

Fathers' Engagement with Child Clinical Psychologists: A Grounded Theory Study of Client and Provider Perspectives.

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This candidate confirms that the work submitted is her own, and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Objectives. The objective of this study was to explore the factors that are perceived to influence fathers' decisions of whether to attend an initial appointment with a Child Clinical Psychologist when their child is referred.

Design. The research explores the perspectives of fathers who are potential service users (n=5), and also those of the service providers: Clinical Psychologists working with children and their families (n=9). A mixture of focus group and individual interview procedures were used to collect data. All interviews were audio recorded and subsequently transcribed. The research employs the method of Grounded Theory to analyse the data. This involved developing codes, categories, and themes from the data and linking them together to form a conceptual understanding of the participants' accounts.

Results. The participating fathers and psychologists gave very similar accounts, often using the same language and constructs to explain why fathers might or might not attend appointments. A theoretical model describing the key factors that are perceived to influence fathers' decisions is presented. Family involvement and commitment was described as a pivotal factor. Whilst it was suggested that uninvolved or uncommitted fathers would not even consider attendance, it was felt that more involved fathers would be affected by a host of other factors that would either inhibit or drive their motivation to attend. Fathers' perceptions of psychology services, socio-cultural barriers to help-seeking, and organisational barriers to help-seeking were perceived to be particularly important.

Conclusions. Difficulties in engaging fathers in child psychology services appear to arise for a number of reasons. First, the engagement of fathers in therapeutic work might mirror their engagement with their family and child outside of the clinic setting. Second, attending child mental health appointments may be perceived by fathers to be at odds with their gender identity. Prevailing societal conceptualisations of masculinity suggest help-seeking, problem sharing, and emotional expression is not 'manly' behaviour. Third, uncertainty about the role of Child Clinical Psychologists and what the appointment might entail, and negative or fearful expectations, may reduce fathers' willingness to engage. It is felt that services need to consider how they might promote father engagement. Improvements in terms of the information fathers receive when their child is referred, and efforts towards portraying a more 'father-friendly' image, might help to encourage some fathers, particularly those who are already involved in childcare.

Table of Contents

Acknowledgements	ii
Abstract	iii
Table of Contents	iv
List of Tables and Figures	vi
List of Abbreviations	vi
INTRODUCTION AND REVIEW OF LITERATURE	
1.1 Introduction to The Research Question	1
1.2 The Father's Place in Child Development Literature	2
1.2.1 Forgotten Fathers: Absent Fathers in Child Development Literature	2
1.2.2 Finding Fathers: The Importance of Paternal Influence	3
1.3 Fathers, Engagement and Resistance	5
1.4 Exploring Reasons for Fathers' Non-Attendance	7
1.4.1 Men and Health Care Usage	7
1.4.2 Men, Masculinity, and Help-Seeking Behaviour	8
1.4.3 Men and Access to CAMHS	9
1.4.4 The Clinician's Role in Engaging Fathers	10
1.5 Summary of the Literature	11
1.6 The Research Question	12
1.7 Aims of the Thesis	13
1.8 Overview of Thesis Structure	14
METHODOLOGICAL FRAMEWORK AND RESEARCH DESIGN	
2.1 A Background to the Study and Methodological Approach	15
2.1.1 The Aims of the Research Project	15
2.1.2 Information About the Researcher	16
2.1.3 The Suitability of a Qualitative Approach	17
2.1.4 Guidelines and Quality in Qualitative Research	18
2.2 Method of Data Collection	19
2.2.1 Overview of the Research Design	19
2.2.2 Care and Protection of Participants	20
2.2.3 Pilot Study: The Focus Groups	22
2.2.4 Main Study: The Interview	27
2.3 Method of Data Analysis	30
2.3.1 A Background to Grounded Theory	30
2.3.2 Grounded Theory Method	31
2.4 Summary of Chapter	35
RESULTS	
3.1 Overview of the Results Section	36
3.2 Quotation Conventions in the Results Section	36
3.3 Descriptive Data: Fathers	36
3.3.1 Response Rate and Participation	37
3.3.2 Background Information About Participants	

3.4	Analysis of Father Data	37
3.4.1	Theme 1: Family Involvement and Commitment	38
3.4.2	Theme 2: Multi-Level Barriers to Help-Seeking	40
3.4.3	Theme 3: [Mis]Perceptions of Psychology	44
3.4.4	Theme 4: Positive and Negative Reinforcers of Help-Seeking	48
3.4.5	Summary of Father Data	49
3.5	Descriptive Data: Psychologists	50
3.5.1	Response Rate and Participation	50
3.5.2	Background Information About Participants	50
3.6	Analysis of Psychologist Data	51
3.6.1	Analytic Process and Reflexivity	51
3.6.2	Introduction to Psychologist Data Analysis	52
3.6.3	Theme 1: Family Involvement and Commitment	52
3.6.4	Theme 2: Multi-Level Barriers to Help-Seeking	55
3.6.5	Theme 3: [Mis]Perceptions of Psychology	62
3.6.6	Theme 4: Positive and Negative Reinforcers of Help-Seeking	65
3.6.7	Summary of Psychologist Data	66
3.7	Results of Credibility Check	66
3.8	Descriptions of Interactions in Overall Model	68
DISCUSSION		
4.1	Introduction	71
4.2	Review of Main Findings	71
4.3	Discussion of Main Findings	72
4.3.1	Review of Main Findings	72
4.3.2	Fathers in the Family and in the Clinic	73
4.3.3	Masculinity, Gender, and Help-Seeking	74
4.3.4	Service Organisational Issues	76
4.3.5	Summary	78
4.4	Implications for Policy and Practice	79
4.5	Limitations of the Study	80
4.6	Directions for Future Research	82
4.7	Reflections: The Research Process	83
4.8	Concluding Comments	84
REFERENCES		85
LIST OF APPENDICES		96
APPENDIX 1: Ethical Approval		97
APPENDIX 2: Consent Forms		99
APPENDIX 3: Topic Guides		104
APPENDIX 4: Two Page Extracts from Transcripts		106
APPENDIX 5: Diagrams Presenting Codes, Categories, and Themes		110
APPENDIX 6: Validation Exercise		112

List of Figures and Tables

Table 1: Overview of Research Design	20
Figure 1: The Building of Data Using Grounded Theory	33
Figure 2: Example of a Memo	34
Figure 3: Model of Interaction Between Themes and Main High-Order Categories	68

List of Abbreviations

B.P.S.	British Psychological Society
CAMHS	Child and Adolescent Mental Health Service
N.H.S.	National Health Service (U.K.)
P.I.C.T.	Psychologist In Clinical Training

CHAPTER ONE

INTRODUCTION AND REVIEW OF LITERATURE

1.1 Introduction

The present study aims to identify factors that contribute to fathers' decision of whether, or not, to attend an appointment with a Child Clinical Psychologist when their child is referred. The findings of this research are intended to help to shape methods of engaging fathers in psychology services at both a service planning and clinical level and provide a context for future research.

In the following chapter, three main fields of literature that are relevant to the research question will be explored. The first of these is the growing body of literature that examines the roles of mothers and fathers in child development. It will be argued that fathers have potentially important influences, both positive and negative, on their children's welfare. Research evidence that implicates a clear role for fathers, as it does mothers, in child psychopathology will be presented. The second field of literature is that which addresses the attendance and engagement of fathers with Child and Adolescent Mental Health Services (CAMHS). Here it is discovered that, whilst the absent father is common within clinic settings, he retains significant influence over the treatment process. It is reported that fathers' attitudes towards engaging with CAMHS appear to be pivotal to the engagement of the rest of the family, and the involvement of fathers appears to be linked with positive outcome of clinical interventions. Finally, the third body of literature of relevance to this study is that which explores the reasons for the non-participation of fathers. The areas of men's health and masculinity provide evidence that the way in which men conceptualise masculinity has important consequences for their willingness to access healthcare. Within the scarcity of psychology literature, evidence suggests that the way in which fathers perceive CAMHS and their role within their child's referral is particularly important. Potential resistance to the engagement of fathers from service providers as well as service users is also considered.

