so she handles all of that kind of thing."***

Father #12 ***"And I guess as far as health issues go with the kids over the years we have both contributed a lot, I am sure XX*** **[wife]** ***has contributed a lot more than me, particularly when they were babies; which I suppose is par for the course." [Inferring women do more for children because they are around more].***

Several men saw themselves as a second best option to a mothers' care stating that they could be called upon if they were really needed.

Father #1 ***"If I was needed, I would be there."***

Father #2	***"Quite often they are alright in the house, just on their own* [referring to 3 of his children*]… and I would be out in the shed … I'd not be far away."***

One man had a very matter of fact approach to his decision to be involved in the care of his sick child and probing questions met with brief responses, inferring that caring for a sick child was a simple matter well within his problem solving capabilities.

Probe question:	**If your wife wasn't available could you take over?**
Father#5	***"Yep!"***
Probe question:	**Did you get instructions on how to care for the sick children when you got home**
Father#5	***"Yep!"***
Probe question:	**Where did your wife get her health information from?**
Father#5	***"She got that from her sister XX* [names the in-law]*, she is a nursing sister."***
Probe question:	**What happened if there was a mishap - the children vomited?**
Father#5	***"I cleaned it up."* [bold statement, matter of fact tone]**

12.2.4. Division of labour: nocturnal responsibilities

One of the most difficult aspects of caring for the sick is attending to their needs overnight. Literature on the lives of working mothers in dual income families highlights that these women become emotionally and physically exhausted from waking in the night to attend their child's needs. Women in this situation live in hope that their spouse / partner would participate equally.

Interview question:	**Who normally gets up in the night for the children?**
Father #1	***"... if you are awake in the middle of the night and they are awake or fallen out of bed of something, I'll do that .....If they are sick during the night, a wet bed or full of vomit, one of you go to the bath and one of you will make the bed, or something like that."***
Father #2	**[in immediate response to father #1comment] *"Yeh! I would too … I'd say, what do you want me to do, the bed or bath?"***

Father #3	***"I've got to tell you about something. My youngest boy got into the middle of the bed with us, just stood there for about 10 seconds, and let her go*** **[interviewee makes a vomiting sound]** ***so we all had to get up fairly quickly*** **[all interviewees laugh].** ***There was no debate about who was going to get up then."***
Father # 10	***"I used to always get up in the night and XX*** **[wife]** ***would sleep*** **[laughs].** ***I've always been a light sleeper so I would hear them. I would get up and change them and give them to XX [wife] to feed them*** **[breast feed].** ***And then I would stick them back in the cot afterwards."***

Father # LL offers a comment outside the discussion on the sick child, highlighting that paternal contribution to childcare was not universal in the group.

Father # LL	***"I don't think I have ever changed a nappy to tell you the truth. And I never really had anything to do with feeding."*** **[long silence from the group]**

12.2.5 Division of labour: Medical appointments

The need to attend medical appointments ranges from routine health checks, acute illness, interventions (x- rays, scans, blood test, fitting of prosthesis). The literature review chapter established that attendance was not an infrequent experience for both young children and teenagers, particularly teenage girls soon after the onset of puberty. Young children with a chronic illness / disability feature highly in the frequency of use of medical services.

Interview question:	**If the children were sick who was most likely to take them to the doctors?**
Father #2	***"I can't say that I have ever taken the kids to the doctor. XX*** **[wife]** ***has done all that. Normally if they've got to go in for cuts and bruises and stiches, XX*** **[wife]** ***does all that."***
Father #2	***"No I can't recall that ever happening*** **[indicating that he had not taken the children to appointments]** ***I'd just stay at home to be with the other kids. XX*** **[wife]** ***was taking XY*** **[daughter]** ***to an appointment over in Adelaide for a few little problems. Nothing serious though."***
Father #12	***"I would certainly be available and I used to do it*** **[take the children to appointments]** ***quite often but XX*** **[wife]** ***would have done it more."***

Father #12	***"When you have got a 9 to 5 job and you're working for somebody, it's very hard to drop tools and do things like that."***
Father #12	***"I just found, because I was always involved with kids going to the doctors and whatever and you just asked questions. Some of the doctors were reluctant to divulge things, and I don't know why."***
Probe question:	**You mentioned the boys and the odd accident; were you involved?**
Father #5	**"*At times I was around …er!*" [stops discussion - requires probing]**
Probe question:	**Were you involved in taking them into casualty?**
Father #5	***"Yeah!"***

One father had a daughter who was unable to walk because of a physical disability. The family lived an hour's drive from the specialist. He makes the comment:

Father #10	**"*We spent a lot of time in Adelaide, with XX* [daughter] *going to doctor's appointments and whatever and if I couldn't make it* [pauses to reconstruct the point] *…well I always went in the first five or six years*. [pauses to reconstruct the point] *…I would always go. So it's more I guess the 'just being there' and that sort of stuff."* [the father infers that he played no specific role in the medical aspect of care – but later reveals he did much of the personal caring for his daughter]**

12.2.6 Sexual / reproductive health

Interview question:	**When it comes to sex, what sort of things do you tell them?**
Father#5	***"Oh As that goes …certainly and its not because dad told me* [inferring that his father had told him little about sexual health] *so I think it is just because it is a matter of course* [inferring that these days it is necessary] *where there is so many more susceptible diseases that HIV and Hepatitis C and…"* [cuts off conversation because he is interrupted by another participant]**
Father#5	***"I said don't have sex without a franger* [latex sheath]. *We* [father and mother] *tried to protect them both* [son & daughter] *but more so protect the girls from the evil of boys."***

Father#5	**"*XX* [names the boys mother] *was pretty paranoid about that stuff [*STD, AIDS] *when he was 16 or 17 so there was a lot more given than just a sly comment. XX* [the interviewee's wife] *and I know what it was like to be a young adult and get absolutely nothing* [sex education]."**
	[the conversation continues to flow from man to man]
Father #13	***"Oh well I emphasise condoms even though XX* [youngest son] *is only 15 not that I would like him to be using them* [the father intimates that his son should be using condoms if he was sexually active before 15 years] *but if something crops up, he should be. I guess a lot of 15 year olds are having sex now-a-days. I certainly have a closer relationship, in that aspect, than my father had with me."***
Probe question:	**What about relationships - sexual in nature?**
Father#5	***"He will probably discuss girl problems with his mother, becausehe he is a 'mother's boy' and we have been very soft with him. And I probably tend to look after his work issues and his financial issues, more so."***
Father #1	***"I will sit with XX* [daughter] *every now and again, particularly in the last twelve months … since she has got older, that um!* [pauses for 7-8 seconds] *…in the years to come, she never wants to get tangled up with a real boozer. And I always say that she will have an unhappy life* [inferring if that was the case]. *That's what I honestly feel; like a real boozer, someone who hits it."***

12.2.7 Transmission of health knowledge - father-to-son

<u>Interview question:</u>	**<u>Can you think of information or skills your father may have passed onto you about health matters?</u>**
Father #13	**"*The only thing would be to drink a lot, yeah to drink a lot of water,* (short pause) *that would be about all."* [as a dry land famer, dehydration from working in the heat is a danger to health] *"He always had a thing that er! If you didn't drink enough during the day, like in warm weather and stuff, you were that thirsty that when you did get back to where you could get a drink, that it didn't matter how much you drink you couldn't quench your thirst… He may have had cordial whatever, it***

	didn't matter he never went anywhere without a water bottle."
Father#13	**"*As a kid my dad was a heavy smoker."* [a 10 second reflective pause indicated deep though on the lack of good health examples from his father] [there were son-to-father transmission of health knowledge] *"We would talk about slip slop slap; he was shocking at it, he had a crew cut and never wore a hat and all that sort of stuff. Yeah! but now he is having skin cancers cut of the side of his fore head, and all that sort of stuff, you know the heat irritates the side of his head. Now! [*emphasis with an exclamation] *he wears hat, big wide brimmed hats. But he has to get the right ones because it irritates the damaged spots."***

As a summary point father #13 stated:

Father #13	***"There was not much in the way of health issues because we didn't really spend a lot of time together; I went out wool classing."***

For the majority of men in the group there was a consensus that their fathers had not passed on any relevant / useful health information to them as a child / teenager. The following is a typical response from one focus group:

Probe question:	**Can you remember any health information that your dad passed onto you?**
Father #11	***"No! Nothing."***
Father #NN	***"Not a word."***
Father #LL	***"My old man wouldn't have said boo."***
Father #AW	***"No… not a cracker!"***
Father #12	***"Just the basics… safety issues around work."***

Interview question:	**What about sexually transmitted diseases?**
Father #DQ	***"Not a word on them."***
Father #LL	***"Nothing."***
Father #NN	***"The most knowledge I ever had was from the school yard."***
Father #AW	***"Nope! Nothing."***
Probe question extended:	**How about the rest of you; did your fathers say anything?**
Father # AW	***"I got absolutely nothing from my dad, absolutely nothing."***
Father # NN	***"My father gave me his genes and that's about all, he just would'nt talk about it."***
Father #	***"I can remember my father putting, 'to be a man' was the book…what was it called, it was a red book, I think I have probably still got it at home. I found it on my bed one night and I think that that explained most things about not just the sexual aspect but everything about women and growing up through adolescence. Yeh! But I can never remember having a discussion about er… being careful and sexually transmitted diseases and looking after treating women as you should treat them"***
Father #AC	***"Dad had several kids and I was second to last so I just used to go with the flow."***
Father #GC	***"I can't think of anything in particular, dad was always very safety conscious, you know, aware of what could go wrong. He would always emphasise that things could go wrong and he still does to this day."***

12.2.8 Health promotion

Promotion of a child's health can encompass a wide range of activities and calls on a diffuse range of parental and health skills. Much of the health promotion within families has to do with the behaviour of the parent and their attitudes to risk taking in the short term and a comprehension of the link between current behaviours and medium and long term health outcomes. Responses on safer sex practices evolved spontaneously in group discussion when a specific sexual health question was offered to the group. The topic of alcohol also appears spontaneously in questions on sexual health and road safety. And protection

from sunburn developed spontaneously with an extended response from one participant. Where possible these iterations were left *in situ*, providing clarity to the context in which they occurred.

Interview question: **Are there any health prompting activities that you focus on?**

Skin cancer: - One man was concerned about the link between sunburn and skin cancer.

Father #1 ***"XX*** **[my son]** ***has got the potential, with fair skin, to get very burnt of course. So I am very conscious of making sure he has got a hat on."***

Father #5 ***"Mum would cover us in zinc cream when we went to the beach…It wasn't the arms so much, it was always the face, nose and cheeks and stuff."*** **[intimating that it was not the fathers role]**

Father #GC **[An ex- smoker did not want his son to smoke]** ***"I always try to find things to tell kids about not smoking, I am an ex-smoker but I am very much anti-smoking now. And if an opportunity crops up I often just drop the hint to XX [*****his daughter]** ***and XY*** **[his son]** ***about not smoking …that if they do it, it will probably end up killing them."***

Father #NN ***"When XX*** **[partner]** ***and the boys moved in I did have a problem with stopping smoking inside but I still smoke."***

Father #DQ ***"Well for a start I spent ten years of our married life, because I don't smoke, convincing XX*** **[wife]** ***to stop smoking. Well she has finally stoped herself and I think we've all, as a family we've all benefited because on the asthma side of this the asthma is not quite as bad. On the negative side XX*** **[wife]** ***has put on more weight."***

Probe question: **Your children are young, is there any health promotion that you can think of?**

Father #AC ***"Yeh! They are 10, 8 and 3. Well whatever you are doing you are persistently drumming something into them. You know that hat and sun screen. But there are no major things, no".***

Father #GC ***"I suppose it's in the back of my mind but it would be very much in the back of my mind. It's not something, you know, that comes to the front really at all. Something I am very conscious of with XX*** **[youngest son]** ***because of his fair skin because XY's*** **[wife]** ***father died of skin cancer***

	and lung cancer basically through his smoking; and that makes me very aware of what could happen to him if he doesn't cover up. That sort of thing is genetic isn't it like if you have got fair skin you are susceptible to the sun."

Father #AC responds to a previous example of a health concern:

Father #AC	***"You mention sexual abuse, there are so many problems but that is always in the back of your mind."***
Probe question:	**In what form XXX?** [addresses the respondent by name]
Father #AC	***"Oh, being molested by the wrong people, like 'stranger danger'."***
Probe question:	**And do you talk to your kids about this sort of thing**
Father #AC	**oh yer! [Exclaims - as if there were any doubt]** ***"Not talking to strangers, that type of thing, they are smart enough so they wouldn't. I have never been exposed to that sort of thing but as a parent you are always worried about it."***
Probe question:	**What about children in cars?**
Father #11	***"Do you mean with the two Littlies?" "Well there is more talk about it on the radio, if we get in the car now, we only had to deal with it with XX*** **[son],** ***and we have the seat belt on."***

Father # DQ states the advice he gives to his children - because country road accidents are more common for young people.

Father # DQ	***"I mean driving to Adelaide with a mobile phone, you shouldn't be doing it, but until you get caught you don't generally pull over to talk."***
Father #1	***"Drink driving I certainly don't like that behaviour close to my home, if I knew he was drinking I'd have dobbed him*** **[son]** ***in. And with XX*** **[names son]** ***the deal was; if you're drinking, basically, it doesn't matter how late so long as he woke us up and let us know he was home."***

Father # AC makes an appropriate interjection, as point of clarification.

Father # AC	***"That would be more of a life style thing wouldn't it? I've been guilty of a bit of drink driving and I am a bit more conscious of it now. If you've got to go out you have got to get home some how."***

Father # GC	***"I said to XX* [eldest child – daughter] *coming down here, they have graded the road after the church, about ten days ago and it hasn't rained since and it's very loose* [referring to the surface of the road] *very floaty, and we were in the car and the car was floating a bit, probably doing about 80 kilometres and I backed it off a bit to 60 or 70. And I explained to XX* [eldest child – daughter] *why I'd done it."***
Debriefing comment:	Following the closure on a focus group a participant took the opportunity to debrief with the researcher about a personal experience he had yet to resolve related to road traffic accidents. This man told of his regular journey on a dirt road and discovery of a rolled car. Inside was a deceased teenage girl '*with not a mark on her*'. He placed the girl in his car and drove her to the mortuary because he didn't want her left alone – this would have occurred if he had gone to inform the police. [*the mobile phone was out of range*]. This man had a teenage daughter who wanted to bring girl friends home to the farm. The man would not let her drive as she only had a provisional licence. He told his daughter '*they are welcome any time, get them to catch the bus and we will collect them*'.
Probe question:	**As a health promotion item -Do you offer comment on dietary intake?**

The men spoke generally of their diet as a child and the food within their household in which their children were raised.

Father #10	***"In the early years we always had a very healthy diet and always did a lot of exercise and all that sort of stuff. We always had a very healthy diet. We're probably worse now that our kids have got older, now that they are in their teenage years."***

This man responds to a question about the dietary norms in his upbringing.

Father #5	***"No!* [meaning there was 'no' emphasis on diet in his family] *and that was pretty much because he* [his father] *worked in shearing sheds a lot; he ate pretty much what ever was put in front of him. Even if it tasted like shit he ate it. And on the other hand they were always on me to eat vegetables and stuff. They would serve it up for tea and if I didn't eat it, then they would try serving it up for breakfast. That wouldn't work because I would just go hungry, I just wouldn't eat it."***

Another man summaries his child's body size:

Father #11	***XX* [eldest daughter] *looks after her self pretty well. XY* [middle daughter] *has fined down a bit and XZ* [youngest daughter] *is just prone to be* [takes 3-4 seconds to chooses words carefully] *…she watches what she eats to a certain extent, but she is just of those who are prone to putting on a bit of weight."* [Father #11 follows through with a comment inferring that they are not doing all they could be doing to keep a healthy diet]**

10-15 seconds later …

Father #11	**"*Err! Well* [pauses] *We encourage them not to eat take-away food but then again we probably go somewhere else that has got just as much fat and grease that most probably tastes better."***

12.2.9 Occupational Health & Safety

Only two of the men interviewed held sedentary occupations, the remainder were directly involved with farming or had a manual occupation. It was anticipated that all men would have some comment; farmers and those working in organisations have a mandatory requirement to be knowledgeable about OH&S legislation and practice (Standard Operating Procedures, handling and storage of dangerous chemicals). All employees are made aware of their obligation to exercise safe work practice.

Interview question:	**How does occupational health and safety relate to your children?**
Father #13	***"As a kid I would ride on the Combine* [large mobile equipment for harvesting] *and jump off it, and then run and jump back on it and all that sort of stuff* [inferring that this was a dangerous activity]. *We had a dog that used to do that a lot, perhaps not a really smart idea, he was a dead dog."***

In a different focus group to that of father # 13, one father stated:

Father #11	***"We certainly don't let kids ride on machinery without us being there … holding onto them and being inside the tractor cabin."***
Father #13	***"Well I put a couple of workers and the 2 boys* [sons] *through an on-farm training course***

	things…I'm pretty hot on OHS…but they were coming back with OHS stuff to me."
Father # 12	***"The general safety issues…when you are working with machinery or around. Yes certainly, he*** **[referring to his father]** ***was good on those. In fact my father got caught in machinery with his overalls one day they were ripped off. And I think that most farmers would have a history of the odd incident."***
Father #AC	***"In fact our children never came over to the work shop if we were welding or busy like that because it's just a haven for something dropping or touching something hot or something like that."***

Two of the men have an extended exchange on occupational health and safety, the common factor being they have children about the same age and both men are farmers.

Father #GC	***"And the kids know to cover up their eyes if they hear the welder going. So they can come in and sit down."***
Father #AC	***"They are all conscious of that, I think most kids would be, wouldn't they?"***
Moderators comment:	**I am most interested in knowing how you effect this other than simply telling them that that is not a good thing to do!**
Father #GC	***"I think I would probably do a bit of roaring if they didn't do it, but I have never had to do that. They seem to sense*** **[pause]** ***I think most kids are sensible enough that they seem to sense three is a danger around."***
Father #AC	***There's one thing, if you're backing something out before you start her up*** **[farm machinery]*****, and you know your kids are around… are remotely around you get out and have a look around, or make sure they are standing there*** **[points to the front]** ***and you're backing back here*** **[points to back right hand side].**
Father #GC	***"And as they get older the less you look isn't it? Like you would still be looking a fair bit because you have still got XX*** **[3 year old boy, son of AC]** ***but me myself. As they get older the less you have to think about that."***
Father # 10	***"One of our friends lost*** **[died]** ***their little boy and that sent alarm bells running through me more than anything. I had bad dreams about our boy who was 7 at the time… We realised it was all too***

	easy, I mean we weren't careful enough, just too blasé."

Comments of this type, in both focus groups, leads onto a general discussion about accidents and injuries.