Following the literature review, a summary is provided and it is concluded that further exploratory research into the reasons for fathers' non-participation in CAMHS when their child is referred is a research priority. To conclude the chapter, the research question and the aims of the thesis are discussed and an overview of the structure of the thesis is presented.

1.2 The Father's Place in Child Development Literature

1.2.1 Forgotten Fathers: Absent Fathers in Child Development Literature

Observation of the literature on child development, both normal and abnormal, reveals that the role of the father has traditionally been a somewhat neglected area of research (Phares, 1992). It is likely that this bias toward researching the mother and child originated from the historical division of labour and the birth of hegemonic masculinity that are associated with the industrial revolution (Lamb, 2000). Societal structure and socio-cultural constructions of men and masculinity at that time meant that most fathers did not contribute a great deal in terms of parenting their children (Lamb, 2000). It is therefore unsurprising that they may have been overlooked within early research literature. However, in more modern times, it seems that there is little excuse. Research suggests that, from year to year, fathers are spending more time with their children (Pleck, 1997; Lamb, Pleck, Charnov, & Levine, 1987) and that women are spending more time at work (Lee & Owens, 2002). Alongside these social changes, Phares (1992) argues that research assumptions are frequently based on outdated social norms and sexist theories. It is argued that research efforts continue to concentrate on maternal influences and neglect those of the father (Lee & Owens, 2002; Phares, 1999, 1995; Streat, 1997), a position that is supported by a review of child and adolescent research in eight clinical journals from 1984 to 1991 (Phares & Compass, 1992). The study revealed that whilst forty eight percent of studies exclusively involved mothers, only one percent of the studies exclusively involved fathers. It would seem that fathers are remaining dramatically under-represented in this field (Phares, 1992).

Several authors (Phares & Compass, 1992; Caplan & Hall-McCorquodale, 1985) have raised concerns that the relative scarcity of child development research affording a role for fathers results in a 'mother-bashing' quality within the literature. Whilst the extent to which mothers contribute to psychological or adjustment problems in their children is emphasised and investigated, the contributions of the fathers go largely ignored. Caplan and Hall-McCorquodale (1985) report data that illustrates the extent of this bias. These researchers found that, within the literature, mothers are mentioned in examples of child problems at a ratio of 5:1 compared with fathers. The only area of research that focuses on the impact of fathers and fathering on children is that of sexual abuse. Phares (1995) notes that, on the rare occasions when child psychopathology is investigated in relation to fathers' psychiatric diagnosis, significant relations often arise. This indicates that fathers' influence on their child's adjustment is indeed a useful avenue of exploration that is currently poorly understood.

Phares (1992) highlights two factors that appear to have contributed to the neglect of fathers in clinical research; pragmatic difficulties in recruiting fathers to studies and differential base rates

of maternal and paternal psychopathology. Taking first the practical issues of recruitment, many researchers presume that fathers are more difficult to engage in research, as they are more likely to be at work when the research is conducted (Strean, 1997). As reviews of survey data show (Pleck, 1997; Lamb et al., 1987), despite increased involvement of fathers in parenting tasks, mothers continue to take the bulk of responsibility for childcare and have most contact with health professionals in the line of this duty (Graham, 1984). Overall, mothers are most accessible to health professionals wanting to conduct research, and due to the inconvenience of reaching them, and the scarcity of both the researchers' and the fathers' time, the father's role is often ignored (Strean, 1997). Looking second at base rates of maternal and paternal psychopathology, the high rates of maternal as opposed to paternal depression can explain some of the bias in the literature (Ballard, Davies, Cullen, Mohan, & Dean, 1994; Phares, 1992). Overall, the largest body of literature on parental psychopathology focuses on the effects of depression. As depression is more common in women, the largest body of literature is therefore focused specifically on mothers.

It is interesting to observe that, where fathers are included in the literature, they are often described as purely positive influences on their child's development (Phares, 1992). To a large extent, this literature appears to reflect and maintain social constructions of fatherhood that subscribe to hegemonic conceptualisations of appropriate male behaviour. Bernard (1981) argues that it is all too easy to conclude from the parenting literature that any emotional involvement a father has in his children is above and beyond the requirements of his role and therefore can only be seen in a positive light. Portraying the role of fathers in this manner is purported to grant fathers special dispensations against family participation (Bernard, 1981). Perhaps this same understanding has also granted researchers in the field dispensation from investigating this interesting population.

1.2.2 Finding Fathers: The Importance of Paternal Influence

'The father, present or absent, may be salient or insignificant in the life of a child. If salient, the father's role may promote health and growth, or it may be largely pathogenic'

(Adams, 1984, p.228).

Despite their arguments that there is not enough research effort being directed towards understanding paternal influences, many authors do concede that the last three decades have witnessed a turn of interest towards the 'forgotten fathers' who do play a major part their children's development (Strean, 1997; Phares & Compas, 1992). This relatively new impetus for studying fathers comes from two main sources (Phares & Compas, 1992). The first of these emanates from the concerns that the literature is biased toward studying mothers' contributions

to child psychopathology (Caplan, 1986; Caplan & Hall-McCorquodale, 1985). A second arises from Lamb's (1975) article 'Fathers: Forgotten Contributors to Child Development' which inspired the growing field of research into the role of fathers in normal child development.

Current research investigating the role of fathers in child development is beginning to follow in the footsteps of that investigating maternal influences, drawing on many of the same concepts and methodologies. For example, there is a large body of research that suggests that the effects of maternal psychopathology on children's psychosocial adjustment are determined by multiple processes and pathways (Phares & Compas, 1992). These are thought to include: (a) genetic transmission of disorder or vulnerability, (b) mother-child interactions, (c) maternal parenting practices, and (d) marital conflict. It is assumed that these same basic mechanisms underlie any impact that fathers have on maladjustment in their children (Phares & Compas, 1992). Evidence for this is found both within recent attachment literature and in research regarding the effect of paternal involvement and paternal psychopathology on child development.

Studies based on attachment theory find consistent links between women's working models of their early attachment histories, their behaviour as parents, and their children's attachment and diagnostic status. Recent investigation of paternal attachment reveals evidence that indicates that infants show a very similar pattern of attachment to their fathers as they do to their mothers (Fox, Kimmerly, & Schafer, 1991). Cowan and his colleagues (Cowan, Cowan, Cohn, & Pearson, 1996) also found that models that include the fathers' attachment histories predicted more variance in teachers' descriptions of children's externalising behaviour than did those only including the mothers' attachment history. Likewise, models that include mothers' attachment histories predict more variance in children's internalising behaviours. Clearly, this research suggests that fathers' relationships with their children are important and influential to their emotional adjustment (Cowan et al., 1996).

Consistent with the findings in the attachment literature, research into paternal influences suggests that paternal behaviour, personality, and psychopathology are all significant sources of influence on a child's psychosocial adjustment. Overall, paternal psychopathology is more clearly implicated in children's externalising problems than their internalising behaviours (Phares, 1992). In a review of the literature, Phares (1992) reports that children whose father has been referred to mental health services are at increased risk for a variety of types of psychopathology. Fathers of children referred to mental health services also show increased levels of psychopathology compared to fathers of non-referred children (Phares, 1992). Recent research also points to a positive role for fathers suggesting that father involvement in early life is a factor that protects children from the risk of psychosocial maladjustment and distress in adulthood (Flouri & Buchanan, 2003; Amato, 1994). Father involvement has also been

positively associated with factors such as their children's school attainment, occupational and educational mobility, and ability to form intimate relationships (Flouri & Buchanan, 2002, 2003; Hwang & Lamb, 1997; Amato, 1994). Together this evidence points to the importance of considering paternal as well as maternal influences in child development.

In addition to effects that fathers might have on their children, one recent study provides an interesting illustration of the effects children might have on their fathers (Deater-Deckard, Scarr, McCartney, & Eisenberg, 1994). This study also exemplifies a situation where researchers made incorrect assumptions about fathers derived from hegemonic conceptualisations of masculinity. Deater-Deckard and his colleagues (Deater-Deckard et al., 1994) investigated the anxieties of 589 fathers and mothers when they separated from their pre-school children. The authors anticipated that fathers would have less separation anxiety than mothers, and also that they would underestimate the mother's level of anxiety. It was assumed that because work is identified as a 'male role', men would not be anxious about separating from their child for reasons of employment, and would not be aware of their wife's emotions. It was also assumed that because maternal care is identified as a 'female role', women would be more anxious about separating from their child as the care was their responsibility. Contrary to the predictions, Deater-Deckard and his colleagues (Deater-Deckard et al., 1994) found that fathers reported similar levels of separation anxiety to the mothers. In the category 'concern for the child's welfare' fathers actually reported higher levels of anxiety than their wives. This finding would suggest that some contemporary fathers are more emotionally involved with their children than is often presumed (Deater-Deckard et al., 1994).

In summary, it appears that social changes are just beginning to prompt a re-evaluation of the father's contribution to the family (Strean, 1997). Whilst the paternal influence literature continues to lag behind that of maternal influences, a growing body of research indicates that fathers do play a significant and substantial role in the development of their children. Walters (1997) calls for increased recognition of the fathers' mental state and its' relevance to child psychopathology. It is also suggested that, given the significance of the role of fathers in their child's development, fathers are likely to be important to the treatment of child psychopathology and should therefore be included in this by health professionals (Walters, 1997).

1.3 Fathers, Engagement and Resistance

Research into the attendance of fathers at mental health service appointments when their child is referred reveals a notable absence. This is despite evidence that more than four out of five fathers live with their children under the age of eighteen within the UK (Burghes, Clarke, & Cronin, 1997). Berg and Rosenblum (1977) reported that approximately one third of fathers did

not attend initial appointments whereas it is extremely rare for a mother not to attend. This finding replicates those of Slipp and his colleagues (Slipp, Ellis & Kressel, 1974) who reported that initial contact takes place without the father's presence in 30% of cases, and barely ever without the mother. Looking beyond the initial appointment, Slipp and colleagues (Slipp et al., 1974) also found that fathers tend to remain absent when the child is offered individual therapy and the parents are offered counselling. More recently, Walters (1993) reports that attendance by fathers at a child community sleep clinic was as low as 31%, and Walters, Tasker, and Bichard (2001) found that 67.1% of fathers attended a child psychiatry clinic, although in the latter case the fathers had previously engaged in a research interview. No links are reported between fathers' attendance and social class or the gender and age of the referred child (Walters et al., 2001). Streaun (1997) describes this absence of the father in the treatment process as rather disconcerting and refers back to Richmond's (1917) statement that it should be mandatory to consider 'all those who share a common table' in any therapeutic intervention.

A body of literature now confirms the importance of including and engaging fathers when their child is referred to mental health services. Several authors (Gurman & Kniskern, 1978; Love, Kaswan, & Bugental, 1972; Bergin & Garfield, 1971) report that fathers' attendance is associated with better clinical outcomes. In a review of this literature, Heubeck, Watson and Russell (1986) found the evidence to be unclear but they were still able to recommend that fathers should be included. In an analysis of questionnaires completed by family therapists Berg and Rosenblum (1977) found that the father is the member of the family who is most resistant to therapeutic contact. The father was most frequently stated as responsible for absences and cancellations of sessions, and the most common stated reason for non-attendance by mothers was that their spouse didn't want to go. This confirms the earlier findings of Shapiro and Budman (1973) who discovered that fathers are pivotal in family decisions about continuing treatment or termination. Slipp, Ellis and Kressel (1974) also argue that failure to engage a family as a whole is often specifically related to the fathers' attitudes. These authors (Slipp et al., 1974) stress the importance of engaging the father at an early point in therapy, a point now substantiated by further research. Bennun (1989) found a clear association between a family's perceptions of their therapist and clinical outcome. Interestingly, it was found that fathers' perceptions are most influential in affecting the course of treatment. Specifically, if fathers experienced a therapist as competent and active then there was an increased likelihood of a good outcome (Bennun, 1989).

It seems that the consensus throughout the literature is that the father is the most resistant member of many families when it comes to therapy, meaning that father-absence is as commonplace in the clinic as it is in the journals. Fathers' resistance appears to impact on the way in which the rest of his family engage with services. It seems that when the father is

positively involved in the therapeutic intervention, outcome is more likely to be good than if he is not involved at all.

1.4 Exploring the Reasons for Fathers' Non-Attendance

Despite emerging evidence of the importance of including and engaging fathers in clinical interventions, there is a scarcity of research investigating the reasons for father absence in child mental health settings. In exploring the possible reasons why fathers tend not to engage with Child Clinical Psychology Services, the academic literature in the areas of men's health and masculinity is of interest. In particular, there is a body of evidence indicating that men have poorer health than women yet are less likely to access health services. It is suggested by a number of authors (Watson, 2000; Petersen, 1998; Levant, 1995) that men's avoidance of expressing distress, and their reluctance to seek medical or psychological help, can both be seen as arising from the internalisation of values associated with hegemonic masculinity¹ (Lee & Owens, 2002).

1.4.1 Men and Health Care Usage

Turning first to the field of 'men's health', it is clear that this area has received much interest in recent years (White, 2002). O'Dowd and Jewell (1998) suggest that the social and political concern about men's health has arisen out of findings that men have generally poorer health and higher morbidity than women of equivalent ages yet they are less likely to access preventative or restorative health care. In March 2000, the Public Health Minister Yvette Cooper brought this to the attention of the nation stating: *'Men are less likely to visit a doctor when they are ill and are less likely to report on the symptoms of disease or illness'* (DoH, 2000, p.6). It would seem that the 'absent man' is a phenomenon common to a variety of health care settings including; preventative clinics, child health clinics, family planning centres, GP surgeries, and antenatal classes (Wilson, 1998). Wilson (1998) further reports that the settings in which men are most notably absent are those where help is available for emotional or personal difficulties (Jorm, 1994). It is purported that men are less likely to believe that their emotions can influence their well being, or to acknowledge emotional distress as a valid condition (Wilson, 1998). Corney

¹ In Western society, the dominant model of masculinity, often referred to as 'hegemonic masculinity' (Connell, 1987, 1995), describes the traditional, patriarchal view of maleness and appropriate male behaviour. The central tenet of this hegemonic masculinity is that men are fundamentally different from women (Lee & Owens, 2002). Men are positioned as material providers who are relatively unconcerned with family life. Physical strength, self-reliance, and emotional stoicism, are important markers of a 'real man' (Lee & Owens, 2002). Men who subscribe to a hegemonic identity are required to prove and assert their masculinity through competitiveness, aggression and demonstration of wealth and success (Morgan, 2001).