12.2.10 Accidents and injuries

Interview question:	**Is there anything you do to prevent accidents?**
Father #11	***"Well I never ever took the kids to work simply for those reasons."*** **[referring to farm machinery inuring children]**
Probe question:	**Do you have any work shop rules?**
Father #*GC*	***"Yes I put everything back and keep everything tidy and things like that. Just be a bit careful. I don't let them touch too much."***

Another father joins in:

Father #*AC*	***"They're told that they are not allowed in such an area, sprays, well the spray shed. They're the thing they know that are out of bounds. I won't even let mine touch a boom spray".***

Another father explains to the interviewer:

Father #GC	***"There's spray drift on it."***
Probe question:	**Do you XXX [names father #GC)] have a place where you store your sprays?**
Father #GC	***"Just away from everything but not legally."*** **[quiet laugh].**

One man extended the discussion to comment on general farm safety:

Father #12	***"When my children were not even walking my mother-in-law brought some weld mesh … And made me put it over every underground tank on the farm. Which was a good thing, I might have thought of it but I didn't at that stage. As the children have grown older I have been very strong on the safety issues particularly outside garden fence, wandering over to the shed".***
Probe question;	**Did you take steps to reduce sporting injuries?**
Father #12	***"Yes, yep I've done that before…mouth guards and that sort of thing."***

12.2.11 Mental health & sense of wellbeing

<u>Interview question: Are there things you do to promote wellbeing within your family?</u>

One father [#13] had a transient mental health issue and became health literate.

The father then used skills to assist his son manage a problem

Father #13 ***"Even though I'm pretty placid …If he goes off*** **[son]** ***then I'm saying 'now just calm down… take a step back' look at what the problem is what caused it…you can fix it without blowing a fuse and all that sort of stuff. Seems silly, sitting under the pyramid, keep calm and look at things through an open mind."*****[the man is inferring that such strategies do work]**

One father reported that his wife had emotional problem after the birth of his daughter

Father #10 **"*****Not so much physical health but mental health, When XX*** **[daughter*****] was born, I knew I had to um…contribute. I think that's a major thing"***

Father #13 **"*****Oh XX*** **[Father #10's wife]** ***yeh it was pretty tough."***

Probe question: How tough?

Father #10 ***"Devastating. I helped just by being around a lot."***

Though not prominent in the literature fathers can play a key role in promoting a sense of wellbeing either by talking positively with their offspring or managing / deflecting conflict.

Father # 13 **[Explained that his father retired from the farm but had problems letting go]** ***"The emotional tension became unbearable and I found that I became mediator between he and mum.. er …Dad and XX*** **[Father #5's wife]** ***had a stand up screaming match which basically drove our eldest son away cause they got to the point where they would have come to blows… and to top it all off Dad's brother and his eldest son were also warring. So …I had to mediate between those two as well. Yeh!"***

One man explored the issue of sexuality and wellbeing:

Father # 12 ***"Oh absolutely!*** **[agrees with another man's proposition that rejecting the sexuality of your**

child then there would be a real problem] ***having a gay son would be a challenge …and I have a really good friend he is a rather arrogant, he is a funny person he has always been one to crack the jokes and have a drink and party, and his son is gay and he announced he was gay at his 21st birthday party …I think lovely kid! …he really is …and XX*** **[the father]** ***has accepted it*** **[that his son is gay],** ***and they are close… they look as though they are a close family. I am sure XX*** **[the father]** ***would rather he wasn't gay but he has accepted him you know, they socialise together and they get on together. If there was anyone that you would think would be absolutely shocked that his son was gay it would be him but he's fine. But you try and cope with any situation like that even though it must be hard*.”**

12.3 Frame two: Thematic analysis

Theme 1: A welcome shift in gender roles

Sub theme 1.1 The philosophy of gender equity underpinning the need for male role change

Sub theme 1.2 The primacy of motherhood

Sub theme 1.3 Role change without role models

Theme 2: Men, the opportunistic carers

Sub theme 2.1 Life changing events

Theme 3: Quest for health literacy

Subtheme 3.1 Infant care:

Subtheme 3.2 Crisis health management

Theme 4: Acquisition of health related parental skills

Subtheme 4.1 Mental health assessment

Theme 1: A welcome shift in gender roles

Gender is pervasive as a theme, with all interviewees overtly recognising the division of labour within and outside the family as well as being able to clearly identify women's work as separate from that of men's work. Although the spouse / partners of participants in this study were no longer solely stay-at-home mothers, their occupations were those traditionally performed by women (nurse, cleaner, librarian and waitress). Similarly, the men's occupations were traditionally those of male (farmer, mechanic, electrician).

Whilst the vast majority of men performed parenting tasks, much of the descriptions of these tasks were in a language denoting female work.

Father# DQ ***"Well I changed thousands of bloody nappies, rubbed the cream on the top of their heads and all that sort of crap right from the word go."***

This discourse suggests the men still perceived childrearing tasks as women's work with their main motivation for contributing to parenting being an assistant to the mother who had taken on an additional workload outside the home rather than an intention to expand or develop a contemporary fathering role. A few men openly welcomed the time taken to perform these tasks because it gave them an opportunity to be closer to their children.

Father #12 ***"I think there are a couple of reasons why fathers are doing more jobs with their kids, in the kids early years, particularly with changing nappies or even, you know, right through to before they are going to school… is er (a) to give help to the mother and that was probably the early reason but the reason is slowly changing because they want that bond with their children is so important so they are trying to get in early. And it's not that they are trying to get in over the top of their mother and jump in there. It's ...it's that there is two parents and they both want to have that bond with their children and I think that when that happens it makes for a happy childhood."***

Many men felt they were moving away from the limited interaction their fathers had with them and towards a relationship with their children that enriched their lives.

Father #12 ***"I think that over the years the role of the father has changed, there is no doubt; over here*** **[rural**

township] ***and I think it would probably be the same in Adelaide like now there is so much more involvement with the father, not necessarily kids health issues,… but the whole domestic scene, isn't there!*** **[a positive reinforcement of own question].**

All participants in the study recognised that the role of men within the family had shifted substantially from the role their fathers held.

<u>Sub theme 1.1</u>: The philosophy of gender equity underpinning the need for male role change

At interview and group discussion, all men recognised and subscribed to the notion of gender equality; that women were deserving of equal right, treatment and respect. Whilst the men agreed in principle of gender equity for women in the workplace, they held views suggesting that equity was a secondary consideration when compared with welfare of children.

Father #NN ***"I don't have a problem with women's liberation, they were disadvantaged socially, er! Work wise and everything else. I don't have a problem with that change But! You are never going to change the fact that women have babies."***

The notion of women having equal opportunity to employment was tempered with an understanding that work took women away from children and that children came first because of their vulnerability.

Father# GC ***"I would see as a mother's role,*** **[pauses to rephrase sentence]*****…I think a kid, until it's probably eight years old, … his mother plays the most important part in that person's life … and I think that trying to fob that off onto somebody else whether it be a day care centre or a father or what else I think is delegating their*** **[mother]** ***responsibilities, so I don't have a problem with them having their children and going back to work later*** **[after 8 years of age]*****, I think …I think too early is not good."***

A compromise was part-time employment, allowing for income supplementation and appropriate child rearing; this point of view was supported by the men's appreciation of their limited abilities to undertake the necessary and desirable parenting skills and tasks long held by mothers. In addition, men's persistent

identification with the role of the major breadwinner effectively precluded them from extending their contribution to childcare.

This man at interview intimated that current policy arrangements for dual income families were not working.

Father #DQ ***"If we are using the example of the female F 111 pilot, that's fine - where over three million dollars goes into training that person, I believe that that person has a responsibility to return some of that back to the community. Now if after two years or three years she goes off and has a baby, that's fine, I don't have a problem with that but er!.. I think she should certainly return to the workplace."***

Following this comment another man raises the issue of a working mother who used a series of maternity leave entitlements and other leave over a two year period; consequently no one could apply for her position, even though she was not there most of the time. The man's view was that this behaviour was hindering women who had completed their families from re-entering the workforce after years of dedicated motherhood.

Father #10 ***"XX*** **[wife]** ***worked in the library with a young girl that had… was still having a family and she used the system to the nth degree. Like she would take her maternity leave to the last day and then come back and work for three days and then go off on leave for another six months and its like she just worked the system for all its worth and is still doing so…… And really for her sake and for her children's sake she would have been better off, staying home finishing her family, looking after the kids, until they are two or three and then coming back to work."***

It was apparent that most of the men had put considerable thought into the consequence of dual income families and the relationship between mother and child and women in the workplace**.**

Sub theme 1.2: The primacy of motherhood

The men in group sessions and individual interviews all endorsed the notion that there were innate qualities in women that predisposed them to being the main care giver and it was natural for mothers to attend to the matters of child health.

Father# 12	***"…a mother and her children have got that special bond in the early years which a father just can't have. Mothers have the babies so there is an extremely close bond there."***
Father #GC	***"Well it has always happened that way, hasn't it?*** **[referring to women being the main parent involved in taking children to the doctors]…** ***I think that women take that role on and that's just the way it is, isn't it?"***

Another man supports this with the exclamation:

Father #4	***"Well they*** **[mothers]** ***are there aren't they?"*** **[implying mothers are at home with the children most of the time / men go to work].**
Father # AW	***"I agree with XX*** **[father #11]…** ***I know even now with our kids, that the age that they are*** **[teenagers]*****, that if there is anything that er! …sort of worrying them, then they still go to their mother and that's just how it is."***
Father # AW	***"Like even now with older teenage kids like what we've got, with physical pain they'll come to me like a footy injury or a cut on the knee or anything like. But anything that's sort of rather more intimate whether it a relationship or whatever, there still seems to be that um! Mother bonding that they seek."***
Father #12	***"Well XX*** **[the mother of the child]** ***is in charge of course, as the mother, and if I am suspicious that she*** **[a daughter with asthma]** ***should be taking it whenever she isn't, then I speak to my daughter."***

Some men believed that the work mothers did for their children could not be substituted by their efforts.

Father #12	***"…well I think instinctively fathers have never done the things that good mothers have done, have they?"***
Probe question:	**What would happen if your wife got sick or went away for a while?**
Father# AC	***"Panic would set in."*** **[all laugh]**
Father# GC	***"You would have to undertake something your self then wouldn't you."*** **[the man struggles to find a positive response to the suggestion of panic]**

Men were unlikely to develop an equal share of parenting without challenging the primacy of motherhood and acquiring parental skills that have the same utility as those held by their wives / female partners. Secondly, acquiring necessary

parenting skills requires a male role model and / or other means of gaining competency in traditionally feminie work. The gaining of competency is explored in the theme 'health literacy' and 'acquisition of skills'.

<u>Sub theme 1.3</u>: Role change without role models

Prominent among the comments made by all men was a lack of overt role models in support of their current practices within the home; that of domestic duties and childcare. All the men interviewed provided information that identified their fathers' role as breadwinners. The men spoke of exceptional behaviours such as washing the dishes that their fathers performed as symbolic of their contribution to domestic life (few men mentioned fathers washing and drying the dishes).

Probe question:	**Was your father very traditional in his outlook, in terms of what he was expected to do.**
Father # AW	***"Well he had one special thing, he would always do the dishes. He seemed come home, you'd have dinner and he'd do the dishes. Yeh! that was just one thing he used to do…she'd wash them and he'd dry em!"***
Probe question:	**Would he wash and dry?**
Father # AW	***"No no no!*** **[pauses]** ***except if she went into the town or something, then he'd wash and dry… That's one thing that has stuck in my mind."***
<u>Interview question:</u>	**<u>How would you characterise the division of labour in your household when you were a child?</u>**
Father #AC	***"Well there were jobs for mum and jobs for dad …out there on the farm."***
Father #GC	***"Mmm"*** **[Nods head in agreement]**
Probe question:	**Was there any crossing over of jobs? For example the classic roles were dad as breadwinner and mum as home makers and child raiser.**
Father #GC	***"Nah, Nah*** **[no].** ***Dad only learnt to drive the washing machine some months ago when mum went to Sydney. He never ever did any cooking or anything like that."***
Father #AC	**[asks a question of father # GC]** ***"Did your mother ever get out and drive the tractor?"***
Father #GC	***"No she wouldn't do that. So she would'nt see that as her role either."***

One father used a period in history to describe his fathers' division of household labour.

Father #11	*"He* **[father]** *came from a very Victorian type of household where the wife did everything."*
Father #12	*"He was certainly a caring father but dad was a very hard-worker."* **[Inferring that the father was not generally available for everyday parenting]**

and

Father #12	*"When we were kids dad was definitely not domestic."*
Father #10	*"We were very stereo-typed, which is the rural stereo-type of the past generation. Very stereo-type* **[re-emphasis]** *and yeh!... mum never worked except for domestic duties and that kind of thing. Yeh! Her job was to keep every one fed and watered and clothed and everything else while he* **[father]** *made the money.*
Probe question:	**Do you think you are more tuned-in to childcare and parenting than your father was?**
Father # GC	*"No I don't think so."*
Probe question:	**Are you anymore tuned into family health issues?**
Father # GC	*"Nup, nup."* **[no]**
Probe question:	**That's an interesting statement, why not?**

The absolute certainty with which this man responded to questions reflects his limited parenting role and is linked to his appreciation of the specialisation of labour within his family, with his wife totally in control of child raising and domestic duties.

Father # AC	*"Well it would be a big shock if something happened to XX and XY* **[wives]***."*
Father # AC	*"How would we cope?"*
Father # GC	*"Well we wouldn't be able to cope I don't reckon."*
Father # AC	*"That would be huge!"*

Probe question: **Do you think you might be able to cope better than your dad might have done?**

Father # GC *"Nup." [no]*

Father # AC *"Nup." [no]*

Although there was mention of fathers being generally supportive of the family there was a general consensus that fathers specialised as income earners and left the child raising workload to mothers. Probing questions at interview and focus group discussion revealed that men's fathers were indeed role models for their sons' fathering practices because many continued with the traditional division of labour leaving much of the parenting work to their spouse / partner. However, approximately half of the participants gave clear comment that, although their fathers had had a minimal role in direct childcare, they were much more involved in parenting. Ergo, the men's fathers were not always role models for contemporary fathers and their parenting practices / workload.

There was no common element that could be used to explain why some men had increased their parental workload in response to a working mother's absence from the family whilst other men did not. Individual men appeared to be working through the complex relationship between a personal philosophy of fathering, a perceived need to support their spouse / partner who had a dual workload and the utility of specialising their labour so as to maximise income. For those men who perceived benefits from having flexible roles within the family, guidance on how best to change their role, from that of a traditional father, was limited to negotiation with their spouse / partner and a general consensus of social change as portrayed by the media. Almost all the men at interview had forged some new roles within their family in accordance to the changing availability of their spouse / partner.

Theme 2: Men, the opportunistic carers

Fathers have the potential to be deterministic in the way they approach parenting but this potential is maximised when the father and the mother have employment conditions that are structured and supportive. One man took a planned approach to adopting a shared parenting role by taking leave before, during and after his child's birth.

Father *#RR* ***"I took another batch of holidays, as well, during the change over*** **[his wife was returning to work after one year's maternity leave]** ***…sort of to get an idea of family*** **[for his daughter to get an idea of family] –** ***of who goes where and when because she*** **[wife]** ***works shift work and sort of juggles time. And she went back to work at point six*** **[0.6 of full-time work]."**

The remainder of the men at interview were opportunistic providers of parental care because workplace arrangements were not well structured. When their spouse / partner worked, their role was to 'fill in' on home duties including transporting children to events.

Father #GC ***"…you can always drop tools and do that other times yeh! I would certainly be available*** **[to care for the children]** ***and I used to do it quite often but XX*** **[wife]** ***would have done it more."***

One man's wife was unable to care for all three children because the youngest was ill and required intensive care. Consequently, he filled in as child minder as required.

Father # AW ***"Yeh I always used to, probably shouldn't have, but take XX*** **[first born son]** ***on the tractor with me and that sort of thing. I'd taken him along with a bag of nappies and that sort of stuff and chuck em in the back of the tractor yep! Occupational Health and Safety would slaughter me but … that's the way it used to be."***

Another man cared for young children when his wife began casual employment starting at 5 am. When he commenced work early in the morning he would cope in the following manner:

Father # LL ***"Every now and then I'd take them out on the tractor. Just put them in your arms and they would go to sleep with the jigging on the tractor and the sun coming through the window. And yeh! … soon as you saw mum driving along the road we would stop and pass them off, as she was going home from work."***

Father # LL revisits the impact of his wife's employment on his workload and responsibilities; justifying the changes that 'had to' be made.

Probe question:	**What do you mean when you say 'had to'?**
Father # LL	***"Well she just wasn't there to er!... to do it. Before she was put on as a permanent one* [work roster] *she would start at five o'clock in the morning I'd have to put the kids on the school bus. Do all the washing."***
Probe question:	**How did you know how to do all those things?**
Father # LL	**[Laughs and stammers] *"Well er!… I had to have a couple of lessons* [the group simultaneously laughs with him] *and as time went on a few things came along, a dish washer and a few luxury things."* [Suggestive of labour saving white goods]**
Father # AW	***"You soon learn that there is a few things that you don't attempt to wash.* [all laugh]. *Light tops. You soon learn to put all the whites in together and er! and all the colours in the other one, put it that way."***

These comments strongly suggest that most men were opportunistic carers of children and associated tasks rather than deterministic carers. Few men determined, a personal decision, that they were intent on being more of a parent than their fathers were to them. The non-rural fathers were more deterministic in their attitude to new fatherhood.

Sub theme 2.1: Life changing events

Several of the men experienced life changing events in their relationship with their spouse that gave them an opportunity to respond with greater involvement in their child's wellbeing and health. One man separated from his wife, another man's wife became wheelchair bound and a third had a child with physical disability leaving the mother in need of substantial psychological support.

Father # AC had a parenting role thrust upon him when his wife moved to another residence. At first interview the father had given information that portrayed his role as the traditional breadwinner.

Father #AC	***"If the harvest is on you don't see me from 5 o'clock in the morning until 9 o'clock at night. If it's the dollar end of the season then that takes a fair priority."***
Father #AC	***"I can't say that I have ever taken the kids to the doctor. XX* [Wife] *has done all that."***

Father #AC *"XX* [Wife] *would do that, Panadol and that sort of thing."*

Probe question: **What would happen if one of your boys had a boy problem?**

Father #AC *"Well er! I reckon he would probably feel more comfortable talking to XX* [Wife]."

Probe question: **What would happen if your wife got sick or they went away for a while?**

Father #AC *"Panic would set in."*

At a second interview, some months later, the father revealed that he and his wife had separated and as a consequence of her relocating he was a sole parent. Eventually this father had shared parenting whereby his three children spent most of their time with him. This father was providing the vast majority of care supported intermittently by a visiting sister and mother.

Father # 12 had a parenting role thrust upon him when his wife became wheelchair bound following a life threatening event and although she had made a good recovery much of her parenting tasks were necessarily devolved to her husband of three children (Father #12).