(1990) found that men are less likely than women to report psychosocial problems as an additional reason for consulting. Similarly, Lewis and O'Brien (1987) have reported that men tend not to be the first to seek help for marital, childcare, or other relationship problems.

Given the apparent reluctance of men to attend medical settings, and their specific reluctance to access services concerned with emotional well being, it is perhaps unsurprising that so few fathers are present at appointments with a Child Clinical Psychologist. However, several authors (Gijsbers van Wijk, Kolk, van den Bosch, & van den Hoogen, 1992; Briscoe, 1984; Clarke, 1983; Nathanson, 1978) have criticised the validity of health survey data and argue that it is an inadequate base from which to draw firm conclusions concerning men's help-seeking behaviour. The methodological flaws included the sex-biased formulation of questions, the use of behavioural indices, the use of proxy-interviews and mainly female respondents, and the conceptualisation of health and illness in the surveys. A more wide ranging review of the literature concerning help-seeking and service utilisation reveals a more complex and inconsistent picture. Whilst some studies support the notion of gender-specific health behaviour (Davies, McCrae, Frank, Dochnahl, Pickering, Harrison, Zakrewski, & Wilson, 2000; Wyke, Hunt, & Ford, 1998), several studies also provide evidence that gender differences in subjective health are not explained entirely by gender *per se* (Emslie, Hunt, & Macintyre, 1999a, 1999b; Macintyre, Ford, & Hunt, 1999; Feeney, North, Canner, & Marmot, 1998; Macintyre, 1993). In these studies social and employment factors that frequently, but not always, co-vary with gender appear to affect people's relationships with their bodies and their health (Lee & Owens, 2002). It would appear that gender should be considered as one amongst a number of factors that influence health and health-related behaviour.

1.4.2 Men, Masculinity and Help-Seeking Behaviour

Lloyd (1996) draws attention to three ways in which men's health is conceptually defined and understood within the literature. Firstly, men's health can be defined in purely biological terms with the differences in health viewed as reflecting purported biological differences between men and women. Clearly, this biomedical model is rather reductionist and, whilst it may offer an explanation of health status, it fails to explain gender differences in help-seeking behaviour. The second perspective emphasises risk factors that might operate differently for men and women as a result of biological or lifestyle variation. Whilst risk perspectives do seek a more social explanation of men's health, they fail to describe the mechanisms that result in male risk-taking. Finally, from a third perspective it is argued that men's health and health behaviour reflects the ways in which masculinity has been constructed and lived in society. Verbrugge (1985) argues that dominant socio-cultural conceptualisations of hegemonic masculinity produce acquired risks in men as they try to live up to a 'manly' image. It is suggested that gender differences in

perception and evaluation of illness, use of preventative and restorative health practices, and social roles and lifestyle, have a major, and negative, effect on men's health.

Petersen (1998) argues that concern for one's own health is perceived as a feminine trait within the hegemonic model of masculinity. Men are also positioned as being naturally resistant to disease, unresponsive to pain or physical distress, and unconcerned with emotions. To admit to being unwell, or to require help from another person, is a sign of male weakness that flies in the face of the strong and self-reliant hegemonic man (Wilson, 1998). Several qualitative studies have provided evidence that men under report health problems in order to project an identity that is consistent with cultural expectations (Roos, Prattaka, & Koski, 2001; White, 2000; White & Johnson, 1998; Cameron & Bernardes, 1998; Moynihan, 1987). For example, White and Johnson (1998) reported that some men ignored feelings of ill-health due to 'masculine feelings of invincibility' and Moynihan (1987) reported that participants who were suffering from anxiety and/or depression did not express their symptoms because of their need to be controlled and silent about their emotions as a way of acting out the male script. As O'Brien (1990) suggests, where problems are recognised, men may be reluctant to articulate and disclose because it would make them less of a man.

Clearly, men's reluctance to acknowledge symptoms and seek help in medical settings as a whole informs understanding of father's non-attendance at Child Clinical Psychology appointments. Indeed, several authors (Lee & Owens, 2002; Petersen, 1998; Levant, 1995) suggest that the requirement for men to be strong, independent, and emotionally restrained, makes it particularly difficult for them to seek psychological assistance. A man who requires help with his emotions has failed in two of the fundamental tasks of successful male adulthood, emotional stoicism and self-reliance (Lee & Owens, 2002). O'Brien (1988, 1990) also points out that health care services may be perceived by men to be places for women. Psychology settings in particular might be seen as inappropriate by men who subscribe to a hegemonic identity because of therapeutic techniques such as expression, sharing and exploration of emotions. In these ways, hegemonic masculinity is constricting for men in times of illness, as Watson (2000) has argued, it appears to be how masculinity is conceptualised rather than maleness *per se* that reduces the well-being of men.

1.4.3 Men and Access to CAMHS

One recent study begins to explore the reasons for father non-attendance specifically within a Child Psychology setting. Walters, Tasker, and Bichard (2001) interviewed forty fathers whose children had been referred to a Child and Family Consultation Service. Fathers frequently reported their work as a reason for not attending clinic sessions, however, a number of further

factors were also highlighted. Feeling awkward, having their masculinity attacked, not wanting to admit to problems, children being closer to their mothers, and the clinic atmosphere as being controlled by women were all mentioned. It was also commented that men are generally more secretive, have less responsibility for the children, and that women are quick to take on the burden. Fathers also reported that their partners were more concerned than they were about their child's problems. Statistical analysis of the data revealed no significant differences in attendance rates according to; the child's age or gender, the family size, whether the father lived with the family, whether the father was in work, the families social class, or whether the mother worked.

1.4.4 The Clinician's Role in Engaging Fathers

As well as recognising the resistance of fathers to engaging in therapy, a number of authors have also referred to a resistance within mental health services to including these dads (Lee & Owens, 2002; Walters et al., 2001; Flynn, 1998; Streaan, 1997; Robertson & Fitzgerald, 1990). Streaan (1997) refers to the counter-resistance of therapists and suggests that fathers are subtly rejected before they attend clinic. Lee and Owens (2002) also allude to this suggesting that healthcare providers, on a subconscious level, might perceive their services to be predominantly for women. Dienhart (2001) expands on this and considers how clinicians might conceptualise men attending family therapy. It is felt that within our pervasive culture of 'hegemonic masculinity' help-seeking in men is equated with weakness, by men, by women, and by male and female clinicians (Deinhart, 2001). When men do seek help they may be seen by the therapist as unwilling participants having been coerced by others, or viewed in a negative light based on culture ideologies of masculinity (Robertson & Fitzgerald, 1990).

Streaan (1997) argues that because therapy is generally equated with the 'women's world', fathers may frequently feel they are not wanted in it. Services that are organised around office hours, and that employ mainly women, and work mainly with women and their children, create and maintain this impression. Walters (1997) argues that clinicians tend to assume that fathers are too busy to attend, and excuse them from attendance because they have work commitments or because they are not the prime caretakers of their children. It is suggested that clinicians should look beyond these reasons and attempt to work on making fathers feel that their role is far from peripheral. This ideal of clinicians taking a more pro-active approach to engage fathers is echoed throughout the literature with many authors raising awareness of the importance of fathers and advocating their active inclusion in CAMHS (Walters et al., 2001; Littlejohn & Bruggen, 1994; Carr, 1991; Hecker, 1991).

Despite current enthusiasm for engaging fathers, several authors (Flynn, 1998; Robertson & Fitzgerald, 1990) have suggested that clinicians find this difficult to put into practice. Flynn

(1998) reported that, although clinicians were verbally enthusiastic about the idea of engaging fathers and felt it to be of great importance, their behaviour did not always reflect this. The results of the study revealed that clinicians were much more likely to make initial contact with mothers, and to rely on mothers to make contact with the fathers if they did not attend a session (Flynn, 1998). On the rare occasion when a father would attend without the mother, substantial time was devoted to her whereabouts and the significance of her engagement tended to be emphasised, perhaps leaving the father with a feeling of lesser importance. Robertson and Fitzgerald (1990) speculate that perhaps clinicians do not feel skilled in working with fathers and therefore do not tend to actively seek out this experience. It is certainly the case that the literature offers far fewer therapeutic strategies and tools specifically designed for working with men than it does for women (Robertson & Fitzgerald, 1990).

In summary, it seems possible that some clinicians working with families feel that they lack skills to work with men and/or make assumptions that fathers are disinterested or unavailable. Acknowledging the possibility of resistance to the inclusion of fathers within mental health services may be of importance in gaining an understanding of the absent father phenomenon. If a father perceives resistance from professionals he might feel unwelcome or come to view the health service in a negative way and generally not be inspired to attend (Stearn, 1997).

1.5 Summary of the Literature Review

Having reviewed the body of literature that explores parental influences on child development, in particular with reference to child psychopathology, it was first noted that the role of father has traditionally been neglected. Despite increased interest in the last few decades, paternal influence remains under-represented within the field and the mother's influence on her children remains better understood. The literature that does exist provides evidence that paternal as well as maternal influences are significant in both normal and abnormal development of children. Reflecting the relative absence of the father on the paper of child development journals, it would appear that he is also absent in person in child clinics, especially those health service settings where child psychopathology is treated. The disparity between the father's role in his child's emotional adjustment and his lack of role within CAMHS has been noted by some authors as cause for concern.

Absent or present, research suggests that fathers' attitudes towards therapeutic interventions are particularly influential in determining engagement of the whole family and overall clinical outcomes. It appears that when fathers engage with CAMHS, and form positive perceptions of the clinician they are working with, the chances of a beneficial outcome improve. The difficulty for services is that fathers seem to be resistant to involvement in the therapeutic process.

Exploration of the wider literature of men's health has revealed that this phenomenon of the absent or resistant father is not confined to child mental health services but is found across a variety of medical and psychological settings. Many writers in the field of masculinity argue that the prevailing hegemonic conceptualisation of masculinity works against men expressing or sharing their emotions, and seeking help from another. Whilst it should not be presumed that the exact same mechanisms explain non-attendance at CAMHS appointments, this explanation has found some support in the results of a recent study. Walters, Tasker, and Bichard's (2001) exploration of the reasons for fathers' non-attendance within a Child Psychology setting revealed a number of explanations that are consistent with the masculinity theory. However, firm conclusions cannot be drawn from a single study and further investigation of this and other explanations of non-attendance are required.

Current research that specifically addresses men's help-seeking behaviour within CAMHS settings is limited in terms of both quantity and quality. Whilst quantitative studies provide useful insight, they are unable to reflect the potential complexity of the subject matter. Much of the research is also unclear about the amount of contact the research participants have had with psychology services. That is, it is not clear whether reasons for non-attendance are obtained before or after the non-attendance has actually occurred. In addition to the methodological flaws, current research also fails to locate the findings within the broader socio-cultural context of masculinity. As Galdas (2003) argues:

'Although 'gender-role' and masculinities are frequently postulated to play a role in the observed phenomenon [men's poor health and reduced access to health care] few studies have integrated this into their analyses and/or methodology and furthermore, even fewer studies investigate the perceived and real barriers that may prevent men from accessing health care.'

(p.27)

1.6 The Research Question

It seems that whilst most researchers who comment on father involvement in CAMHS settings agree that efforts should be made to engage fathers in the psychological treatment of their children (Walters et al., 2001; Littlejohn & Bruggen, 1994; Carr, 1991; Hecker, 1991), there is little research evidence that addresses the reasons why engaging fathers proves difficult or that guides clinicians in how this might be achieved. Given that the involvement of the father appears to be linked with positive outcome of clinical interventions in CAMHS, exploratory research

into the reasons for his non-participation should be high on the list of research priorities. Several important questions remain to be answered:

1. What are the factors that contribute to fathers' decisions of whether to access CAMHS when their child is initially referred?
2. What are the factors that contribute to fathers' continued engagement or dis-engagement when they access CAMHS?
3. What specific skills could help clinicians engage and work with fathers in CAMHS settings?
4. How do clinicians perceive the involvement of fathers in CAMHS and what impact do these perceptions have on how they work with fathers?

Clearly, it is not possible to cover each of these questions within a single research project. In light of this I have chosen to contribute to the investigation of the first question: the question of what factors contribute to fathers' decisions of whether to attend a CAMHS appointment when their child is initially referred. Although CAMHS teams are multidisciplinary in nature, it may be that fathers may have different perceptions of, and attitudes towards, the different health professionals within the team. An exploration of whether different factors contribute to fathers' attendance according to the professional they are invited to see is beyond the scope of this study. This study will therefore focus on the profession of Child Clinical Psychology.

1.7 The Aims of The Research

The present study aims to identify and explore factors that contribute to fathers' decision of whether, or not, to attend an appointment with a Child Clinical Psychologist when their child is referred. This is achieved through a focus group and individual interviews with fathers exploring their thoughts, attitudes, and beliefs about attending an appointment. A focus group and individual interviews with Child Clinical Psychologists explore the same issue from the perspective of the service providers. The research is based on the assumption that the way a father views the idea of therapy and contact with a psychologist is an important determinant of whether that individual will attend and engage with psychology services and make use of therapeutic space. It is hoped that research illuminating how fathers conceptualise psychological services and consider their potential attendance will provide clinically useful insight. Increasing understanding of the reasons why fathers might or might not attend an appointment will hopefully prompt service providers to consider and act on the problem of the absent father.

As Galdas (2003) aptly states:

'To work effectively with men, policy makers and practitioners need to have an understanding of how men interact with health services, health professionals, and most importantly themselves in times of ill-health, so to develop and deliver services that are appropriately aimed at a target group of the male population.' (p.27)

Given that a number of authors talk of the father as being the key to engaging a family (Walters et al., 2001; Littlejohn & Bruggen, 1994) attracting the missing father has the potential to increase the therapeutic efficacy of psychological interventions in CAMHS.

1.8 Overview of Thesis Structure

This thesis contains four chapters. The following chapter, **Chapter Two**, describes the methodological framework and research design. It includes a discussion about the use of qualitative methodology, a section on the researcher, ethical considerations, and the specific methods of data collection and analysis. **Chapter Three** describes the results of the analysis, group by group, describing and explaining each of the key themes that arose from the analysis in turn. Credibility checks on the analysis are described and reported. Following this, an overview of the main results briefly draws together the research findings and a model of the factors that influence fathers' decisions is presented. Finally, **Chapter Four** situates the research findings within the wider literature. Implications of the findings for policy and practice, methodological limitations, and suggestions for future research are discussed and the thesis is briefly concluded.

CHAPTER TWO

METHODOLOGICAL FRAMEWORK AND RESEARCH DESIGN

The following chapter is divided into three main sections. The first of these sections introduces the aims of the research project and the methodological approach through which these aims are met. Information about the researcher's own interests, experience, and background is also given. The second section contains an overview of the research design and describes the manner in which the data were collected. Finally, the third section of this chapter provides a background to Grounded Theory and describes how this method was used to analyse the research data.