Probe question: **How old were the children when XX [wife] had this problem?**

Father #12 "*XX 12 months, XY was four and XZ was 7".*

Probe question: **How did you cope?**

Father # 12 "*Oh yes certainly, we were very lucky at that stage in that we had some good friends that and XX* [son] *and XY* [daughter] *stayed with XZ* [mother-in-law] *for a while ZZ* [eldest son] *stayed with my brother … they were there for only two months and I used to take them on weekends particularly when she* [wife] *was rehabilitating at Hampstead and….it was a whole new experience* [parenting alone]*."*

and later:

Father # 12 *"I am being a bit wishy washy here Tom! I found it very hard to cope emotionally right from the start… Well in XX's case* [wife] *being in a wheelchair she's never experienced that before … And I certainly never experienced living with someone who was disabled so um…it is something I probably would not recommend it to anybody."*

Probing questions revealed that father #12 had adopted a parenting role inclusive of health care for his children.

Probe question:	**When your children were sick were you ever involved in giving them Panadol or measuring out other drugs?**
Father # 12	***"Yes definitely, oh all that sort of thing, cough mixture or …, I'd like to think that I did more of the nappies but XX*** **[wife]** ***tells me that I didn't."***
Probe question:	**Did you ever get any information from pharmacists?**
Father # 12	***"Er! Yes pharmacists are renowned for giving out information, their um… sometimes I think that they think that they know more than the doctor does. Sometimes they relate to you, particularly for simple illnesses better than any doctor on earth."***

After rehabilitation his wife commenced employment and this emphasised the need to broaden his already substantial parenting load.

Father# 12	***"When you say kids health issues it's not just to do with sickness is it, its to do with the whole spectrum?*** **[Father 12 clarifies probe question]** ***XX*** **[wife]** ***didn't start work until um around about 8 years ago when the kids were all at school. I suppose I took a bit more of an interest in kids' health issues."***

This response belittles the actual work load father #12 had adopted.

Father # AW had a parenting role thrust upon him when his daughter was born with a substantial birth defect and his wife was coping with the diagnosis.

Father # 10	***"Yeh I probably did a lot of baby sitting, because um! …especially when XX*** **[daughter]** ***came along it was just a lot of work*** **[pauses- reflects]** ***yeh! extra work. We fiddled around for years fitting callipers and that sort of crap. Before XX*** **[daughter]** ***went into a wheelchair I used to have to put her into plaster casts at night so that she could go to bed and then three to four hours a day she would have to go into this frame, a calliper frame and strap her onto a board on wheels so that she was upright to get a bit of strength into her bones. That sort of thing! And that was just yeh! … a lot of work. So I was quite conscious of contributing because that was just more than a one person job."***

Father # AW	***"Yeh I used to always get up in the night and XX* [wife] *would sleep* [laughs]. *I've always been a light sleeper so I would hear them. I would get up and change them and give them to XX* [wife] *to feed them* [breastfeed]. *And then I would stick them back in the cot afterwards."***

The examples of changes of life identify men who responded to the call for more equitable parenting but the interviews and group sessions did not include men who had not coped with the life change and had left the family. Ergo, it is reasonable to assume that these men possessed some personal quality (resilience) that allowed them to adapt to a workload in addition to their breadwinner role.

<u>Theme 3: Quests for health literacy</u>

Prior to men's health emerging as a public health issue men were not well informed on matters of health and illness and conversely, health professionals had not developed literature specific to understanding men's experiences of the health care system and their information needs (Laws, 2006). Although men have become better at understanding their health and ways to maximise this personal asset because of the men's health literature marketed specifically toward them (Laws, 2007), most men have not become literate on children health issues (Laws, 1998).

In principle, men require health literacy to make informed decisions on treatment options and health interventions. Perhaps one of the first considerations new fathers have to make is to decide if their son needs to be circumcised. The men at interview illustrate that in practice it is the mother or matriarch in the family that is the key determinant of what is allowed to happen to the newborn.

Probe question:	**Did the issue of circumcision get discussed with you XX?**
Father #GC	***"Um yer, XX* [wife] *said it was happening."***
Probe question:	**How did you feel about that?**
Father #GC	***"Ah! I couldn't have cared less like. Like whatever she said went* [refers to wife]*."***
Probe question:	**Are you circumcised?**
Father #GC	***"Yep!"***

Probe question: **And is your dad circumcised?**

Father #GC *"No."*

Father #AC interjects [in a manner suggesting that Father # needed support]

Father #AC ***"My mother would have been disgusted if our kids weren't circumcised. Oh!*** **[he pauses to rephrase]** ***I don't know about disgusted …but she would have been disappointed. It was just a matter of fact."***

Later it unfolds that the men had been informed that there was a health reason behind the mother's position on circumcision.

Father #CG ***"And XX*** **[wife]** ***told me also…I mean I never questioned or suggested that they shouldn't be or question it, she also told me that she had seen several adults circumcised through necessity."***

Father #AC ***"And my mother said the same. She had heard of adult people, going through the agony of it, and er! 10 or 12 year old boys had to have it for cleanliness reasons."***

In this case the influential health literacy of the mothers was out of line with that of the expert advice issued at the time and that which continues to be circulated to parents.

> **"The British Association of Paediatric Surgeons (2001) advises that there is rarely a clinical identification for circumcision."**
>
> **"The American Academy of Pediatrics (1995), making it clear that although there are potential benefits from circumcision, existing evidence is not sufficient to recommend routine neonatal circumcision."**
>
> (Laws, 2006: 135)

This means that fathers were swayed by the assumed health literacy of the mothers / grandmothers rather than having knowledge that allowed them to independently assess the merit of circumcision prior to a discussion with their spouse / partner.

Subtheme 3.1: Infant care

Prominent among the comments made by all men was a lack of role modelling for personal health practices and health practices directed toward dependent children. The men at interview and group discussion reveal that there was no formal process within these men's education, other than English literacy, which assisted in their development of child health literacy.

Probe question:	**Can you remember searching for information on infant care?**
Father# DQ	***"No I didn't go search for any information on infant health problems."***
Father# DQ	***"I would say to XX* [wife] *'what's going on here' and she would go and get the books and she would look it up and say well 'I reckon it's this' so lets go and see Dr XY. Because most blokes tend to leave things unless it's absolutely bloody painful and say 'ah-well! I'll go and get that checked out'."***

Men noted that their health literacy per se was nowhere near being on par with that of their spouse / partner. Two of the men were married to qualified nurses.

Subtheme 3.2: Crisis health management

About half of the men were able to relate incidents when there was a health crisis in the family and they were involved in having to comprehend the severity of the situation and treatment options. When a crisis arose these men were in partnership with their wives in steering towards the best outcome. Several of the men were less than satisfied with the support and quality of information they received from medical doctors.

Father #AW	***"I just found, because I was always involved with kids going to the doctors and whatever and you just asked questions. Some of the doctors were reluctant to divulge things, and I don't know why. They think you're the half-wit and you don't understand and all that sort of thing. The orthopaedic surgeon was an arrogant arsehole. We told him a few home truths and told him that he wasn't just doing his bone sawing and that sort with XX* [daughter] *he wasn't looking at the patient as a person, he was just looking at her as a skeleton that he had to rearrange basically. And he was an arrogant…* [break off his conversation to restructure his thoughts]*… his bedside manner was just hopeless. He* [stammers slightly] *he did actually change a little after that to tell you the truth."***
Father #LL	***"You got to do a lot of research. XX* [wife] *and I found that we did a lot of research into XY's* [oldest son] *problem for a start* [respiratory problem]. *And last year with XZ* [youngest son] *he ended up with Chron's disease. We ended up going to a library in the children's hospital. And just looking up books and that and just finding out***

	for ourselves what it really involved what it was and how to fix it. I think these days you got to do your homework. Once they diagnose something I like to know as much about it as you can how to fix it and what it is and what the signs are everything else its something new coming along and you just want to delve into it."
Father #LL	***"You get left in the dark sometimes I think, and that was a classical case with the young one, he was over there for 7-8 days and XX* [wife] *was there for the whole time and I just went there for the weekend. And naturally when I got over there I wanted to know as much as I could about it and like I said I went to the library. And what I found, in the women's and children's hospital, I was really disgusted in. We walked into the library and said that our child has just been diagnosed as having Chrons disease. And then they said 'well the public is not really allowed in here'. And we were told that the public wasn't really allowed into this library. And she* [Librarian] *just let us in there and she looked up these big medical books for us 'cause we didn't know where we were going or anything and she gave us the books that should have it in it and she said there are the books and she said there's the photocopier and you can use that but we weren't allowed to use any of the computers or anything like that in the women's and children's Hospital. Which I found a little bit disgusting because …on a computer you probably would have found it straight away. And she gave us the books and that made it a lot easier. Like I said we just walked into the library and …well where do you go! You just see rows of books so we went down the row looking for 'c' for Chron's disease naturally. And there was nothing in there 'cause you don't know what you are looking for. On the ward, at the end they did give us a pamphlet and that sort of thing."***
Father #LL	***XX* [youngest son] *was the first one to go on this medicine that he had. He was the first in South Australia to even go on it so they were learning.* [pause] *In his case they were learning themselves. The professor that we were under, yeh! He was very good, but then it took him a long time to say Chrons disease to us actually. They were treating him but they wouldn't tell us straight-out 'that's it' but now he's admitted straight out that that is what it is…. But we had to prise it out of him what that was specifically."***

Father#LL *"The eldest one he had a lot of trouble when he was younger. With asthma, they reckoned he had asthma and um well. XX* **[wife]** *and I said they were killing him, which they were. We took him into Minlaton hospital one day and all they were doing was pumping the stuff into him, saying that he had asthma. We got jack of it, took him straight out of the hospital and took him down to Yorketown."*

Probe question: **How did you come to the conclusion that they were doing the wrong thing?**

Father#LL *"Well he was just getting sicker and sicker with the Ventolin and everything that they were pumping into him and you could see his eyes going back into his head, and er! They tried when he was in year seven* **[breaks off from the story for a moment]** *he used to have the stuff and Ventolin and everything at school. He was just getting worse and worse. And like I said, one day he really got crook and they put him in there* **[Minlaton hospital]** *and we took him somewhere else, and the guy said straight away, he's got kids himself with asthma, he said he hasn't got asthma at all. And we eventually got to town* **[Adelaide]** *and we got it proved that he only had sensitive lungs; so then he went on a diet which has improved his health. They did a lot of tests and everything and he couldn't have cows milk and all that sort of stuff. That's why I milk a goat, for his lactose intolerances and that type of thing. That's all it was and now he is as healthy as a Mally Bull.*

Another father had issues with the accuracy of medical advice about his wife but chose not to pursue the topic.

Father#12 *"We saw a Neuro-surgeon, so that we knew what was going on and… he assured us he didn't think anything else would happen, well it did. Yeh! That was very traumatic, and she became a paraplegic at about T7."* [T7 is a medical term for the 7th thoracic vertebra]

It is standard practice, within Australian health services for doctors and specialised nurses to provide newly diagnosed children with asthma an asthma management plan. The plan is given to parents and teachers and sets out information for:

i) the surveillance of factors that trigger an attack;

ii) the monitoring of signs when an attack is impending and;

iii) the sequencing of actions that should be taken when an attack/ crisis is occurring.

One father [#1] had a daughter diagnosed with asthma three months prior to the focus group. When asked if he had been told about an asthma management plan for his child, the man replied:

Father #GC	***"No, no I haven't. XX*** **[the mother of the child]** ***probably has, but I haven't."***

When asked about his plan for dealing with an acute asthma attack he responded:

Father #GC	***"I wouldn't have a clue and I would get her into the town very quickly."*** **[a medical facility was available within a 15 - 20 minute drive]**

Theme 4: Acquisition of parental health skills

Few men were able to identify any formal training they had received in support of their gaining skills in infant care and health assessment of illness (mental and physical). The main reason for this lack of knowledge is that most men were able to defer to their wife / partner. However, there were glimpses of competencies, for example the father with the disabled child response.

Probe question:	**Did you put the harness on and were there any special exercises you were involved in?**
Father #10	***"Yep all of those, Yep Yep*** **[sighs].** ***I was involved in everything. I used to catheterise her and all that sort of stuff. Right up until …"***
Probe question:	**Who taught you how to catheterise her**
Father #10	***"Nurse at the hospital. And I got good at it, I used to be able to do it in the dark. No I didn't have a hassle with that. No er! it didn't bother me at all.'***

Probing questions revealed a greater readiness of men to disclose on their lack of competency than there was on their abilities.

Father #AC	***"XX*** **[young daughter]** ***once fell off the trampoline and doing what they weren't meant to be doing they didn't actually tell me the full story. They put something under the trampoline and misjudged it and she got a cut under there*** **[points to the back of the head]** ***it was a bit of a bad cut, but it stopped***

bleeding so I left it. And when XX* [wife] *got home later that night she said 'Oh you should have taken her to the doctors', she took her in and got a couple of stitches. I wouldn't have thought it was bad enough to worry about. I got told off.* [returning to previous question] *It wasn't as if I have ever had to rush off to outpatients or anything."

Subtheme 4.1: Mental health assessment

Whilst several of the fathers had encountered mental health / emotional issues in their family none were prepared to provide details. This was evident by the manner in which they returned to earlier questions rather than add details to their statement about their child's / wife's emotional reactions. Consequently, it was difficult to determine if the men were competent at elementary mental health assessment. However, one man gave an account of his lack of capacity to recognise his own mental health plight at an individual interview.

Father #13

"The first couple of times I thought I was going to die for sure."

"What usually occurred was, if I was doing something physical or if something went wrong I thought Oh! I'm having an asthma attack. So, I couldn't breathe, I had to get my jumper off, and on two or three occasions I actually ripped my shirt of, because I couldn't get air in, headed straight for a Ventolin."

"Oh! It was incredible. The first couple of times I thought I was going to die for sure. This is the worst asthma attack I have ever had, this is what these poor buggers go through all the time Oh I hate it."

"Not being able to go to sleep at night then waking up in a dead cold sweat. And I thought. I can't handle this and I've got to do something different."

"When it got to that point I went and saw the GP at Yorketown …he said, you say that you just reach for Ventolin and you just overload on Ventolin and that makes the symptoms go away (I replied) Oh Yeh! , Yeh they go away. …And he said are you wheezing. No I said I just can't breathe. Well he said if you were having an asthma attack you should be wheezing. I replied

	***well I am not wheezing but I'm having an asthma attack* [insistence in his voice]*.*"**
	"Well he said, you're having a panic attack. Panic attack!* [exclamation]*…Oh piss off! Public servants have them when they want a payout. Then we had a 45 minute GP session and he gave me a book to read and now I understand what triggers it. I've still got it. But I can control it better."
Probe question:	**What was the book titled, can you recall?**
Father #13	***"Stress, recognising it* [pauses*] er!* [reflects] *recognising it, how to deal with it and managing it."***
Probe question:	**And did that help you turn the problem around?**
Father #13	***"Yeah! …And I had not even finished reading the book. The biggest problem for me was recognising I had a problem in the first place. Once I did that.. OK …how do we fix it?"***

The analysis of the focus group discussion and subsequent individual interviews showed that the two methods had identified the same central themes. From this it can be inferred that the two focus groups were sufficient to meet the research objectives. A comparison between the two sets of data was further strengthened in that the focus group data was analysed in the same manner as that of the individual interviews. Sloan (1998), in reference to qualitative research states that:

> **"Analysing data from focus groups is essentially the same as analysing qualitative data from other sources."**
>
> (Sloan, 1998: 41)

Having the same approach to analysis meant that the data could be aggregated.

CHAPTER THIRTEEN: RESULTS HOUSEHOLD SURVEY

13 Introduction

This chapter contains an analysis of data produced from a household survey distributed to 1,000 South Australian homes. The purpose of the survey was to quantify the health practice performed my men in dual income families and to assess societal attitudes toward an equitable sharing of parental responsibilities. SPSS version 13.0 was used in coding and data analysis. The data was cleaned and missing values were noted for items such as income and sex. As the number of missing values was < 5% across all questions imputations was applied using the algorithm – Expectations Maximization (EM) of SPSS missing variables routines.

The questionnaire was addressed to actual and potential parents. This allowed every adult responding to the survey to complete the attitudinal questions in the first section of the questionnaire. A filtering question directed those respondents who had not lived in a dual income family and had not parented children in the past 10 years to complete the demographic sections of the survey.

The analysis occurs in four sections; with section one containing attitudinal questions corresponding with the analytical framework described in the chapters *Masculinity* and *Fatherhood*. Section two contained an initial question that divided respondents into those living in dual income families and those that did not. Section three contained questions that allowed for the recording of health literacy and skills as well as the frequency of health practices performed for children. The final section provided options for recording demographic details of respondents.

13.1 Response rate

There were 1,000 survey questionnaires delivered to households within the city of Adelaide, South Australia with a response rate of 406 and there were 342 respondents who had lived in a dual income family in the ten years prior to the survey (these respondents were actual or potential parents). *Table 13.1* illustrates the respondents' characteristics as a result of the filtering process to identify those of dual income status and those of potential parents with dual income status. The respondents who were actual parents living in a dual income family numbered 320 and 86 potential parents responded; the latter are an important source of attitudinal data, projecting their opinions on the desirability of a more equitable sharing of parenting, should they become a parent.

Table 13.1 –Filtering of questionnaire responses

Sex	Respondent category	***n =***	Attitudes data	Health practices
Men (n =331)	Actual parent	285	completed	completed
	Potential parent	46	completed	Not applicable
Women (n =75)	Actual parent	35	completed	completed
	Potential parent	40	completed	Not applicable
Total 406		**406**		

The response rate from households who were dual income families was 72.7% (295). This is a high response rate when compared with the proportion of dual income families found in the three districts surveyed. *Table 13.2* shows a range of 38.2% to 50.8% for dual income status across the three districts. The high response rate can be attributed to the enthusiasm of the dual income parent when informed about the purpose of the survey at door knock.