2.1 A Background to the Study and Methodological Approach

2.1.1 The Aims of the Research Project

My interest lies in discovering why so few fathers attend initial appointments when their child is referred to a Clinical Psychologist. Detailed searching of the relevant literature has revealed a notable paucity of quantitative research, and no published articles utilising qualitative methodology. This is despite considerable evidence indicating that the non-attendance of fathers correlates strongly with poorer clinical outcomes. Clearly, the question of why fathers do, or do not, attend appointments with Child Clinical Psychologists is a potentially important one to answer. Given that this is a developing field of study it seems that an exploration of meaning from an individual point of view would be of greatest use to the research field at this stage in its development. A qualitative approach is also best placed to explore this phenomenon in depth, and to present individual differences and the potential complexity of the subject matter in a digestible format.

The present study is primarily concerned with exploring the meaning of fathers' utilisation of Child Clinical Psychology Services when their child is referred. The study aims to increase understanding of the fathers' thoughts, perceptions, and feelings about a forthcoming appointment, and to explore how these might impact upon his decision of whether or not to attend. It is hoped that this will allow the construction of a theoretical model of the processes involved in the fathers' experience of decision-making. A second and related aim of this research is to explore and gain insight into the ways in which Clinical Psychologists perceive and make sense of the attendance patterns of fathers invited to their clinics. Collecting data from these two sample groups will allow the similarities and differences between the fathers' reasons for attending, and the Clinical Psychologists' beliefs about why fathers do or do not attend, to be

compared. This also allows the problem of fathers attending appointments to be examined from both service-user and service-provider perspectives.

The qualitative nature of the research is reflected in the methods of data collection; focus groups (n=2) and in-depth interviews (n=8), and in the method of data analysis; Grounded Theory. This is also reflected in the way in which I have approached the research. I have adopted the position that all research has an inherent personal component, and have sought to acknowledge and reflect upon how my own values, interests, and experiences have influenced the research process. Much of this research is written in the first person as I have found this has helped me to reveal rather than conceal the level of my personal involvement and engagement (Banister, Burman, Parker, Taylor, & Tindall, 1994). This is a common practice in the writing of qualitative research (Banister et al., 1994).

The following chapter describes and introduces the methodological approach that has been adopted for the purpose of this research.

2.1.2 Information About the Researcher

Before introducing the methodology to this study in greater depth, I feel that it is important to give a brief background about myself. Guidelines for the publication of qualitative research recommend that the researcher is open about any background experiences, interests, or values that may be relevant to their research (Elliot, Fischer, & Rennie, 1999). The reason for this is that it allows readers to consider the researcher's position and how this may have influenced their understanding and interpretation of the data.

I am currently a Psychologist In Clinical Training (P.I.C.T.) at The University of Leeds, and have completed this study over the last two years of the Doctor of Clinical Psychology Training Programme. As a white, middle class, female psychologist I was aware that my gender, my cultural background, and my own beliefs about fatherhood, and the role of Clinical Psychology, would not only influence some of my questions at interview and my interpretations of the transcripts, but would also influence the way in which the participants might respond to me. It was possible that participants would feel uncomfortable about speaking openly during their interviews and that this could impact upon the quality of my data. I was aware of this issue, but also of the way in which the differences between myself and my potential research participants could provide a means of maintaining a position of enquiry (Burnham & Harris, 1996; Cecchin, 1987). I felt that overt differences between myself and the participants in my study might reduce the extent to which we were drawn to making assumptions about shared beliefs and

understandings. Thus it could potentially open up the discussion to include a more full description of the participants' thoughts and experiences.

Despite my efforts to maintain a position of unbiased enquiry, I was aware that my approach to this area of work would not, and could not, be value-free. I am aware that I am, in general, in favour of fathers attending appointments with Clinical Psychologists and being involved with their children in a more global sense. I also am aware that I have been frustrated at times during my training when I have been unable to engage fathers in my work with their child. There have been several occasions on which I have specifically invited fathers to attend appointments but despite this have only ever met the mother of the child. It is these experiences that spurred my own interest in this area of research. I became keen to discover, and to understand from the perspective of the father, why they would not wish to become involved when their child was being seen by a Clinical Psychologist.

2.1.3 The Suitability of a Qualitative Approach

For the past two centuries, a dominant approach to enquiry has been the 'Scientific Method'. This method holds within it what is referred to as an objectivist, realist, positivist, or 'received' view of the world (Guba & Lincoln, 1994). These labels describe the central belief that there is a rational, real, and quantifiable world amenable to discovery through objective study using rigorous quantitative methodology. Quantitative research tends to employ heavily structured means of data collection where topics are fixed by the questionnaire, experiment, or interview format. This type of research concentrates its efforts in establishing broad trends and cause and effect variables, and quantifying these using statistical methods. What this type of research does not turn its hand to is the gaining of insight into the quality and texture of human experience (Willig, 2001). It is here that qualitative methodology has something to offer, and, in the last two decades we have witnessed a dramatic increase in the use of qualitative methodologies, both across various disciplines and several countries (Elliot et al., 1999).

In contrast to those advocating a positivist or received philosophy, qualitative researchers do not claim to have privileged access to an objective reality, or to be able to set aside their own perspectives. Indeed, most qualitative researchers argue that it is impossible to truly separate oneself from the world of objects in order to study them (Draucker, 1990; Heidegger, 1962). As Henwood and Pidgeon (1992) acknowledge, '*the person is always present*' (p.105). Research activities are inextricably tied up with the interests and life experiences of the researcher and woven into every activity involved in the process of research (Burr, 1995). Rather than attempting to eliminate this subjectivity, the qualitative researcher instead attempts to recognise and openly identify their own pre-conceptions that they bring to their research. Henwood and

Pidgeon (1992) describe this as the 'reflexive approach', an approach that other authors (Banister et al., 1994) have referred to as being the most distinctive feature of qualitative research.

The methodological approaches employed by qualitative researchers are diverse and include Empirical Phenomenology, Ethnography, Discourse Analysis, Conversation Analysis, Ethnomethodology, Narrative Inquiry, Social Action Research, and Grounded Theory (Elliot et al., 1999). Although the different approaches vary in their epistemologies, they share in common their purpose of exploring meaning in depth in order to enrich understanding. As Elliot, Fischer and Rennie (1999) argue:

'The aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage, and live through situations.' (p.216).

Reflecting the aim to explore meaning and experience in depth, qualitative methods of data collection are designed to incorporate flexibility (Richardson, 1996). This allows unusual avenues to be pursued and explored, and encourages the participants to freely express their thoughts and feelings along with the complexities and contradictions often inherent in the way individuals perceive the world (Rubin & Rubin, 1995). Whilst qualitative research methods do not immediately lend themselves to the generation of widely 'generalisable' results, they instead provide an opportunity to develop deeper theoretical understandings of important psychological phenomena in specific contexts and with specific populations (Elliot et al., 1999). This is especially the case when, as in the present study, the area of research is relatively new or unexplored and the current theory is undeveloped (Silverman, 2000). Yardley (2001) has also suggested that the qualitative approach can be particularly useful in healthcare research.

'With respect to our basic understanding of the experience of health and illness, qualitative methods are generally best suited for inquiring into subjective meanings and their socio-cultural context' (Yardley, 2001, p.8).