Table 13.2 – Comparison of distribution of household types between sampling locality and respondents

	Prospect (a)	West Torrens (b)	Adelaide Hills (c)	Mean	Respondents (n=406)	
Single parent	*14.0%*	*15.9%*	*10.4%*	*13.4%*	20	*4.9%*
Couple	*44.1%*	*38.2%*	*50.8%*	*44.4%*	295	*72.7%*
Other	*41.9%*	*45.9%*	*38.8%*	*42.2%*	91	*22.4%*

Source:
(a) City of Prospect: community profile http://www.id.com.au/prospect/commprofile/Default.asp?bhcp=1 (accessed 5 Jan 2006 1pm)
(b) City of West Torrens: community profile http://www.id.com.au/westtorrens/commprofile/Default.asp?bhcp=1 (accessed 5 Jan 2006 1.30pm)
(c) Adelaide Hills : community profile http://www.id.com.au/adelaidehills/commprofile/Default.asp?bhcp=1 (accessed 5 Jan 2006 1.50 pm)

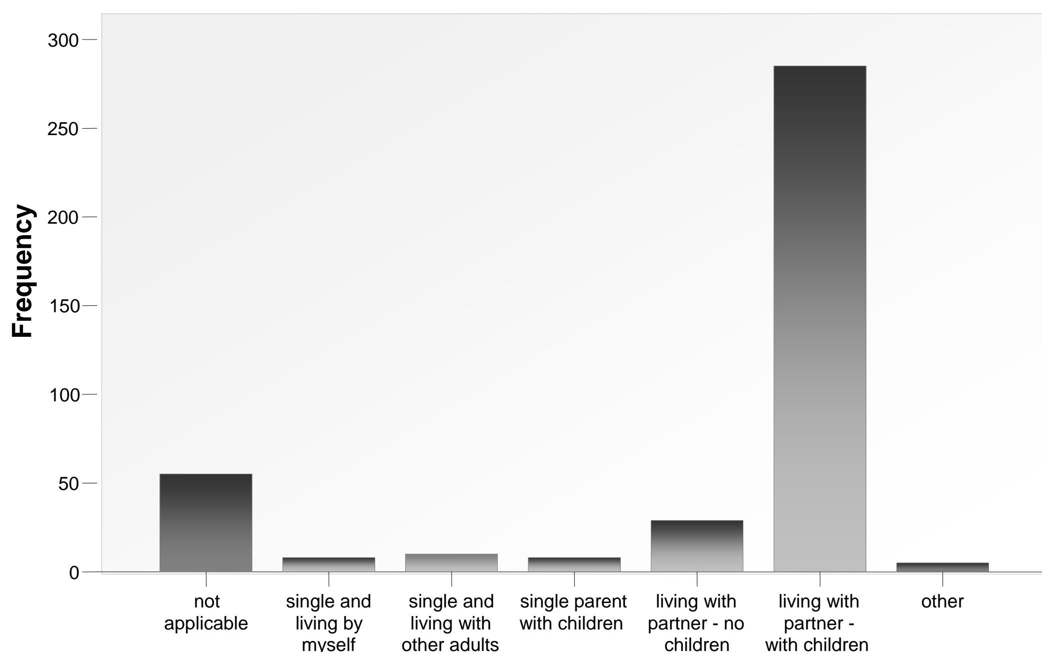


Figure 13.1 : Type of household respondent lived in during past 10 years

13.2 Description of the sample

13.2.1 Age

The age distribution of the sample is set out in *Table 13.3*. There were five respondents who did not record their age. Although men over the age of 60 (*n*=17) could be considered as outliers, a large proportion of this group recorded themselves as caring for children within the last 10 years.

Table 13.3 – Age distribution

Age (years)	N	Minimum	Maximum	Mean	Std. Deviation
Sample	401	19	79	40.96	9.666 years

13.2.2 Culture

The three main cultural identifiers used by the Australian Bureau of Statistics and incorporated into this survey are birthplace, ancestry and language spoken in the home. The cultural identities found in this survey correspond with those reported in the 2001 Australian National Census.

13.2.3 Birthplace

In *Table 13.4* the proportion of respondents in the sample who were born in Australia and overseas is similar to that reported in the South Australia population with 75.4% (*n*=1,099,591) Australian-born and 20.3% (*n*=296,459) born overseas (ABS, 2001).

Table 13.4 – Place of birth for South Australians and the sample

	Sample		Born in SA
	Frequency	Percent	Percent
Australia	316	*77.8%*	*75.4%*
Overseas	87	*21.4%*	*24.6%*
Missing	3	*0.7%*	*100%*
Total	**406**	***100%***	

Source:
Australian Bureau of Statistics (2002), Census of Population and Housing: Selected Social and Housing Characteristics, Australia, Catalogue No. 2015.0, Australian Bureau of Statistics, Canberra.

13.2.4 Ancestry

The three most common ancestries reported from the 2001 Census were British: 38.4% (560,505); Australian: 36.7% (535,798) and Irish 8.2% (119,063) (ABS, 2002); the national data for ancestry corresponds with that of the sample, shown in *Table 13.5*. The proportion of the population in these three ancestral groups (71%) corresponds closely to that in the sample (72%).

Table 13.5 – Ancestry

Country	Sample Frequency	Valid Percent	ABS Census 2001
British	176	*44.3%*	38.4
Australian	77	*19.4%*	36.7
Irish	34	*8.6%*	8.2
German	33	*8.3%*	Not available
Italian	23	*5.8%*	Not available
Greek	15	*3.8%*	Not available
Chinese	4	*1.0%*	Not available
Aboriginal	1	*0.3%*	Not available
Other	59	*8.5%*	
Total	**406**	***100%***	

Source:
Australian Bureau of Statistics (2001) Census Basic Community Profile and Snapshot Families and Households**:** South Australia; Australia, EMBARGO:

13.2.5 Language used at home

The language used in the home by respondents reflects the languages used in South Australian homes (ABS, 2001) *[Table 13.6]*. English was stated as the only language spoken at home by 90.4% of respondents and in the 2001 census data, 84.5% of South Australians spoke only English. The three most common languages spoken at home other than English in the 2001 Census were: Italian: 2.8% (*n*=40,176); Greek: 1.9% (*n*=27,363) and; Vietnamese: 12,582 (0.9%). As 13.6 shown in Table 13, these findings are comparable with the data from this survey with 3.5% Italian speaking and 2.8% Greek speaking.

Table 13.6 – Language

Language	Sample Frequency	Valid	ABS data
English only	359	*90.4%*	*84.5%*
Italian	14	*3.5%*	*2.8%*
Greek	11	*2.8%*	*1.9%*
Other	22	*3.3%*	*0.8%*
Missing	9		
Total	**406**	***100.0%***	***100.0%***

Source:
ABS 2001 Census Basic Community Profile and Snapshot: Language Spoken at Home[5] South Australia,

13.3 Socioeconomic data

13.3.1 Income

The recording of respondents' income and partners' income allowed for identification of those living in a dual income family. Secondly, income is an important element used to denote social class (determinants of social class are explored in the discussion section). There were 342 dual income families within the sample (*n*=406). The income data from this survey showed the median income for the respondent was between $35,001 - $50,000 and the median income of their spouse / partner of $20,001 - $35,000. The large number of missing values suggests that questioning income is a sensitive issue.

In 2003, the median Australian weekly parental income for couple families with children aged 0-17 years was $1,167, and this equates to $60,684 per year. The median weekly parental income for intact and step families was similar. The median weekly income of lone parents with children aged 0-17 years was $412; this is less than half the income of parents in couple families with children ($1,167 per week) (ABS, 2004). A limitation of this survey is that family income was categorised in bands of income so that a combination of the respondents' and spouse / partner income would not yield a mean total family income. Nevertheless, the respondents' income approximates the patterns of income seen in national data for dual income families and single parents.

The income data from this survey as shown in *Table 13.7*, and in *Figure 13.2* showed the modal income for the respondent was between $35,001 - $50,000 and the modal income of their partner was $20,001 - $35,000. In the category of less than $10,000 per year there were 9.4% (*n*=58) of respondents and 1.2% (*n*=5) recorded an income >$100,000. The median income for South Australian families was $41,600 - $51,948 (ABS, 2004).

Table 13.7 Income of respondent and partner.

	Respondents income		Spouse / partner income	
	Frequency	Valid percent	Frequency	Valid percent
$10,000 or less	38	*9.9%*	85	*24.7%*
$10,001 - $20,000	27	*7.0%*	60	*17.4%*
$20,001 - $35,000	100	*26.0%*	95	*27.6%*
$35,001 - $50,000	109	*28.4%*	51	*14.8%*
$50,001 - $100,000	105	*27.3%*	47	*13.7%*
$100,000 or more	5	*1.3%*	6	*1.7%*
missing	22		62	
Total	**406**	***100.0%***	**406**	***100.0%***
Median	**$35,001 - $50,000**		**$20,001 - $35,000**	

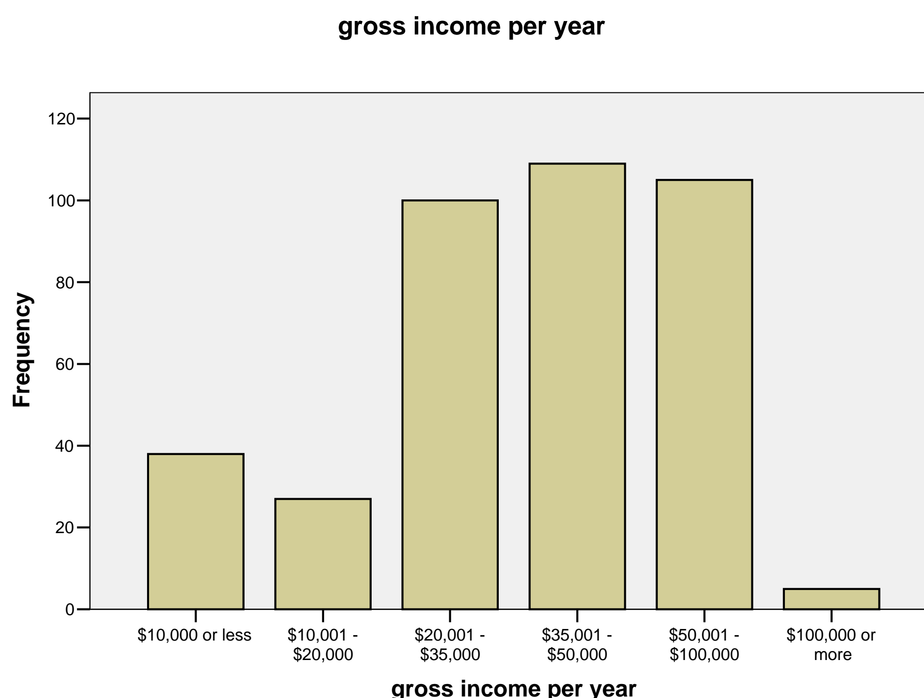


Figure 13.2 : Gross income per year

13.3.2 Education

Type of education was recorded by 399 of the respondents. Within the data there were wide variations in the type of education completed *[Table 13.8 and Figure 13.3]* Those not completing high school represented 22.6% (*n*=90) of the sample. Those completing a certificate of education after high school comprised 21.8% (*n*=87) of the sample. And 41.6% (*n*=166) had entered a tertiary or university course or completed a university degree.

Table 13.8– Highest level of education

Type of education	Sample	
	Frequency	Valid Percent
primary school	3	*0.8%*
some high school	87	*21.8%*
completed high school	56	*14.0%*
technical or trade certificate	87	*21.8%*
tertiary/university courses	39	*9.8%*
tertiary/university qualification	127	*31.8%*
Missing value	9	*0%*
Total	**399**	***100.0%***

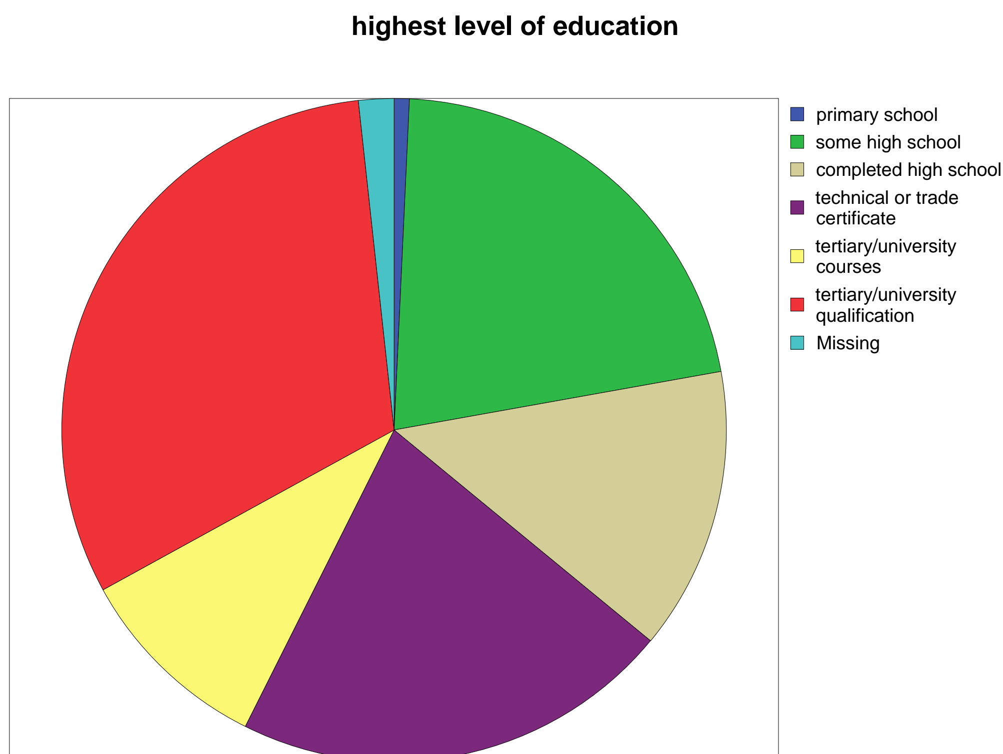


Figure 13.3 : Highest level of education received

Section One: Attitudinal data

A recording of respondents' opinions toward gendered work and a more equitable sharing of parental workloads is recorded in Section One. Methodological justification for dividing section one into seven subjections was provided in the Methods Chapter, Table 5.1. An abridged version of Table 5.2 is presented here *[Table 13.9]*.

Table 13.9 Sections for the grouping of attitudinal questions

Section One	Topic heading
1.1	Men and work
1.2	Women and the family
1.3	Fathering today
1.4	Combining work and family
1.5	Parenting in dual income families
1.6	Equality of the sexes
1.7	Sexuality

Pearson Chi-square has been used to examine the relationship between pairs of categorical variables using the conventional probability criterion of $p < 0.05$. Values for $p < 0.05$ reject the null hypothesis leading to the conclusion that there is a statistically significant relationship between variables (e.g. gender and health practice). The analysis involves multiple testing which is likely to inflate the possibility of a type one error. Consequently, the reader should give more attention to the patterns of results rather than the p values.

Although the tables could have been ranked according to higher to lower p values this was not appropriate because of the way the questions have been grouped. Questions that do not directly relate to a section have been used for cross validating respondents' opinions. For example, in section 1.3 there are a set of questions on the theme 'fathering today' but a similar question also exists in section 1.2 with the theme: 'Women and the family' where respondents are asked to comment on the statement *'In a single family it is more important for the child to be with the mother than the father?'* By combining these questions across themes it is possible to identify consistency and contradiction in respondents' attitudes.

Analysis of attitudinal data

Section 1.1 Men and work

Questions 1.1.1 to 1.1.9 identified in *Table 13.10* were developed to evaluate respondents' opinions on the importance of paid labour to men. There is good support for the notion that work is an important activity for men with 50.8% of men and 49.3% of women recording that full-time employment was more important to men than women [Q 1.1.1]. Supporting this notion, only 8.2 % of men and 17.3% of women indicated that men would prefer caring for children than going to work [Q.1.1.9]. Despite the findings emphasising the importance of work to men, job prestige and income were not key factors for men. Less than 15% of men and only 12% of women believed that job prestige is more important to a man [Q.1.1.9]. Approximately half of the respondents did not believe it was important to be the major income earner in the family [breadwinner - Q. 1.1.1].

The notion of gender equity in the labour market is strongly supported because less than 36% of men and 26% of women believed that a man should be given a

job in preference to a woman [Q. 1.1.2]. And over 90% of men and women believed that women should have employment opportunities equal to that of men [Q. 1.1.7]. Pregnancy was not perceived as a barrier to employment by 74.8% of men and 85.3% of women.

There was strong support for the cross gendering of labour with nearly 87% of men and 92% of women agreeing with the idea that boys should not be deterred from choosing a career that has been traditionally denoted as female labour (nursing) [Q1.1.5]. This leads support to the central tenet of this doctorial thesis; that men are willing to practice health in support of their children.

Significance was reached for only two questions; those asking about the suitability of women for technical problems [0.008] and men preferring to work as opposed to caring for children [0.021]. These findings suggest that both men and women believe there are important social reasons for having a gender based division of labour; this is despite other responses to survey items where respondents recorded a preference for gender equity. A possible explanation is women's long standing affiliation with caring for children and men's historical association with science and technology. The following section illuminates women's role within the family.

Table13.10 Response in agreement with statement for: Men and work

Quest.	Theme : Men and work	Men		Women		Sig.
1.1.1	Being in full-time work is more important to a man than a woman.	167	*50.8%*	37	*49.3%*	0.898
1.1.2	Men should be the major breadwinners in a family.	95	*28.9%*	18	*24.0%*	0.476
1.1.3	Men should be given a job in preference to a woman, if he has a family to support and she does not.	117	*35.6%*	19	*25.3%*	0.105
1.1.4	The possibility of pregnancy should not make women less suitable to employers than men.	246	*74.8%*	64	*85.3%*	0.068

(Table 13.10 cont'd)

Quest.	Theme : Men at work	Men		Women		Sig.
1.1.5	Young boys should not be deterred from choosing nursing as a career.	286	*86.9%*	69	*92.0%*	0.248
1.1.6	Women are just as suited to dealing with technical problems as men.	198	*60.2%*	58	*77.3%*	0.008
1.1.7	Women should have opportunities equal to that of men when it comes to gaining employment.	297	*90.3%*	71	*94.7%*	0.269
1.1.8	Most men would prefer to raise their children than go to work or pursue a career.	27	*8.2%*	13	*17.3%*	0.021
1.1.9	It is more important for a man to have a prestigious job than it is for a woman.	49	*14.9%*	9	*12.0%*	0.588

Section 1.2 Women and the family

Questions 1.2.10 to 1.2.13 evaluate the notion that there is somehow an innate ability within females to child raise and care for vulnerable children *[Table 13.11]*. Statistical significance was achieved (0.019) in the question suggesting that mothers are better at caring for sick children (Q 1.2.11). This finding is likely to reflect that women have better health literacy and skills for managing pediatric health problems; a point strongly emphasized in the literature review.

Table13.11 Response in agreement with statement for: Women and the family

Quest.	Theme : Women and the family	Men		Women		Sig.
1.2.10	It is only natural for women to know how to care for young children.	106	*32.2%*	19	*25.3%*	0.27
1.2.11	Women are better than men at caring for sick children.	142	*43.2%*	21	*28.0%*	0.019
1.2.12	In a single parent family it is more important for a child to be with the mother than the father.	48	*14.6%*	16	*21.3%*	0.162
1.2.13	When it comes to decorating the house I let my spouse / partner make the important decisions.	126	*38.3%*	7	*9.3%*	<0.001

The proposition that women are better able to care for sick children [Q1.2.11] was agreed to by less than half of the men (43.2%) and less than a third of the women (28.0%). And even fewer respondents (32.2% men, 25.3% women) believed that women had a natural ability to care for young children [Q1.2.10].

Section 1.3 Fathering today

Section 1.3 evaluates the importance of fatherhood *[Table 13.12]*. Men are rated as capable as women of caring for babies [Q1.3.14] by 86.7% of women and 76.6% men. Yet only 57.8% men and 50.7% of women felt that most men had a desire for the same level of parenting skills as women [Q1.3.17]. This supports the fatherhood literature expressing the idea that men are competent parents but parent differently to women.

Both men and women believe that contemporary men desire to spend more time with their children than their forefathers (90.9% men and 89.3% women) [Q1.3.15]. And children want more time with their fathers (99.1% men and 89.3% women) [Q1.3.15]. However, a large percentage of respondents believed that society does not provide men with enough time to be in direct contact with their children (71.7% men and 69.3% women); suggesting a structural barrier to achieving a meaningful fatherhood role [Q1.3.17]. None of the questions in Section 1.3 - *Fathering today,* reached a level of significance. A cross check question [Q 1.2.12] on fathering showed that very few respondents supported the

idea that children in single parent families should be with their mother (14.6% men and 21.3% women). Ergo, the responses presented indicate that both men and women believe that fatherhood is an important role for men, more so than in the past and children desire to spend more time with both parents, rather than supporting the primacy of maternal contact.

Table 13.12 Response in agreement with statement for: Fathering today

Quest.	Theme : Fathering today	Men		Women		Sig.
1.3.14	Apart from breast feeding men can be as capable of caring for babies as women are.	252	*76.6%*	65	*86.7%*	0.062
1.3.15	Children want to have both parents caring for them and caring about them.	326	*99.1%*	74	*98.7%*	1.000
1.3.16	Society does not give men enough time to be with their children.	236	*71.7%*	52	*69.3%*	0.777
1.3.17	Most men would like to have the same level of parenting skills that women have.	190	*57.8%*	38	*50.7%*	0.302
1.3.18	Men want to be more involved with their children than their forefathers were.	299	*90.9%*	67	*89.3%*	0.827

Section 1.4 Combining work and family

Section 1.4, summarised in *Table 13.13*, suggests that dual income families are experiencing stress and even crisis. Although women can successfully combine a career and motherhood [Q1.4.20] a proposition supported by 69.3% men and 73.3% of women; over half the respondents believed that mothers should be at home when their children were young (54.4% men and 53.3% women) [Q1.4.21]. The responses for successfully combining a career with motherhood are almost identical to the responses on women's ability to mix part-time work with home based childcare (64.7% men and 74.7% women) [Q1.4.22].

Table 13.13 Response in agreement with statement for: Combining work and family

Quest.	Theme: Combining work and family	Men		Women		Sig.
1.4.19	Women prefer some form of employment to doing home duties on a full-time basis.	254	*77.2%*	53	*70.7%*	0.249
1.4.20	Women can successfully combine a career with motherhood.	228	*69.3%*	55	*73.3%*	0.577
1.4.21	Mothers should stay at home when children are young	179	*54.4%*	40	*53.3%*	0.898
1.4.22	Women who have part-time jobs are able to mix home duties satisfactorily with child care and work commitments.	213	*64.7%*	56	*74.7%*	0.16
1.4.23	Many mothers have to go to work because a man's wage is simply not enough to support a family these days.	261	*79.3%*	53	*70.7%*	0.104

Section 1.5 Parenting in dual income families

Section 1.5 evaluates the beliefs about the need for a more equitable sharing of parenting in dual income families *[Table 13.14]*. The first question [Q 1.5.24], gives a strong indication that respondents believe both parents should share parenting workloads equally (91.2% men and 97.3% women). This notion of equity extends to transporting children to and fro childcare (90.0% men and 97.3% women) [Q 1.5.26] as well as providing supportive housework (89.4% men and 96.0% women) [Q 1.5.28]. However, very few respondents saw that men should be involved in locating an appropriate childcare facility (9.4% men and 8.0% women) [Q 1.5.25]. An important indicator of equity was tested in the belief that, if a child was too sick to attend childcare, it should be the mother who takes time from work to provide sickness care in the home. Question 1.5.27 is central to this survey and the issue of equity; very few respondents believed that when a child becomes ill the mother should be the parent required to take time from employment to provide sickness care (15.2% men and 12.0% women).

Table 13.14 Response in agreement with statement for: Parenting in dual income families

Quest.	Theme: Parenting in dual income families	Men		Women		Sig.
1.5.24	When both parents work full-time they should have an equal share in parenting and caring for the children.	300	*91.2%*	73	*97.3%*	0.091
1.5.25	Finding suitable childcare when both parents work is the responsibility of the mother.	31	*9.4%*	6	*8.0%*	0.827
1.5.26	In principle, working parents should share the load of getting children to childcare before and after work.	296	*90.0%*	73	*97.3%*	0.065
1.5.27	If both parents work and their child becomes ill, it should be the mother who stays at home to care for the child.	50	*15.2%*	9	*12%*	0.588
1.5.28	If both parents work full-time the housework should be shared equally between them.	294	*89.4%*	72	*96%*	0.082
1.5.29	Men should know how to change a nappy.	312	*94.8%*	74	*98.7%*	0.216

Section 1.6 Equality of the sexes

Section 1.6 is summarised in *Table 13.15* and is concerned with assessing beliefs about cross gender work using subjective statements (*should*). The suggestion that men should be socialised into nursing sick family members met with the response of agree for 83.9% men and 96.0% women [Q 1.6.30]; the response is similar to a cross check question in the previous section [Q 1.5.20] where it was suggested that men should change nappies (94.8% men and 98.7% women). The idea that men should be concerned about the health of others was explored in question 1.6.36 relating to sexual health, where 88.1% of men and 97.35% of women felt that men should be responsible for safe sex and contraception. A single question was used to determine cross gendered work for women, with 91.8% of men and 96% of women believing that women should know how to

check the oil level in a car [Q 1.6.13]. An assessment of whether equality actually occurs met with a mixed response. Only 66.9% of men and 58.7% of women felt that young Australian men and women had achieved equal rights [Q 1.6.32]. Only 46.7% of women thought that women had gained equality and it was now time to focus on men's problems [Q 1.6.34] however, 69% of men agreed with this statement.

Table 13.15 Response in agreement with statement for: Equality of the sexes

Quest.	Theme: Equality of the sexes	Men		Women		Sig.
1.6.30	Men should be shown how to nurse a sick family member.	276	*83.9%*	72	*96%*	0.009
1.6.31	Women should be able to check the oil level in their car.	302	*91.8%*	72	*96%*	0.237
1.6.32	Young Australian men and women do have equal rights.	220	*66.9%*	44	*58.7%*	0,182
1.6.33	Equal opportunity in the workplace has put too much pressure on the Australian family.	107	*32.5%*	17	*22.7%*	0.098
1.6.34	Women have gained equality and it is now time to give men's problems some consideration.	227	*69%*	35	*46.7%*	<0.001
1.6.35	A husband should consider his wife's needs before his own.	109	*33.1%*	13	*17.3%*	0.008
1.6.36	Men should be as responsible as women when it comes to planning contraception and having safe sex.	290	*88.1%*	75	*97.3%*	0.018

Section 1.7 Sexuality

Section 1.7 is summarised in *Table 13.16* and is intended to give some insight into the equitable right of a third gender (homosexual / lesbian). Few respondents openly declared that they disliked homosexual and lesbian behaviour (40.7% men and 17.3 % women) [Q 1.7.38] and they supported their right to equal employment (example; the armed forces) (69.3% men and 17.3 % women) [Q 1.7.38] and equal civil rights in general; (66.3% men and 73.3% women) [Q 1.7.39]. However, the equality did not extend to parenting with only 27.7% of

men and 44% of women supporting the statement that homosexual and lesbians should be allowed to parent.

Table 13.16 Response in agreement with statement for: Sexuality

Quest.	Theme : Sexuality	Men		Women		Sig.
1.7.37	I dislike men who are sexist toward women.	251	*76.3%*	70	*93.3%*	<0.001
1.7.38	I dislike homosexual and lesbian behaviour.	134	*40.7%*	13	*17.3 %*	<0.001
1.7.39	Homosexuals should have rights equal to those of other members of society.	218	*66.3%*	55	*73.3%*	0.275
1.7.40	Homosexuals and lesbians should be allowed to join the armed forces.	228	*69.3%*	61	*81.3%*	0.046
1.7.41	Homosexuals and lesbians should be allowed to parent children.	91	*27.7%*	33	*44%*	0.008

Section 2.1 Family structures

Question 2.1 effectively separated all respondents into those that had parented in the past ten years and those that were potential parents. Of the 406 respondents there were 316 who identified themselves as having lived with a child within the period stated in the survey.

Section 2.2 Childcare arrangements

From the total sample (*n*=406) there were 154 (37.9%) *[Table 13.17]* respondents recording that they had been involved in making childcare arrangements [Q 2.2.1-Q 2.2.8]. In every category women performed more of the tasks / responsibilities than their spouse / partner. Mothers prepared children for childcare with women stating they perform this task 60% of the time and only 5.4% of men stating they have sole responsibility; there was similarity in men's and women's idea of sharing the load (42.6% men and 40% women) [Q 2.2.1]. Over the seven items the estimations of sharing were similar for male and female respondents. The giving of child health information to staff occurred 60% of the time by mothers, men supported this by indicating that 53.9% of the time their wife / partner took this responsibility [Q 2.2.3]. Women also cancelled childcare when their child

was ill (76% women) with only 36.2% of men stating it was a shared responsibility and 7.9% performing the task themselves [Q 2.2.4]. Special events at childcare, important to their child's sense of wellbeing, were the most heavily shared item (67.2% men and 54.2% women [Q 2.2.5].

Table 13.17: Childcare arrangements [Q 2.2]

Q2.2 Childcare arrangements		Men n=129									Women n=25									Sig.
		Self		Partner		Shared		Others		Total	Self		Partner		Shared		Others	Total		
2.2.1	Getting child ready for childcare	7	*5.4%*	67	*51.9%*	55	*42.6%*	0	*0.0%*	*100%*	15	*60.0%*	0	*0.0%*	10	*40%*	0	*100%*		<0.001
2.2.2	Driving the child to and from childcare	16	*12.8%*	42	*33.6%*	67	*53.6%*	0	*0.0%*	*100%*	13	*52.0%*	1	*4.0%*	11	*44%*	0	*100%*		<0.001
2.2.3	Giving information, about your child's health to staff	14	*10.9%*	69	*53.9%*	45	*35.2%*	0	*0.0%*	*100%*	15	*60.0%*	1	*4.0%*	9	*36%*	0	*100%*		<0.001
2.2.4	Cancelling childcare when the child was ill	10	*7.9%*	70	*55.1%*	46	*36.2%*	3	*2.4%*	*100%*	19	*76.0%*	0	*0.0%*	6	*24%*	0	*100%*		<0.001
2.2.5	Attending special child care events	7	*5.7%*	30	*24.6%*	82	*67.2%*	0	*0.0%*	*100%*	10	*41.7%*	1	*4.2%*	13	*54.2%*	0	*100%*		<0.001
2.2.6	Rearranging childcare dates / times	8	*6.5%*	72	*58.1%*	44	*35.5%*	0	*0.0%*	*100%*	18	*72.0%*	0	*0.0%*	7	*28%*	0	*100%*		<0.001
2.2.7	Paying childcare fees	25	*19.7%*	54	*42.5%*	48	*37.8%*	0	*0.0%*	*100%*	17	*68.0%*	2	*8.0%*	6	*24%*	0	*100%*		<0.001
2.2.8	Taking a phone call from staff when there were problems	13	*10.3%*	54	*42.9%*	55	*43.7%*	0	*0.0%*	*100%*	27	*17.9%*	56	*37.1%*	64	*42.4%*	0	*100%*		<0.001

Section 2.3 Episodes of illness

Episodes of illness [Question 2.3.1]

The questions asking about parenting arrangements for children who developed illness drew responses from 373 adults (306 men and 67 women) [Q 2.1.1- 2.3.6]. Women recorded that they cared for the child 96.3% of the time. This figure was supported by men responding to the same question but identifying that their wife or partner provided sickness care 73.9% of the time *[Table 13.18]*. Less than 5% of the respondents, male and female, relied on grandparents, family friends or other sources of sickness care. Although 18.9% of men claimed that they provide sickness care, only 3.6% of women indicated that sickness care was provided by their spouse /partner. The *p* value is significant; the responses of men and women are quite different.

Table 13.18: Episodes of illness [Q 2.3.1]

Caring for sick child	Men		Women		Total	
		P.<0.001				
Self	48	*18.9%*	53	*96.3%*	101	*27.1%*
Spouse / partner	167	*73.9%*	2	*3.6%*	189	*50.7%*
Grandparent	8	*3.2%*	0	*0%*	8	*2.1%*
Family friend	3	*1.2%*	0	*0%*	3	*8%*
Other	7	*2.7%*	0	*0%*	7	*1.9%*
Total	**253**	***100.0%***	**55**	***100.0%***	**308**	***100.0%***

Satisfaction with care arrangements [Question 2.3.2]

Table 13.19 shows a high proportion of men (95.3%) and women (90.5%) indicated that they were satisfied with sickness care arrangements and the responses to the previous question had shown that most care was provided by the mother. More women (9.5%) than men (4.0%) were dissatisfied with arrangements. The *p* value is not significant and the raw data shows responses are similar for men and women.

Table 13.19: Episodes of illness – satisfaction with care arrangements [Q 2.3.2]

Satisfaction with care arrangements	Men		Women	
P = 0.0138				
Yes - satisfied	261	*95.3%*	57	*90.5%*
No – not satisfied	13	*4.0%*	6	*9.5%*
Total	**274**	***100.0%***	**63**	***100.0%***

Last episode of caring for sick child [Question 2.3.3]

Of the 404 respondents, 69 were not required to respond because they had not cared for a child in the past 10 years. Of the remaining sample 37.5% of men and 33.3% *[Table 13.20]* of women had never cared for a sick child in their home. An indication of the incidence of childhood illness can be determined from responses showing that 23.8% of women and 10.3% of men had provided sickness care within four weeks prior to the survey. These figures show that over a third of respondents (men and women) had cared for a sick child within 4 weeks (34.1%). This supports a central theme of the study, that childhood illness is a frequent feature for dual income family life.

Table 13.20: Episodes of illness – when did you last provide sickness care? [Q 2.3.3]

Last sickness care provided	Men		Women	
P = 0.076				
Applicable but never cared	102	*37.5%*	21	*33.3%*
between 1 and 4 weeks ago	28	*10.3%*	15	*23.8%*
between 1 and 6 months ago	51	*18.8%*	9	*14.3%*
between 6 and 12 months	35	*12.9%*	7	*11.1%*
Longer	56	*20.6%*	11	*17.5%*
Total	**272**	***100.0%***	**63**	***100.0%***

Length of care provided for a sick child [Question 2.3.4]

The frequency of having cared for a sick child for one-two days was similar for fathers (63.3%) and mothers (64.3%) *[Table 13.21]* However, more fathers took just a single day (24.5%) compared to mothers (9.5%). The largest category for care was for two days representing a substantial call on parent resources.

Table 13.21: Episodes of illness – Length of care provided for a sick child [Q 2.3.4]

Length of care	Men *P = 0.022*		Women	
Less than 1 day	45	*24.5%*	4	*9.5%*
1-2 days	112	*63.3%*	27	*64.3%*
3-7 days	16	*9.0%*	8	*19%*
1-4 weeks	1	*0.6%*	2	*4.8%*
Greater than 1 month	3	*1.7%*	1	*2.4%*
Total	**177**	***100.0%***	**42**	***100.0%***

How respondent found time to care for child [Question 2.3.5]

A substantial proportion of respondents, both mothers and fathers indicated that they needed to break from work in order to care for their child (special leave, long holidays / service leave or rearrange work hours) *[Table 13.22]*. The most frequently indicated method of care leave was 'special leave or sick leave' (fathers 45.9% and mothers 37.2%), with the next category being a rearrangement for working hours (fathers 38.2% and mothers 25.6%).

Table 13.22: Episodes of illness – how respondent found time to care [Q 2.3.5]

Finding time to care *P = 0.002*	Men		Women	
Took special leave/sick leave from work	78	*45.9%*	16	*37.2%*
Took holidays/long service leave	8	*4.7%*	1	*2.3%*
Rearranged my working hours	65	*38.2%*	11	*25.6%*
Was between jobs/didn't work	19	*11.2%*	15	*34.9%*
Total	**170**	***100.0%***	**43**	***100.0%***

Employers reaction to the need for sickness care [Question 2.3.6]

Very few respondents found their employer to be 'not supportive' (fathers 6.3% and mothers 6.5%) *[Table 13.23]* with more men than women indicating that their employer was neutral on the topic. More than twice as many men found their employer to be 'neutral' than mothers (fathers 45.5% and mothers 16.1%). The highest category recorded, for both sexes, was 'very supportive' (fathers 6.3% and mothers 6.5%).

Table 13.23: Episodes of illness – Employers reaction to sickness care [Q 2.3.6]

Perceived reaction from employers	Men		Women	
	P = 0.613			
Very supportive	64	*57.1%*	18	*58.1%*
Somewhat supportive	33	*29.5%*	6	*19.4%*
Neutral	51	*45.5%*	5	*16.1%*
Not supportive	7	*6.3%*	2	*6.5%*
Total	112	*100.0%*	31	*100.0%*

Section 2.4 Episodes of illness

Typical activities performed for sick children [Q 2.4.1 -2.4.5]

The top four health practices ‘always’ performed by men for a sick or injured child were, comforting a child in pain (20.4%) comforting a child during a medical procedure (20.2%), cleaning up vomit (19.5%), bandaging a sprain (17.1%) *[Table 13.24]*. The top four in the ‘always’ category for women were comforting a child during a medical procedure (68.9%), toileting a child with diarrhoea (68.0%), cleaning up vomit (59.6%) and treating a fever (58.7%). The high proportion of women toileting a child with diarrhoea and cleaning up vomit is an indication of how close at hand to a child mothers are during illness.

There were substantially fewer men than women performing care ‘often’ across all ten items. Conversely, there were substantially fewer women than men performing care ‘sometimes’ across all ten items. All of the ten items reached significance ($p < 0.001$) indicating differences in the frequency with which health practices were performed. Women identified that they explained illness or a health problem to a child ‘almost always’ (50.0%) and ‘often’ (30.7%) whereas men were less likely to explain recording ‘almost always’ (8.2%) and ‘often’ (21.3%).