2.1.4 Guidelines and Quality in Qualitative Research

In recent years several authors have attempted to formulate quality standards for qualitative research (e.g. Elliot et al., 1999; Stiles, 1993; Mishler, 1990; Lincoln & Guba, 1985). It is suggested that introducing explicit guidelines for the conducting and reporting of qualitative enquiry will be of benefit to this evolving and expanding field. Elliot, Fischer and Rennie (1999) argue that the use of guidelines for qualitative research can help to maintain high standards by encouraging researchers to examine their work more reflectively. Further to this, the guidelines

themselves suggest appropriate criteria against which the standards of qualitative research can be judged. This highlights the understanding that it is not appropriate to evaluate qualitative studies through the same criteria as their quantitative counterparts (Elliot et al., 1999). It is argued that providing researchers, especially those who are unfamiliar with qualitative methods, with an accessible means of evaluating research papers will foster more valid reviews of qualitative research. In this way, the existence of quality standards contributes to a wider understanding and acceptance of qualitative methods.

Elliot, Fischer, and Rennie (1999) reported that a number of established qualitative researchers wrote to them with concerns about the development of explicit guidelines. These researchers (not named by the authors) argued that imposing principles of practice on qualitative researchers is fundamentally at odds with the spirit of qualitative enquiry. It was felt that there is a risk that guidelines could stifle the potential richness of the emerging qualitative tradition. Barbour (2001) suggests that guidelines and checklists can indeed be counterproductive if they are used prescriptively. It is noted that qualitative methods vary enormously in their philosophical stance, methodologies employed, and overall aims. This may mean that it is not entirely appropriate to use a single yardstick to measure their success (Barbour, 2001). Elliot and his colleagues (Elliot et al., 1999) argue that the evaluative guidelines are subject to continuing revision as the qualitative tradition continues to evolve and that it is not suggested that they are used in a rigid manner. These authors (Elliot et al., 1999) emphasise that the guidelines are intended to serve qualitative researchers by *'helping them to examine their research more reflectively at both design and writing stages'* (p.218). Indeed, as a novice researcher I have found the guidelines published by Elliot and his colleagues (Elliot et al., 1999) useful in the designing of my research, and in maintaining awareness of the need for reflexivity as a researcher. I have, however, heeded the warnings (Barbour, 2001; Elliot et al., 1999) that guidelines can quell creativity if used rigidly, and have been careful to maintain awareness of this issue.

2.2 Method of Data Collection

2.2.1 Overview of the Research Design

The present research incorporates two studies completed in parallel. Each is aimed at exploring the meanings of fathers' attendance or non-attendance at appointments with a Child Clinical Psychologist. The first study examines this phenomenon from the perspective of the father, whereas the second study explores the perspective of the Child Clinical Psychologist. The two studies each comprised of a pilot focus group followed by a number of in-depth individual interviews. This method provided four sources of data. Each source of data was analysed separately using Grounded Theory methodology giving multiple perspectives of the same

problem. It was then possible to compare and contrast fathers' and psychologists' perceptions, experiences and ideas about the attendance of fathers at Child Clinical Psychology appointments. The design is illustrated in the table below.

Table 1: Overview of Research Design

Study One	Study Two
<p>PILOT: FOCUS GROUP</p> <p>Opportunistic sample: Fathers who had recently been positively engaged with a Child Clinical Psychologist (n=2)</p>	<p>PILOT: FOCUS GROUP</p> <p>Opportunistic sample: P.I.C.T.s who had recently completed a placement working with children and their families (n=4)</p>
<p>INDIVIDUAL INTERVIEWS</p> <p>Fathers who had been invited to attend an initial appointment with a Child Clinical Psychology (n=3)</p>	<p>INDIVIDUAL INTERVIEWS</p> <p>Qualified Clinical Psychologists who are currently working with children and their families (n=5)</p>

2.2.2 Care and Protection of Participants

Ethical Approval

In designing and completing this study, the protection of the psychological well being of potential participants was a major consideration. Ethical approval was sought and gained from the two participating NHS Trusts (Leeds Teaching Hospitals NHS Trust Local Research Ethics Committee and Wakefield Health Authority Local Research Ethics Committee) before any approach was made towards recruiting participants (Appendix 1a, 1b). I was also careful to follow the recommendations set out in The British Psychological Society publication 'Code of Conduct, Ethical Principles and Guidelines' (BPS, 2000) which specifies what is considered to be acceptable research practice. The research design was considered by the committees to be appropriate, and no amendments were necessary.

Information and Informed Consent

All participants were given a leaflet clearly explaining the nature and purpose of the research and what their role would be if they chose to participate (see Appendix 1a and 1b). The rights of the participants were outlined clearly. These included the right to confidentiality, the right not to

answer questions, and the right to withdraw at any stage without giving a reason for doing so. Immediately before each interview or focus group, the researcher reiterated this information and asked participants to read and sign a second consent form (see Appendix 1c). Participants were also offered the opportunity to ask questions about the research both before and after their interview.

Dealing with Sensitive Issues

I felt that the subject matter of the research was unlikely to cause significant distress for the research participants, or their families. In line with the qualitative philosophy of the research, all the questions were designed to be broad, and to allow the participant to tell their own story in their own words. This meant that research participants had a great amount of control over what was discussed. However, this freedom within the research design also meant that the material that was raised could not be predicted. I therefore felt that it was important to consider the possibility that emotionally sensitive topics could be discussed, and to plan how this would be handled. I decided that it was best to make clear, at the beginning of each interview, that I was there as a researcher and not as a Clinical Psychologist. Participants were informed that if the interview did raise some distressing material for them and they felt the need to discuss it further there was a list of numbers they could contact for support.

On a positive note, I discovered through my literature review that when fathers have been interviewed in similar studies to this, they have responded positively and have been more willing to engage with the service to which their child has been referred following the research interview (Walters, 1997; Walters, Tasker, & Bichard, 2001). Given the association between positive father-engagement and favourable clinical outcome (Bennun, 1989) it would seem that fathers and their families stood to gain from their participation in the research.

Confidentiality

All data collected as part of this research was treated with the strictest confidentiality. The data were made anonymous by removing names and identifying details during transcription, and by marking tapes with the interview number and date only. All information whether on tape, paper, or CD-ROM was stored in accordance with the Data Protection Act (1998). Research participants were given the names of supervisors involved in the research, and were informed that a secretary would undertake the transcription only after signing a confidentiality agreement.

Personal Safety

Throughout the design of the research, my own personal safety as a researcher was considered carefully. Two focus groups were conducted and, in each of these, a fellow colleague was recruited to co-facilitate. This is generally considered to be good practice in running groups, but also addressed some of the issues of safety as the group was conducted in a quiet and private place in the evening. Individual interviews were also conducted and in the case of these I was a lone researcher, on occasion visiting the participants own home in the evening. As a security precaution, a scheme was developed by which a third party was contacted immediately before and after each interview. There was no occasion on which I felt in any kind of danger throughout the research, as all participants were friendly and hospitable.

2.2.3 Pilot Study: The Focus Groups

Focus Groups in Qualitative Research

In planning this research, I was aware that I needed to prepare an informed interview guide for the qualitative interviews that I planned to conduct. I needed to broach the right topics in the right way to gain maximum information from both the fathers and the Clinical Psychologists during their interviews. Although my personal experience as a P.I.C.T., and my review of the relevant literature, provided some clues as to what I should be asking my participants, I felt that it would also be invaluable to ask those more experienced in the realms of fatherhood and of Child Psychology. I chose to do this by conducting a focus group as a pilot stage in each of the two studies.