Table 13.24: Activities performed for sick children by respondents [Q 2.4.1 – 2.4.10]

Question 2.4		Men										Women										Sig.
		always		often		sometimes		never		total		always		often		sometimes		never		total		
2.4.1	Treating fever	26	*14.5%*	47	*26.3%*	94	*52.5%*	12	*6.7%*	179	*100%*	27	*58.7%*	10	*21.7%*	8	*17.4%*	61	2.2%	46	*100%*	**<0.001**
2.4.2	Comforting child in pain	39	*20.4%*	96	*50.3%*	54	*28.3%*	2	*1.0%*	191	*100%*	26	*54.2%*	14	*29.2 %*	8	*16.7%*	0	0.0%	48	*100%*	**<0.001**
2.4.3	Cleaning up vomit	36	*19.5%*	46	*24.9%*	88	*47.6%*	15	*8.1%*	185	*100%*	28	*59.6%*	6	*12.8%*	13	*27.7%*	0	0.0%	47	*100%*	**<0.001**
2.4.4	Toileting a child with diarrhoea	20	*12.9%*	33	*21.3%*	81	*52.3%*	21	*13.5%*	155	*100%*	27	*68%*	5	*11.6%*	8	*18.6%*	3	7.0%	43	*100%*	**<0.001**
2.4.5	Giving medication	30	*9.1%*	85	*25.8%*	77	*23.4%*	1	*0.5%*	193	*100%*	29	*38.7%*	10	*13.3%*	8	*10.7%*	0	0.0%	47	*100%*	**<0.001**
2.4.6	Comforting child during a medical procedure	35	*10.6%*	55	*16.7%*	68	*20.7%*	15	*8.7%*	173	*100%*	31	*68.9%*	5	*11.1%*	8	*17.8%*	1	2.2%	45	*100%*	**<0.001**
2.4.7	Explaining an illness / health problem to a child	27	*8.2%*	70	*21.3%*	76	*23.2%*	6	*3.4%*	179	*100%*	23	*50.0%*	14	*30.7%*	8	*17.8%*	1	2.2%	46	*100%*	**<0.001**
2.4.8	Bandaging a sprain	24	*7.3%*	43	*13.1%*	47	*14.3%*	26	*18.6%*	140	*100%*	19	*47.5%*	3	*7.5%*	9	*22.5%*	9	22.5%	140	*100%*	**<0.001**
2.4.9	Treating a burn or scold	21	*6.4%*	34	*10.4%*	60	*18.3%*	23	*16.7%*	138	*100%*	19	*51.4%*	2	*5.4%*	9	*24.3%*	7	18.9%	138	*100%*	**<0.001**
2.4.10	Treating a sting or bite	26	*7.9%*	48	*14.6%*	84	*25.6%*	11	*6.5%*	169	*100%*	18	*43.9%*	10	*24.4%*	12	*29.3%*	1	2.4%	169	*100%*	**<0.001**

Section 2.5 Health promotion

Health promotion activities performed by parents [Q 2.5.1- 2.5.4]

Men do apply anti-sunburn lotion always (16.6%) or often (37.7%) but a higher proportion of mothers apply the lotion always (69.5%) *[Table 13.25]*. A large proportion of male respondents indicated that they were not in the habit of applying the lotion, with 41.5% recording 'sometimes'. Both men and women indicate the same level of ensuring care restraints are applied always (77.8%) or often (20.6%). Women more often than men lock medicines and poisons away from children (88.5% vs 40.3%); with men indicating that they are less rigorous with the practice by recording 'sometimes' (22.0%). Women more often than men 'always' conduct surveillance of children near a stove or open fire (88.3% vs 41.6%); with men indicating that they are less rigorous with the practice by recording 'sometimes' (18.0%).

Table13.25: Health promotion activities performed by parents [Q 2.5.1- 2.5.4]

Question 2.5		Men										Women										Sign.
		always		often		sometimes		never		total		always		often		sometimes		never		total		
2.5.1	Applying anti – sunburn lotion	44	*16.6%*	100	*37.7%*	110	*41.5%*	11	*4.2%*	265	*100%*	41	*69.5%*	17	*28.8%*	1	*1.7%*	0	0.0%	69	*100%*	<0.001
2.5.2	Ensuring car restraints are worn	42	*77.8%*	107	*20.6%*	25	*1.6%*	0	*0.0%*	274	*100%*	49	*77.8%*	13	*20.6%*	1	*1.6%*	0	0.0%	63	*100%*	<0.001
2.5.3	Locking away medicines & poisons	108	*40.3%*	90	*33.6%*	59	*22.0%*	11	*4.1%*	268	*100%*	54	*88.5%*	5	*8.2%*	1	*1.6%*	1	1.6%	61	*100%*	<0.001
2.5.4	Surveillance of child near fire / stove	104	*41.6%*	98	*39.2%*	45	*18.0%*	3	*1.2%*	250	*100%*	50	*83.3%*	8	*13.3%*	1	*1.7%*	1	1.7%	59	*100%*	<0.001

Section 2.6 Sharing home duties

Amount of time spent of home duties after spouse or partner retuned to work [Q 2.6.1- 2.6.13]

Men reported performing more duties associated with food preparation (did a little more or did a lot more) in the form of grocery shopping (48.9%) cooking (55.2%) and washing dishes (62.1%). There was also indication that the men contributed to the day to day housework (did a little more and did a lot more), tidying-up (55.6%), vacuuming and dusting (42.6%). There was also more activity in the performance of domestic activities associated with linen and clothes; men indicated they 'did a little more' or 'did a lot more' making beds (62.3%), washing cloths (55.9%), ironing (60.8%). However, women also indicated that they 'did a little more' and 'did a lot more' grocery shopping (31.3%), cooking (43.8%) and washing dishes (33.3%) as well as day to day housework; tidying-up (36.4%), vacuuming and dusting (36.4%). A large proportion of men recorded an unchanged workload for pet care (64.1%) and gardening (59.1%) once their spouse / partner returned to work; with some indicating they did a little or a lot more (pet care 29.3% ; gardening 38.2%). For a group of items recognised as men's work there was little change; with men recording they did the same for car maintenance (73.3%), home maintenance (68.8%), tidying up the shed / garage (72.6%), with 9% -13.6% of men stating they did more across the three items. However, working mothers 'did less' of these tasks car maintenance (24.2%), home maintenance (24.4%) tidying up the shed / garage (21.9%) *[Table 13.26]*.

Table 13.26: Amount of household duties performed after mother returned to work [Q 2.6.1 – 2.6.13]

Question 2.6		Men										Women										Sig
		Did less		Did the same		Did a little more		Did a lot more		Total		Did less		Did the same		Did a little more		Did a lot more		Total		Pearson Chi-Square
2.6.1	Grocery shopping	20	*9.0%*	93	*42%*	59	*26.7%*	49	*22.2%*	221	*100%*	3	*9.4%*	19	*59.4%*	4	*12.5%*	6	*18.8%*	32	*100%*	0.23
2.6.2	Cooking	20	*9.0%*	79	*35.7%*	84	*38%*	38	*17.2%*	221	*100%*	3	*9.4%*	15	*46.9%*	8	*25.0%*	6	*18.8%*	32	*100%*	0.517
2.6.3	Washing the dishes	9	*4.1%*	76	*34.7%*	73	*33.3%*	61	*27.9%*	219	*100%*	7	*21.1%*	15	*45.5%*	3	*9.1%*	8	*24.2%*	33	*100%*	<0.00
2.6.4	Tidying up the house	17	*7.7%*	81	*36.7%*	73	*33.3%*	50	*22.6%*	221	*100%*	3	*9.1%*	18	*54.5%*	6	*18.2%*	6	*18.2%*	33	*100%*	0.193
2.6.5	Vacuuming and dusting	17	*7.7%*	110	*49.8%*	64	*29%*	30	*13.6%*	221	*100%*	3	*9.1%*	18	*54.5%*	6	*18.2%*	6	*18.2%*	33	*100%*	0.606
2.6.6	Making beds	24	*10.9%*	137	*62.3%*	44	*20%*	15	*6.8%*	220	*100%*	5	*15.2%*	19	*57.6%*	4	*12.1%*	5	*15.2%*	33	*100%*	0.260
2.6.7	Washing the clothes	28	*12.7%*	123	*55.9%*	47	*21.4%*	22	*10%*	220	*100%*	4	*12.5%*	15	*46.9%*	4	*12.5%*	9	*28.1%*	32	*100%*	0.030
2.6.8	Ironing	37	*17.1%*	132	*60.8%*	31	*14.3%*	17	*7.8%*	217	*100%*	7	*21.9%*	19	*59.4%*	1	*3.1%*	5	*15.6%*	32	*100%*	0.172
2.6.9	Pet care	13	*6.6%*	127	*64.1%*	41	*20.7%*	17	*8.6%*	198	*100%*	6	*27.3%*	11	*50%*	4	*18.2%*	1	*4.5%*	22	*100%*	0.012
2.6.10	Gardening	14	*6.4%*	130	*59.1%*	42	*19.1%*	42	*19.1%*	220	*100%*	8	*24.2%*	16	*48.5%*	3	*9.1%*	6	*18.2%*	33	*100%*	0.005
2.6.11	Car maintenance	5	*2.3%*	162	*73.3%*	20	*9%*	34	*15.4%*	221	*100%*	8	*24.2%*	18	*54.5%*	2	*6.1%*	22	*56.4%*	39	*100%*	< 0.00
2.6.12	Home maintenance	7	*3.2%*	152	*68.8%*	30	*13.6%*	32	*14.5%*	221	*100%*	8	*24.2%*	18	*54.5%*	4	*12.1%*	3	*18.2%*	33	*100%*	< 0.00
2.6.13	Tidying up the shed / garage	8	*3.7%*	159	*72.6%*	23	*10.5%*	29	*13.2%*	219	*100%*	7	*21.9%*	19	*59.5%*	0	*0%*	6	*18.8%*	32	*100%*	< 0.00

Section 3.1 Health topic taught at school or elsewhere

Health topics that respondents had received education [Q 3.1.1- 3.1.12]

The highest four items of health education experienced by men were first aid (82%), personal hygiene (79.2%), cardiac resuscitation (75.4%) and occupational health and safety (73.5%) *[Table 13.27]*. The top four items for women were - personal hygiene (92.1%), diet and foods (85.7%), first aid (82%), cardiac resuscitation (75.4%). Education for 'safe sex' was the fifth most common topic for men (66.8%) and women (73%). The four categories of education lacking most by respondents were the same for men and women but the percentage for each category varied with men not being educated for care of an infant (59.2%), common child hood illness (52.3%) general nursing care (50.5%) and administration of medication (48%). Women lacked education (not taught) in general nursing care (46.8%) administration of medication (44.4%), care of an infant (44.4%) and common child hood illness (39.7%).

Significant differences were shown for types of immunisation (*p* 0.004) infant care (*p* 0.031) and general nursing care (*p* 0.006) suggesting that whilst both men and women lacked education on these topics they differed in the extent of lack (men lacked more education than women in all four topics).

Table 13.27: Health topics that respondents had been educated or not educated for. [Q 3.1.1- 3.1.12]

Question 3.1		Men								Women								Sig.
		Yes		Uncertain		No		Total		Yes		Uncertain		No		Total		
3.1.1	First aid	233	*82.0%*	6	*2.1%*	45	*15.8%*	284	*100%*	49	*77.8%*	3	*4.8%*	11	*17.5%*	63	*100%*	0.451
3.1.2	Cardiac resuscitation	215	*75.4%*	9	*3.2%*	61	*21.4%*	285	*100%*	46	*73%*	1	*1.6%*	16	*25.4%*	63	*100*	0.652
3.1.3	General nursing care	100	*35.6%*	39	*13.9%*	142	*50.5%*	281	*100%*	32	*51.6%*	1	*1.6%*	29	*46.8%*	62	*100%*	0.006
3.1.4	Care of an infant	98	*34.8%*	17	*6.0%*	167	*59.2%*	282	*100%*	33	*52.4%*	2	*3.2%*	28	*44.4%*	63	*100%*	0.031
3.1.5	Diet and foods	192	*67.6%*	28	*9.9%*	64	*22.5%*	284	*100%*	54	*85.7%*	3	*4.8%*	6	*9.5%*	63	*100%*	0.016
3.1.6	Occupational health & safety	208	*73.5%*	11	*3.9%*	64	*22.6%*	283	*100%*	40	*63.5%*	5	*7.9%*	18	*28.6%*	63	*100%*	0.190
3.1.7	Family planning	147	*52.9%*	28	*10.1%*	103	*37.1%*	287	*100%*	45	*71.4%*	2	*3.2%*	16	*25.4%*	63	*100%*	0.190
3.1.8	Safe sex	189	*66.8%*	16	*5.7%*	78	*27.6%*	283	*100%*	46	*73%*	2	*3.2%*	15	*23.8%*	63	*100%*	0.556
3.1.9	Common childhood illness	105	*37.4%*	29	*10.3%*	147	*52.3%*	281	*100%*	35	*55.6%*	3	*4.8%*	25	*39.7%*	63	*100%*	0.023
3.1.10	Types of immunisation	140	*49.5%*	29	*10.2%*	114	*40.3%*	283	*100%*	43	*68.3%*	0	*0%*	20	*31.7%*	63	*100%*	0.004
3.1.11	Administration of medication	114	*40.6%*	32	*11.4%*	135	*48%*	281	*100%*	33	*52.4%*	2	*3.2%*	28	*44.4%*	63	*100%*	0.069
3.1.12	Personal hygiene	224	*79.2%*	13	*4.6%*	46	*16.3%*	283	*100%*	58	*92.1%*	1	*1.6%*	4	*6.3%*	63	*100%*	0.058

Section 3.2 Looking after a newborn child

Activities performed when managing babies or infants [Q 3.2.1- 3.2.8]

Section 3.2 was designed to record perceptions of difficulties in performing a task rather the frequency with which a task was performed. Therefore *Table 13.28* identifies only those parents that attempted the tasks; there were a large number of respondents that did not attempt the task. For example, only six women responded to cleaning nappies [Q3.2.5] suggesting that most used disposable nappies.

The vast majority of men had no difficulty in performing a large range of tasks, giving medication (94.4%), changing a nappy (92.2%), bathing (85.5 %), putting baby to sleep (83.9%), that are commonly required in the care of an infant. Only a small proportion of men required assistance with tasks and 'getting up in the night' (5.4%) was rated the most difficult. Tasks rated most difficult were calming a screaming infant (24.3%), getting up in the night (19.7%), preparing bottle feeds (18.4%) and cleaning nappies (16.3%). Women found putting a baby to sleep as the most difficult (34.2%) whereas men rated this fifth (16.3%). Women also rated calming a screaming child (23.4%) and getting up in the night (22.2%) as two of the top three difficulties. Men required assistance with five items (getting up in the night 5.4%, cleaning nappies 4.7%, putting baby to sleep – 3.2%, preparing bottles 2.6%, calming a screaming child 2.1%; whereas women required assistance with only two: calming a screaming child (2.1%) and getting up in the night (2.2%).

Table 13.28: Activities performed for a newborn child – perception of difficulty [Q 3.2.1- 3.2.8]

Section 3.2		Men								Women								Sig.
		Not Difficult		Difficult but managed		Require help		Total		Not Difficult		Difficult but managed		Require help		Total		Pearson Chi-Square
3.2.1	Bathing child	69	*88.5%*	9	*11.5%*	0	*0%*	78	*100%*	12	*80.0%*	3	*20.0%*	0	*0%*	15	*100%*	0.371
3.2.2	Changing nappy	47	*92.2%*	4	*7.8%*	0	*0%*	51	*100%*	5	*83.3%*	1	*16.7%*	0	*0%*	6	*100%*	0.470
3.2.3	Preparing bottle feeds	30	*78.9%*	7	*18.4%*	1	*2.6%*	38	*100%*	3	*75.0%*	1	*25.0%*	0	*0%*	42	*100%*	0.907
3.2.4	Getting up at night to attend child	110	*74.8%*	29	*19.7%*	8	*5.4%*	147	*100%*	34	*75.6%*	10	*22.2%*	1	*2.2%*	45	*100%*	0.647
3.2.5	Cleaning nappies	34	*79.1%*	7	*16.3%*	2	*4.7%*	43	*100%*	6	*100%*	0	*0%*	0	*0%*	6	*100%*	0.463
3.2.6	Putting baby to sleep	104	*83.9%*	16	*12.9%*	4	*3.2%*	124	*100%*	25	*65.8%*	13	*34.2%*	0	*0%*	38	*100%*	0.007
3.2.7	Giving medication	51	*94.4%*	3	*5.6%*	0	*0%*	54	*100%*	10	*83.3%*	2	*16.7%*	0	*0%*	12	*100%*	0.188
3.2.8	Calming a screaming infant	139	*73.5%*	46	*24.3%*	4	*2.1%*	189	*100%*	35	*74.5%*	1	*23.4%*	1	*2.1%*	47	*100%*	0.991

Section 3.3 Health problems in your family at present

Incidence of family health problems [Q 3.3.1 -3.3.7]

For households with children at the time of the survey (*n*=329) many parents reported health problems among cohabitating relatives. This report of the results focuses on children with health problems. Short term illness was reported for 13.4% sons and 14.6% daughters *[Table 13.29]*. For chronic illness there were 7.6% of households that had an affected son and 5.5% had daughters who were affected. Injuries were present for 9.4% of sons and 6.7% of daughters.

Table: 13.29: Health problems experienced by a family member at the time of survey [Q 3.3.1 -3.3.7]

Incidence of health problem in family (n=345)	Percentage of men recording a family member with a health problem (n=329)		
Short term illness 147/ *42.3%*	Spouse / partner	47	*14.3%*
	Son	44	*13.4%*
	Daughter	48	*14.6%*
	Other relative	8	*2.4%*
	Total	**147**	***100%***
Recent injury 95 / *27.5%*	Spouse / partner	20	*6.1%*
	Son	31	*9.4%*
	Daughter	22	*6.7%*
	Other relative	5	*1.5%*
Chronic physical problem 92 / *26.6%*	Spouse / partner	29	*8.8%*
	Son	25	*7.6%*
	Daughter	18	*5.5%*
	Other relative	10	*3.0%*
A physical disability 46 / *11.4%*	Spouse / partner	13	*4.0%*
	Son	11	*3.3%*
	Daughter	8	*2.4%*
	Other relative	9	*2.7%*
Medical investigation 87 / *21.5%*	Spouse / partner	41	*12.5%*
	Son	9	*2.7%*
	Daughter	12	*3.6%*
	Other relative	12	*3.6%*
A childhood illness 22 / *5.4%*	Spouse / partner	N/A	*N/A*
	Son	14	*4.3%*
	Daughter	8	*2.4%*
	Other relative	3	*0.9%*
Mental health problem 42 / *10.4%*	Spouse / partner	18	*5.5%*
	Son	5	*1.5%*
	Daughter	3	*0.9%*
	Other relative	7	*2.1%*

Section 3.4 Medication use and purchase [Q 3.4.1 – 3.4.7]

Of the 329 males who had lived in a dual income family, 80.2% (264) had 'visited a pharmacy' in the year prior to the survey. *[Table 13.30]* A high proportion of men had visited a pharmacy more than 11 times in a year (28%) with women having a higher frequency (45.3%).

Table 13.30: Frequency of pharmacy visits [Q 3.4.1]

Frequency per year	Men *P = < 0.001*		Women	
Never	65	*19.8%*	12	*19.0%*
1-5 times	94	*28.6%*	15	*23.8%*
6-10 times	78	*23.7%*	13	*20.6%*
11-20 times	54	*16.4%*	12	*19.0%*
>20 times	38	*11.6%*	22	*17.5%*
Total	**329**	***100%***	**64**	***100%***

Purchased drugs in a Pharmacy [Q 3.4.2].

The majority of men (73.3%), 'purchased medications' from a pharmacy in the year leading up to the survey [Table 13.31].

Table 13.31: Purchased drugs in a pharmacy [Q 3.4.2]

Frequency per year	Men *P = 0.257*		Women	
Not applicable	66	*20.1%*	12	*16.0%*
No	22	*6.7%*	2	*2.7%*
Yes	241	*73.3%*	61	*81.3%*
Total	**329**	***100%***	**75**	***100%***

Type of medication purchased [Q 3.4.3]

Of the 324 male respondents to section 3.4, there were 26.9% (87) categorised as not applicable leaving 237 responses of interest *[Table 13.32]*. Similarly 17.3% (13) females were not applicable leaving 62 responses of interest. A high proportion of men and women had purchased either prescription drugs (12% male, 14.7% females) or both types of medications (53.7% male, 65.3% females) indicating a need for understanding of the reason for the medication, the correct dose and knowledge of side effects.

Table 13.32: Type of medication purchased [Q 3.4.3]

Types of medication	Males (n=324) *P = 0.229*		Females (n=75)	
Non – prescription drugs	24	*7.4%*	2	*2.7%*
Prescription drugs	39	*12%*	11	*14.7%*
Both types	174	*53.7%*	49	*65.3%*
Total	**237**	***100%***	**62**	***100%***

Frequency of being instructed by staff on correct dose [Q 3.4.4]

There were 27.1% (89) of men indicating this question was not applicable leaving 240 respondents of interest *[Table 13.33]*. There were 17.3% (13) of women indicating this question was not applicable leaving 62 respondents of interest. A small proportion of men recorded that they were either 'never' informed by staff on the correct dose of a prescription drug they had purchased or were 'rarely' informed (never 14.6%, rarely 10.4%). A similar response was found for women (never 6.5%, rarely 16.1%). Nearly half of the men indicated that they were either 'always' (28.8%) informed or 'often' (19.2%) informed by staff. A large proportion of women were also 'always' informed or 'often' informed on the correct dose of medication.

Table 13.33: Frequency of being instructed by staff on correct dose [Q 3.4.4]

Frequency of instruction	Males *P = 0.284*		Females	
Never	35	14.6%	4	6.5%
Rarely	25	10.4%	10	16.1%
Sometimes	65	27.0%	14	22.6%
Often	46	19.2%	12	19.4%
Always	69	28.8%	22	35.5%
Total	**240**	**100%**	**62**	**100%**

Frequency of being instructed by staff on side effects [Q 3.4.5.]

There were 27.1% (89) of men indicating this question was not applicable leaving 236 respondents of interest. There were 17.3% (13) of women indicating this question was not applicable leaving 62 respondents of interest *[Table 13.34]*.

A large proportion of men recorded that they were either 'never' instructed by staff on the side effects of a prescription drug they had purchased or 'rarely' informed (never 28.0%, rarely 20.8%). A similar response was found for females (never 32.3%, rarely 24.2%). Few men (8.1%) indicated they were always informed by staff and a similar response was recorded by women (11.3%).

Table 13.34: Frequency of being instructed by staff on side effects [Q 3.4.5]

Frequency of instruction	Males		Females	
	P = 0.479			
Never	66	28.0%	20	32.3%
Rarely	49	20.8%	15	24.2%
Sometimes	73	30.9%	12	19.4%
Often	29	12.3%	8	12.9%
Always	19	8.1%	7	11.3%
Total	**236**	**100%**	**62**	**100%**

Frequency of suggesting to family member to take medication [Q 3.4.6]

There were 14.3% (47) of men indicating this question was not applicable leaving 282 respondents of interest. There were 16.0% (12) of women indicating this question was not applicable leaving 62 respondents of interest *[Table 13.35]*.

Combining the responses of 'never' and 'rarely' for men shows that over a third (36.1%) were hesitant to encourage others in the family to gain comfort from analgesic medication. Women were less likely than men to be hesitant in encouraging a family member to use pain relief with only 22.2% indicating that they 'never' or 'rarely' suggested this medication.

Table 13.35: Frequency of suggesting to family member to take medication [Q 3.4.6]

Frequency of instruction	Males		Females	
	P = 0.063			
Never	48	17.0%	9	14.3%
Rarely	54	19.1%	5	7.9%
Sometimes	180	63.8%	49	77.8%
Total	**282**	**100%**	**63**	**100%**

Knowledge of medication use – differences between gender [Q 3.4.7]

There were 14.9% (49) of men indicating this question was not applicable leaving 280 respondents of interest. There were 16.0% (12) of women indicating this question was not applicable leaving 62 respondents of interest *[Table 13.35]*.

Almost half of the male respondents felt that men either knew 'less' or knew 'much less' than women on the topic of family medications. Approximately 40% of the female respondents felt that men either knew 'less' or knew 'much less' than women on the topic of family medications. The data did not reach statistical significance.

Table 13.36: Knowledge of medication use – differences between gender [Q 3.4.7]

Knowledge of Medication use	Males		Females	
	P = 0.371			
Men know more	4	1.4%	1	1.6%
Men know about the same	141	50.4%	25	39.7%
Men know less	123	43.9%	32	50.8%
Men know much less	12	4.3%	5	7.9%
Total	**280**	**100%**	**63**	**100%**

Section 3.5 Children and medication use [Q 3.5.8 – 3.5.14]

To the question: have children in the family taken 'regular medication' [Q 3.5.8], there were 279 male respondents to which this question was applicable of these 127 had give medication and 152 had not. There were 61 female respondents to which this question was applicable; of these 29 had give medication and 32 had not.

Who usually gave regular medicine to your child? [Q 3.5.9]

Of the 315 male respondents, 120 had a child receiving regular medication. Of the 68 female respondents, 23 had a child receiving regular medication, with the total number of 143 parents having children using regular medication *[Table 13.37]*.

Table 13.37: Who usually gives regular medicine to your child? [Q 3.5.9]

Who gives regular medication	Males		Females	
	P = <0.001			
The child	16	13.3%	2	8.7%
Spouse or Partner	74	61.0%	2	8.7%
Myself	24	20.0%	19	82.6%
Others	6	5.0%	0	0.0%
Total	**120**	**100%**	**23**	**100%**

Who is the person who usually gives medicine to children in family [Q 3.5.10]

Of the 311 male respondents, 253 indicated that an adult or other person gave medication (myself, partner, relative, other) to their children. Of the 72 male respondents 58 indicated that an adult regularly gave medication; in total 311 children had adults administering medication at some point *[Table 13.8]*. A large proportion of men (73.5%) indicated that their spouse or partner gave the medication and this data was supported by 87.9% of women indicating that they gave the medication; the variables are significantly related.

Table 13.38: Who usually gives medicine to your child? [Q 3.5.10]

Who gives medication to child	Males		Females	
	P = <0.001			
Spouse or partner	186	73.5%	4	6.9%
Myself	51	20.2%	51	87.9%
Relative	4	1.6%	1	1.7%
Others	12	4.7%	2	3.4%
Total	**253**	**100%**	**58**	**100%**

Have you ever given pain killers or medicines for colds to your children? [Q 3.5.11]

Of the 329 male respondents, 54 recorded the question as not applicable leaving 275 responses of interest *[Table 13.39]*. Of the 75 female respondents 14 recorded the question as not applicable leaving 61 responses of interest.

Table 13.39: Administration of pain killers or medicines for colds to your children [Q 3.5.11]

Do you give medication for colds?	Males		Females	
	P = 0.487			
No	46	16.7%	8	13.1%
Yes	229	83.3%	53	86.9%
Total	**275**	**100%**	**61**	**100%**

How confident did you feel about calculating the required dose?

Those parents indicating that they gave pain killers or medication for colds [Q 3.5.11] were asked how confident they felt in calculating the required dose [Q 3.5.12]. Of the 329 male respondents, 93 recorded the question as not applicable leaving 236 responses of interest *[Table 13.40]*. Very few males (1.3%) and no females had no confidence in their ability to calculate the correct dose of medication required. The category ‘reasonably confident’ suggests there is an unknown margin for error in 25% of men and 22.6% of women.

Table 13.40 How confident did you feel about calculating the required dose [Q 3.5.12]

Level of confidence	Males		Females	
	P = 0.654			
Not at all confident	3	1.3%	0	0.0%
Reasonably confident	59	25.0%	12	22.6%
Very confident	174	73.7%	41	77.4%
Total	236	100%	53	100%

How comfortable would you feel about telephoning a pharmacy for advice? [Q 3.5.13]

Of the 329 male respondents 52 recorded the question as not applicable leaving 277 responses of interest. Of the 75 female respondents 14 recorded the question as not applicable leaving 61 responses of interest, *[Table 13.41]*. Very few males (9.0%) and females (11.5%) indicated that they did not feel comfortable about telephoning a pharmacy to ask for advice.

Table 13.41: How comfortable would you feel about telephoning a pharmacy for advice? [Q 3.5.13]

Level of comfort	Males		Females	
	P = 0.143			
Not at all confident	25	9.0%	7	11.5%
Reasonably confident	100	36.1%	14	23.0%
Very confident	152	54.9%	40	65.5%
Total	277	100%	61	100%

CHAPTER 14:
DISCUSSION

14.1 Gender equality and women's employment

The thesis was premised on **the concept of gender equity**, and the literature review chapter *Dual income families in crisis* described women's progress toward equity in the workplace. The theoretical framework chapter *Masculinity* identified the case for equity as well as barriers to women achieving equity. The attitudinal data within the household survey shows strong in-principle support for mothers to be in the workforce and pursue a career, with over 90% of male and female respondents believing that women should have employment opportunities equal to that of men. The majority of respondents (91.2% men and 97.3% women, p = 0.091) believed that a more equitable sharing of parental responsibilities was an important means to women achieving equitable access to employment. The men in focus group discussions and individual interviews also indicated strong in-principle support for women's right to work. However, the men made an exception in the case of mothers with young children by way of expressing the belief that, an absence of maternal care put young children's development and safety at risk. The survey data also supported the primacy of motherhood, with over half the respondents believing that mothers should be at home when their children were young (54.4% men and 53.3% of women, p = 0.898).

14.1.1 Pragmatic support for working mothers

The men in the group discussions spoke of a range of tasks they had undertaken in support of their working spouse or partner and there was a general consensus that these family based activities went far beyond what their forefathers had performed for their non-working spouse. The main reason given for an expansion of family based activities was a recognition that they had to compensate their spouse or partner in some way for the employment workload they had taken on in addition to homemaking and childrearing. A minority of men acknowledged that their contribution was mostly symbolic whilst most were convinced that their efforts were very pragmatic and released the working mother

from an entire category of responsibility. The survey data also showed in-principle support for a more equitable sharing of housework (89.4% men and 96.0% women) and for equitable parental responsibilities (91.2% men and 97.3% women) and this included the actual transportation to childcare facilities (90.0% men and 97.3% women). The survey data showed that when a mother returned to work 50% of men 'did more' domestic work (grocery shopping, cooking, washing the dishes, tidying up the house and vacuuming) but far fewer men contributed to a particular set of tasks (washing the clothes, ironing and bed making); it may be that their spouse had a particular way of performing this set of tasks and consequently wanted to retain control over them. There were also increases in men's contribution to labour normally performed by men (car maintenance, home maintenance and tidying up the shed / garage). There was no attempt to compare the frequency of these tasks with other studies measuring men and women's work within dual income families. However, the studies quantifying the sharing of household duties and parental responsibilities, as presented in the chapter *Dual income families in crisis,* noted that, whilst there have been increases in men's contributions to family work, these come from a very low base and mothers continue to do the bulk of the work (Bittman,1997; Bittman & Rice 2004; Budig, 2008). The literature search findings are similar to the survey findings, showing that few women felt they were doing less because of support from their spouse / partner. The survey data showed fewer than 10% of the women believed they ended up doing less grocery shopping, cooking, tidying up the house and vacuuming with only sightly more doing less bed making (15.2%) and washing of clothes (12.5%).

The men in discussion groups stated they were not prepared to role swap with their spouse or partner and the survey data did not differ from this finding. That is to say, the survey data indicates that men are reluctant to relinquish their employment to provide parental care and in so doing provide their spouse with opportunities for full-time employment; only 8.2 % of men and 17.3% of women indicated that men would prefer caring for children than going to work. Men's preference for work over family care was also made clear within the chapter *Masculinity* where it was argued that work defined men and therefore men would resist any effort to diminish their male identity. An additional explanation, not

found in the literature, is that men do not feel comfortable with full-time family care because social structures and networks currently do not exist to support stay-at-home fathers, but they are well established and in abundance for mothers. This point was raised by two of the men at interview who had taken extended leave to care for their children. Whilst these men found childcare easy, they felt socially isolated because they were unable to locate other fathers in the same role and were not invited to participate in mothers' groups.

14.1.2 Expansion of fatherhood roles

The chapter *Fatherhood*, identified key works produced since the early 1990s reporting that men were more willing to increase their parental responsibilities in ways that enhanced their child's wellbeing and development. This suggests that men would be taking a more equitable share of childcare. A limitation to this point is that the literature does not explore fatherhood practices across a wide range of cultures and socio-demographic groups; many researchers focus on white educated fathers and absent fathers. The men in the discussion groups clearly identified the difference between their style of parenting and that of their fathers; a key difference was their communication style with their children and the time they were prepared to invest in building an interdependent relationship. The men felt as though there had been a reawaking of the importance of fatherhood over the past 20 years and intimated that this phenomenon may have occurred as a rebound effect from the emotional distance they felt between themselves and their fathers. Almost all men in the discussion groups, apart from two men who lived in blended families, felt that their closeness to their children provided opportunities for their spouse or partner to do work outside the family because the children felt equally as comfortable with them as they did with their mothers. The survey data gave strong support to the notion that the importance of fatherhood was on the rise, with 90.9% of men and 89.3% of women believing that men want to be more involved with their children than their forefathers were. Commensurate with this view was the belief that children want to have both parents caring for them and caring about them (99.1% men and 98.7% women).

14.2 Dual income families approaching crisis

The extent to which working mothers were able to realise gender equity was discussed in the literature review chapter *Dual income families in crisis*. The literature exploring the experiences of working mothers with a dual income family lifestyle revealed a coalescence of factors contributing to near crisis rather than a clear appreciation of net benefits gained from equality. Firstly, mothers found it difficult to locate affordable and local childcare facilities and remained concerned over the possible long term effects of care provided outside their family. These items were not explored in the household survey but the men in the discussion groups and interviews made it clear that locating childcare was predominantly a role they left to their wife and considered childcare a second best option to maternal care and childrearing within the home.

A second feature of the literature review was difficulties in achieving a work-life balance because the time required to prepare for work, commute to work, do work, and make the return journey home left little time for parents who worked full-time. The survey showed that adjunct to these activities was a range of ancillary activities performed by mothers such as rearranging childcare dates and times (72% mothers and 6.5% fathers, $p < 0.001$) and organising payment (68% mothers and 17.9% fathers, $p < 0.001$). Consequently, securing work – life balance is often perceived as a workload in itself. These points help explain why a majority of respondents (74.4% of women and 64.7% of men, $p = 0.16$) held a preference for mothers taking part-time work as a means to achieving a satisfactory mix of home duties, childcare and commitments to employment. Despite a preference for part-time work, over 73% of women in the survey believed that a woman could successfully combine a career with motherhood; this finding is in contradiction to the findings of the literature review chapter where it was revealed that women in part-time work are paid less and are largely restricted to unskilled or semi skilled work. The contradiction can be explained by women's interpretation of what a career is; women in the survey may have assumed that being able to stay in the labour force until retirement is a career rather than have a career pathway that trends upward to better paid and more responsible work. The survey data showed that the vast majority of men believed a father's work-life balance to be unsatisfactory, with 90.9% of men desiring

more time with their children than in previous generations. In addition, a majority of men (71.7%) believed that society did not give men enough time to be with their children. Despite respondents' discontent with work-life balance only a small percentage attributed the imbalance to women's need for equality in the workplace (32.5% men and 22.7% women, $p = 0.098$).

Analysis of both survey data and group discussions revealed difficulties experienced by parents in trying to balance a desirable family life with the time taken by commitments to employment; most men at interview had found part-time employment for their spouse or partner to be the best solution. Several of the men had wives or partners who worked full-time because the shift work allowed them to alternate parental care, one man characterised his marriage as a 'tag team'; the men concluded that this was an exhausting and less than ideal life style. Although 69.3% men and 73.3% of women in the survey believed that women could successfully combine a career with family commitments, these responses appear aspirational when compared to a subsequent respons showing that a large proportion of men (64.7%) and women (74.7%) felt that part-time employment offered a satisfactory mix of childcare and maternal employment.

Thirdly, the literature clearly indicates that the additional income and emotional rewards of employment are a positive choice for women. The survey data indicates the perception of a positive choice with 70.7% of women preferring employment to being at home on a full-time basis and 77.2% of male respondents agring. However, the concept of a 'negative choice', as described in the literature review chapter, highlights that women can ill afford to be a stay at home mother and care for their child because forgoing an additional income would be unpalatable and result in hardship. The perception of a negative choice also appears in the survey data showing 79.3% of men and 70.7% of women believed that mothers have to go to work because a man's wage is simply not enough to support a family. The men in group discussions felt that a second income was no longer an option but a requirement for the modern family and whilst the men recognised that their spouse or partner had emotional gains from their employment successes they also cited workplace conflict as detracting from these gains. All men felt that women should still be afforded the option of staying at

home to raise their young children and lamented the current social and economic circumstances that had contributed to the loss of this option.

A coalescence of the three factors just discussed has created a moral and work-life balance crisis for many women. The literature attributes this crisis to doctrinal confusion, a term used by Hewison and Dowswell (1994), to identify the in-congruency between the state upholding equity in the framework of family and workplace policy and the state's or free market's ability to provide women with adequate resources to achieve the equity promised to them.

Despite the strong in-principle support for gender equity found in the survey data, only 58.7% of women in the survey felt that young Australian women had achieved equal rights. There were limitations to who was deserving of equity. Although there was strong in-principle support for allowing homosexuals and lesbians to be part of the armed forces (69.3% of men and 81.3% women, $p = 0.046$) there was much less support for homosexuals and lesbians' right to parent children (27.7% of men and 44% women, $p = 0.008$). The latter finding reinforces the societal notions that biological parents should be the main carers of their children. The men in group discussions believed that inequality was rooted in women's reproductive role and that maternal care, particularly in the early years of the child's development should not be devolved to others outside the family. Mothers were also considered by several of the men to be indispensable when child health problems occurred because only their spouse possessed the necessary health literacy and skills. These group discussion points were also supported by a small proportion of survey respondents, 43.2% of men and 28.0% of women believed that women were better at caring for sick children. The inverse of this finding is that a large proportion of men and women believe that men are equally as capable of caring for sick children. If this belief is acted out in reality why is there no literature identifying this role?

14.3 Searching for evidence of men's health practices

Each of the six document search chapters (acute illness, chronic illness, mental health, terminal illness, injury prevention and health promotion) began with a detailed account of the incidence or prevalence of an actual or potential child health problem. This approach established that a substantial amount of families

found it necessary to devote time and resources to managing child health across the life span of infancy to adolescence. Inferred in these epidemiological findings was a need for fathers to:

a) be involved in child health whilst their spouse or partner worked or,
b) provide respite for working mothers providing sickness care.

The survey data supports the claim that health problems and accidental injury are a frequent feature of family life (short term illness was reported for 13.4% of sons and 14.6% of daughters; chronic illness was reported for 7.6% of sons and 5.5% of daughters; injuries were present for 9.4% of sons and 6.7% of daughters).

Attitudinal data from the household survey showed strong support for men practicing health. When both parents work full-time they should have an equal share in parenting and caring for the children (91.2% of men and 97.3% of women, $p = 0.091$). And very few respondents believed that when a child became ill, it should be the mother who stays at home to care for the child (15.2% of men and 12% of women, $p = 0.588$). In preparation for caring for children with health problems the majority of respondents believed that men should be shown how to nurse a sick family member (83.9% of men and 96% of women, $p = 0.009$). General support for men adopting caring roles traditionally performed by women could be found in responses to the notion that 'apart from breast feeding men can be as capable of caring for babies as women' (76.6% of men and 86.7% of women, $p = 0.062$) and boys should not be deterred from a nursing career (86.9% of men and 92% of women, $p = 0.248$). The attitudinal data just presented compared well with the findings in each of the six document search chapters in that there were either calls by mothers for greater involvement of the father in child health practices or comments by authors on the lack of involvement by men in meeting child health needs. In opposition to men's direct involvement was the mothers' personal need to be the main carer should the child become ill (Oakley, 1976; Finch & Groves, 1983; Eiser, 1994; Englund et al., 2001; Eiser et al., 1992; Horner, 1998). This left fathers with the role of caring for the sick child's siblings and the home. This phenomenon was most pronounced in the chapter *Terminal illness*. Education was a key barrier for many men. A lack of literacy and health literacy meant that many men were not able to sufficiently comprehend child health issues making it difficult to play an active part in

grasping the severity of symptoms, the importance of the diagnosis, making an informed choice between treatment options and providing the requisite nursing care. Consequently, many men felt on-the-outer from the very beginning of the health issue, and this resulted in some men experiencing a sense of rejection from their spouse causing them to exhibit confronting behaviour which jeopardised their relationship with the child's mother and health professionals. However, rejection was not a universal experience within the literature. Better educated fathers were able to accelerate their health literacy by conducting web based searches and calling on heath concepts they had learnt from previous first hand experience of child health care.

14.3.1 Actual health practice: health promotion

The types of health promotional activities performed by fathers or in conjunction with the mother were not well documented in the literature. The survey data offers frequency of health promotional activities performed by fathers; no similar data could be located in the literature. Although there were calls for parents to take action in injury prevention most researchers focused on mothers and many researchers had mothers as the primary focus of their study. The use of car seat restraints and application of sun protection lotion are highly publicised health promotional activities and the majority of men in the survey indicated that they always or often practiced these protective activities for their child. Male respondents also practiced health promotion in the home with the majority of fathers locking away medications and being vigilant of children near fires and kitchen stoves. The men in the discussion groups stressed the need for safe travel for their children and skin protection from sun damage; almost without exception each man commented on the lack of precautions in their own childhood implying that things were better nowadays. The men were acutely aware of the high risk of child injury around the home, with rural men making comment on the need to comply with new legislation on the storage of poisons on the property and the omnipresent dangers associated with moving farm machinery when children were at home. Most men proffered incidents in which children's lives had been lost by neighbours, friends or relatives through a transient lack of parental vigilance. Many men made statements indicating that being the cause of a child accident was their worst nightmare.

14.3.2 *Actual health practice: Newborn child*

The survey data revealed that the majority of men felt confident in caring for the basic needs of a newborn child. Over 75% of the men indicated that they had no difficulty in bathing a child, changing a nappy, preparing a bottle feed, cleaning nappies, putting the baby to sleep and administering medication. Between 70—75% found no difficulty in calming a screaming child and getting up in the night to attend their child. The survey data suggests that the vast majority of fathers had the ability to support a mother with infant care prior to her returning to work. The men at interview and group discussions indicated that they had been involved in basic infant care on a regular basis but acknowledged that the mother of the child was likely to down-grade their contribution if asked; such comments were frequently associated with humorous comments. The men acknowledged that they would do less infant care if work commitments became demanding, particularly if they determined that a good night's sleep would reduce the risk of a mishap the next day.

14.3.3 *Actual health practice: Activities performed for sick children*

The six document search chapters (acute illness, chronic illness, mental health, terminal illness, injury prevention and health promotion) gave details of search strategies with each concluding that little was known of men's health practices. Results from the searches of the health literature and documents clearly showed the difficulty in locating any accounts of men's health practices beyond excerpts from individual cases; when accounts were found they were couched in terms of the exceptional efforts made by fathers, in their attempt to be involved in their child's care.

The majority of men in the survey indicated that they had a role in the general nursing care of a child with illness; comforting a child in pain (20.4% always, 50.3% often, 28.3% sometimes), cleaning up vomit (19.5% always, 24.9% often, 47.6% sometimes) and toileting a child with diarrhoea (12.9% always, 21.3% often, 52.3% sometimes). Treatment practices were also carried out but to a lesser extent; medication was administered (9.1% always, 25.8% often, 23.4% sometimes), fever treated (14.5% always, 26.3% often, 52.5% sometimes), comfort care provided during medical procedures (10.6% always, 16.7% often, 20.7% sometimes) and many men had been involved in explaining a health

problem to their child (8.2% always, 21.3% often, 23.2% sometimes). Fewer men provided first aid treatment for a sting or bite (7.9% always, 14.6% often, and 25.6% sometimes) or burn (6.4% always, 10.4% often, and 18.3% sometimes) or bandaged a sprain (7.3% always, 13.2% often, and 14.3% sometimes). The survey data showing men's actual health practices corresponds closely with information given by men at interview and group discussions; with all fathers in the focus groups indicating that they had had substabntial first hand experience of practicing health for their child. Over half of the men had a child with a chronic health problem or disability and this provided the basis for them to become involved in transmitting health information to their child. The men spoke of child injuries in terms of transporting them quickly to medical care rather than detailing their first aid practices. The majority of men felt comfortable with their ability to assess the severity of injuries but one man spoke of his inability to make a correct assessment of his child's need for sutures to a laceration and was berated by his wife on her return to the home for not taking earlier action. Two possible explanations for survey respondents recording lower frequency of first aid health practices emerged from group discussion data. The majority of men indicated that they were often not at home when injuries occurred or their child was injured at school, and when men saw their child injured at a sporting event the child was most often treated, in the first instance, by a designated team member trained in first aid.

14.3.4 Actual health practice: Health literacy and skills

The majority of fathers in the survey indicated that they had received first aid training (82%) as well as cardiac resuscitation training (75.4%) and most men had received education for occupational health and safety (73.5%). All men at interview and group discussion had received the three categories of education with the majority explaining that the education had been work based with little or no application of this knowledge to child health. The survey data also indicates that few fathers had received formal education on child specific health topics; care of the infant (34.8%), common childhood illness (37.4%) and general nursing care (35.6%). This is in contrast to the greater proportion of female respondents receiving formal education for care of the infant (52.4%, $p = 0.031$), common childhood illness (55.6%, $p = 0.023$) and general nursing care (51.6%, $p = 0.006$).

Although nearly half of the fathers knew about immunisation (49.5%), a greater number of female respondents had been educated on the topic (68.3%, $p = 0.004$). Each of the six document search chapters noted the need to improve men's health literacy for child health practices as well as a lack of studies evaluating the outcome from any programme designed to improve men's literacy.

14.3.5 Actual health practice: administration of medication

Men were divided on their level of knowledge about medication use with half indicating they knew 'about the same' as women (50.4%) and 43.9% indicating they knew less; only 4.3% considered they knew 'much less' than women. Reassuringly, a large proportion of men felt comfortable with telephoning a pharmacy for information about medication (reasonably comfortable 36.1%, very comfortable 36.15) and nearly half indicated that they had sought advice or instruction from pharmacy staff (often sought advice; 19.2%, always sought advice 28.8%). Despite feeling comfortable about telephoning for advice nearly half the men (48.8%) indicated that they were 'never' or 'rarely' actually instructed by pharmacy staff on the side effects of the medication they were purchasing. Men's lack of knowledge about medication and the side effects of medication is cause for concern as 60.7% of men indicated that they had either purchased 'prescription drugs' (12%) or both prescription and over the counter medication (53.7%) in the year leading up to the survey. The reservations about their medication literacy may explain why only 20% of the fathers in the survey claimed to be administering medication to their child. A large proportion of women respondents (82.6%) stated they regularly administered medication to their child. As anticipated, the fathers in group discussion who had a child with a chronic health problem felt very confident in their administration of medications as well as understanding the appropriate use of prescription and over the counter medications. However, fathers of children who did not have a chronic health problem and those supporting a clear division of labour in the family were reticent to give their child medications unless specifically instructed to do so by their spouse and had little experience with pharmacists. The polarity in medication practices identified among men in discussion reflects the responses found in the survey data.

14.4. Perceived barriers to men's health practices

The household survey did not investigate barriers to men practicing health in the home or society because of the limit to the number of items recommended for questionnaire design. The literature clearly identified several key barriers to men practicing health when their children required medical intervention and the questioning of the men at interview and in discussion groups revealed they had deeply held concerns. The document searches revealed three main barriers. Firstly, when children became ill mothers claimed the right to spend most time with the child leaving the father to care for the sick child's siblings, communicate information about the illness to other family members and deal with the day to day business of running the family. The second barrier is dependent on the extent to which the user of child health care must pay. In countries where health insurance is not universal many fathers determine that they must remain at work in order to generate enough income to cover the cost of care, and the commitment to work limits the time fathers can spend with their sick child. Thirdly, it has become normal for mothers to be the main nexus between the family and providers of health services. Health services and health professionals are directed toward supporting mothers as partners in care. In addition, many health care organisations contain the title 'mothers and babies' or 'women's and children' emphasising the focus of care.

Although the literature made mention of the importance of fathers in the care of a child with a health problem there was no evaluation of any initiatives that could be disseminated to health professionals on how best to include fathers in care. Prominent in the literature were examples of how staff had to cope with aberrant behaviours projected by fathers who in some way had been frustrated in their efforts to be involved. Approximately half of the men in discussion groups or at individual interview declared that they had a child or immediate family member with a serious or long term health problem. Several of the men provided a detailed account of their frustration with medical staff and the problems they had experienced in gaining timely and appropriate information leading up to the diagnosis and choice of treatment options. Amongst the frustration was heart felt appreciation for individual health professionals who demonstrated empathy for

their plight and were able to provide practical support. The men suggested that adequate support from health professionals was an expectation they held rather than the hope of a chance encounter with someone who was attuned to their case and needs. Although several of the men in discussion groups were able to describe how they and their wife were able to work as a team to improve their health literacy and understanding of the processes within health care organisations in order to secure the best care for their child, other men spoke of their need to provide emotional support for their wife who was not coping. Those men in discussion groups whose children did not have a health problem spoke with some anxiety about the prospect of having to respond to the situations described by other men. Many of the men would continue to rely on their wife to be the main nexus between child health problems and health services. One man who took this line of reasoning stated that he simply would not know what to do if his wife were not there; the man subsequently separated from his wife and was caring for all three children for the majority of the time.

14.4.1 Limitations

The men volunteering for group discussion were educated to late high school years or higher, they articulated well in discussion and were good informants. This suggests that the sample may not be representative of all men in the population. The questionnaire was distributed on the basis of random selection of households and consequently the results from the survey are likely to be representative of several demographic groups. However, there is no way of knowing the demographic characteristics of the men who chose not to respond to the survey. A difference between men's and women's responses for some of the questions suggests that men's perception of what they do may differ from women's perception of what men do.

The statistical inference involved performing multiple testing that was likely to inflate the possibility of a type one error. Consequently, the reader was notified of this in the method section. As such, the interpretation of the data was guided by the patterning of the results as well as the significance of the results. There has been no attempt to match attitudinal responses on men's views of male and female roles with actual health practices, as this goes beyond the aim of the study and will be considered as post doctoral work.

CHAPTER 15: CONCLUSIONS

The literature review chapter "*Dual income families in crisis",* established that parents in dual income families face a number of challenges when trying to balance work with their desired family life style. Working mothers, employed on a full-time basis, hold concerns over the effects of out-of-home childcare on their child's health, safety and development as well as the resource issues associated with transporting their child to care facilities at each end of their working day. Obtaining childcare becomes problematic when a child experiences illness or injury as it is difficult to locate an adult who can provide affordable and competent nursing care at short notice; most often it is the mother who takes time from work to provide the care and assume this additional family workload. Many mothers choose part-time work because they want to avoid or minimise issues associated with out-of-home childcare and anticipate the need to be available to provide care for a sick or injured child. Working mothers report physical and emotional exhaustion from having to combine employment workloads with their family workloads and have been calling upon their spouse or partner to take on a more equitable share of parenting, including providing care for a sick child.

The chapter *Masculinity* explored research approaches to and the theorising of the concept. This work provides a framework for analysing normative perceptions of what constitutes women's work and difficulties men might encounter in performing cross gendered work. Child health and sickness care has evolved into a highly feminised work that is performed almost entirely by mothers who are guided by health professionals, of which the vast majority are female. There are two consequences arising from men not being socialised as providers of child health care; many men see health as women's work and they are unable to accommodate the role into their personal perception of what it is to be masculine. Secondly, men are reticent to assume a health role when they have not been provided with the requisite literacy and skills to practice competently and confidently. Participants in the focus group discussions and men responding to

the household survey indicated that they continued to support a division of labour within the family typified by the male breadwinner and mother as child raiser when children were young. However, a larger proportion of men in discussion groups and the survey had assumed and were developing many parenting tasks previously undertaken by mothers; the information they provided is new evidence as literature to – date has not recorded the frequency or repertoire of men's health practices.

The chapter *Fatherhood* identified that a growing number of men are willing to assume parental responsibilities far beyond the scope demonstrated to them by their forefathers. There are two main motivators cited in the literature to explain the trend toward a more equitable sharing of parental responsibilities. Firstly, men held a desire to be able to provide support for their working spouse or partner by substituting for her parenting work. Secondly, fathers believed their lives were enriched by fostering interdependency between themselves and their child; many men regretted that they had not had this type of relationship with their father (Burgess, 1997). The survey data showed strong in-principle support for gender equity and a need to support the working mother. Evidence of actual support for working mothers came from data indicating that men performed more home duties once their spouse or partner returned to work after giving birth. Attitudinal data from the household survey highlighted the importance of fathering today and the desire for children to be with both parents. Evidence of fathers' actual parenting involvement came from data showing a large portion of men were involved in day-to-day care of infants as well providing comfort care for a sick or injured child. The survey findings highlighted the importance of fathering today and fathers' involvement in childcare was congruent with the information gathered at focus group discussions. The men described how their parenting role was vastly different from that of their forefathers and how they had developed a range of parenting and health practices. These skills had been accrued without the support of their father as a role model or mentor.

The six document search chapters had aimed to establish the incidence of child health problems across illness groups (acute, chronic, mental and terminal) and health issues (health promotion and injury prevention) and to characterise men's health practices performed toward their child. The document searches revealed

that despite increasing improvements to the health status of Australian children, the incidence and type of child health problems continue to represent a substantial call on family time and resources. The paucity of description of men's health practices and the patterning of care they provide was highlighted by key family health researchers across all illness groups and there was scant evidence of men's health promotional and injury prevention practices. A key explanation for the lack of evidence of men's health practices was a research focus on mothers, justified by a failure to recruit a sufficient number of fathers into studies combined with an assumption by researchers, that mothers were the sole parent involved in day to day health practices toward children. The survey findings confirmed that in the lead up to completing the questionnaire most households had had a family member with a health problem and this highlighted that parents had an ongoing need to practice health. The data showed that fathers were frequently performing comfort care for a child with a health problem or injury. The positive response to a range of health practices set out in the questionnaire indicated that fathers were involved in treating fever, administering medication, performing first aid and were actively involved in elementary health promotion and injury prevention activities. Men in the focus groups described a repertoire of health practices they had performed that went far beyond any found in the literature. This new knowledge of actual health practices performed by men toward their children, the frequency of these practices and repertoire of skills, are important items for determining the extent to which fathers are adopting a new gender role.

Not all men practice health toward their children or support the notion of equitable parenting within a dual income family. The focus group discussions revealed that many couples continue to uphold a division of labour within the family based on longstanding gender roles; fathers focused on generating income and the working mothers, perceiving health practices to be a core maternal responsibility, did not encourage their spouse or partner to assist them in this work. Working mothers who continue to provide the bulk of health practices are described by their spouse or partner as coping very well with minor child health problems and routine health checks (dental, immunisation). However, data from group discussions revealed that where parental roles are clearly defined there are

limited choices for coping when chronic or serious child health problems arise. Where men had not developed a parental role that incorporated health practices they were unable to substitute for the mother's health practices when she became unavailable.

In conclusion, the relationship between gender and work performed by men and women, at home and in society has shifted substantially over the past three decades. There is little indication that health services have accounted for this social change and created services that meet the needs of men who are equitable in their parenting responsibilities. The lack of information about the private lives of fathers, inclusive of their health practices within the home, can no longer be assumed to be unimportant because contemporary fathers have greater opportunities to be involved with their children and many seek improvement to their health literacy and skills. To date, the literature has provided a modicum of information about men's experiences in attempting to become partners in care for a child with a health problem. Consequently, it is difficult for health professionals to gain empathy and insight into the issues faced by these men. The findings from this doctoral research clearly indicate that men are practicing health yet there has been little information for health professionals to assist them in forming strategies to better engage with these men and support evidence based practice within their profession. Men parent differently and are likely to want to practice health differently; ergo the current structure of health services and nexus between health service providers and fathers may need to be modified.