The focus group interview has been a popular research technique in marketing and business for over forty years, and is beginning to be utilised more frequently within health service settings (Vaughn, Shay-Schumm, & Sinagub, 1996; Kitzinger, 1995). Krueger (1986) describes focus groups as '*Organized group discussions which are focussed around a single theme*' (p.1). A focus group usually involves between four and twelve individuals who have been brought together for the purpose of the research by virtue of something that they have in common. This may be a general characteristic, for example an age between 12 and 15 years, or may be more specific, such as those who play computer games for more than 4 hours per week. The purpose of the group is to address the selected topic through ordinary conversation, along with its diversions, twists, and controversies (Kreuger, 1994).

In considering the purpose of a pilot study there were several characteristics inherent in focus group methodology that appealed. First, on a pragmatic level, the focus group was to be an

initial, information gathering stage of the research and there would therefore be a limit to the investment of time I could dedicate to it. To individually interview the same number of participants would place much higher demands on myself as the researcher conducting the interviews through to analysis. A second consideration was the nature of the data I could collect from a focus group. Rather than aiming to reach consensus, the purpose of a focus group is to create an arena in which a full range of opinions can be aired (Keegan & Legard, 2002). Given that the purpose of this pilot was to generate themes and ideas to be explored in greater depth on an individual level, the emphasis on multiple perspectives was ideal. I felt that perhaps the potential for spontaneity in the group, and for group members to stimulate reflective and creative thinking in each other, would provide a useful collection of salient topics that I could broach in my subsequent interviews. Finally, I felt that it would be useful to use the focus groups to pilot the kind of questions I would be asking, and the language I was intending to use, in the later individual interviews.

The use of focus groups as pilot studies preceding individual interviews was supported by Keegan and Legard (2002) in their recent two day course 'Focus Group Techniques For Qualitative Research' held at the National Centre for Social Research (7th-8th October, 2002). These authors (Keegan & Legard, 2002) suggested that focus groups are especially useful forums in which issues and ideas can be raised, and in which the participants' use of language can be explored. One potential disadvantage of using focus group methodology is the limited opportunity to collect data at an individual level or to explore specific issues or individuals ideas in great depth. It is also possible that group dynamics and processes might inhibit full and open participation and lead to a limited data set. By using both individual interviews and focus groups in the present research, it is possible to take advantage of the strengths of each approach and limit the effect of specific disadvantages on the final results.

Focus Groups in the Present Study

In the present research, two focus groups were conducted as a preliminary stage. Their purpose was to inform the development of the interview guides to be used in the subsequent individual interviews, and to experiment with the interview style. The focus groups also provided an opportunity to pilot some of the questions I would be asking in the main body of the research, and to check that the terms and language that I was using were appropriate. The two focus groups were conducted with (a) fathers who had recently been positively engaged with a Child Clinical Psychologist, and (b) P.I.C.T.s who had recently completed a placement in which they worked with children and their families. These two population samples are not the same as those that I intended to access in the later individual interviews. Instead these represent largely opportunistic samples. I was aware that recruitment of participants for the main body of the

research could be difficult so I felt that it was important to avoid diminishing this population size through pilot study. I also felt that targeting and recruiting the populations for the focus groups would be relatively easy making them a pragmatic choice given the constraints of time. The aims and rationale of the two focus groups will now be discussed in turn.

The focus group with fathers was designed to consist of between six and eight fathers who had been positively engaged with a Child Clinical Psychologist following the referral of their child. The purpose of the group was to explore how these fathers had chosen to become involved with the Clinical Psychologist. Although these fathers were perhaps atypical in their attendance, it was felt that they could potentially provide highly valuable insight. It was felt that these fathers who were already engaged with psychology services might be easier to recruit to the research and also might feel more able or more at ease discussing any fears or worries they had had before attending. Firstly, the fathers had experience of talking with a psychologist, and therefore might feel less daunted by meeting one in the context of the research. Secondly, the fathers were aware that the research was aiming to understand non-attendance. Having attended already, these fathers might feel that they are viewed positively and as a result of this feel safe to express their ideas and experiences. Overall, it was felt that the focus group presented an important opportunity to gain insight into the kind of difficulties or dilemmas that a father might face when deciding whether to attend the appointment.

The focus group with P.I.C.T.s was designed to consist of four P.I.C.T.s in their second year of training who had recently completed a clinical placement in which they worked with children and their families. The purpose of the group was to explore these participants' experiences of fathers attending their clinic appointments, and to elicit their thoughts and ideas about why fathers might or might not attend. As a P.I.C.T. myself I was easily able to gain access to members of the second year to invite them to participate. It was also the case that members of the year group knew each other well and were often required to discuss and reflect on clinical topics in small groups as part of the training. It therefore seemed likely that participants recruited from this population would be well placed to discuss and reflect on their own experiences, as well as perhaps those of their supervisors.

Although the focus group data was intended for use only as a pilot, analysis of the data also provided useful insight in its own right. The results of the focus groups will therefore be discussed in the data analysis and results chapter along with the data from the individual interviews.

Selection and Recruitment of Participants

Describing first the focus group with fathers, the population from which potential participants were selected was fathers who had recently engaged with a Child Clinical Psychologist in one of the CAMHS teams in Wakefield and Pontefract Community Trust. All participants were healthy volunteers, who were English speaking. Several Child Clinical Psychologists within the Trust agreed to introduce the research to fathers with whom they were currently working, or who they had seen within the last six months. Potential participants were given a letter inviting them to participate in the focus group, and an information booklet detailing the nature and purpose of their involvement should they agree to take part. The booklet also contained a consent form and stamped addressed envelope, which participants were asked to return if they wished to become involved in the study (a copy of these items can be found in the appendix). Participants who agreed to take part were contacted five days before the focus group to confirm their attendance.

Potential participants for the focus group with P.I.C.T.s were selected from the population of P.I.C.T.s in the second year of their clinical training at The University of Leeds Doctor of Clinical Psychology Training Programme. All participants were healthy volunteers, who were English speaking and who had recently completed a placement in which they worked with children and their families. Potential participants were given an information sheet detailing the nature and purpose of the study and a consent form to return if they wished to participate. The year group were aware that only four participants were needed. At this time all the P.I.C.T.s were embarking on their own doctoral theses. It is likely that they self-selected on the basis of being interested in qualitative research and focus group methodology.

Focus Group Settings

The two focus groups were held in different settings in order to minimise inconvenience to the participants. The setting chosen for the focus group with fathers was a community centre attached to a church in the Wakefield area. This provided a quiet and private place to meet, adequate parking, and was located in the same geographical area from which participants were recruited. In this setting it was also possible to conduct the group in the evening making it easier for fathers who work office hours to attend. The focus group with P.I.C.T.s was conducted in a family therapy centre at The University of Leeds. This setting also provided a quiet and private place to meet, and was located within The University of Leeds campus where the P.I.C.T.s are based. The focus group with P.I.C.T.s was held immediately after lectures so that participants did not have to make an extra journey to the campus.

Interview Procedure

The purpose of both focus groups was to facilitate free flowing conversation between the participants. It was therefore unnecessary to design a detailed interview schedule or structure as this would be likely to impede the natural flow of conversation. Instead, interview guides were constructed and used flexibly ensure coverage of relevant topics without imposing structure or order on the conversation (Appendix 3a, 3b). Topics were introduced by the facilitators of the group at times when the conversation became stilted, or if the group did not naturally come to discuss particular aspects of a subject that were of interest. Prompts were used where necessary to both encourage the group to talk about a subject matter in greater depth, and also to encourage quieter members of the group to speak. Both focus groups were audio-recorded.

The focus group with fathers was facilitated by myself and another P.I.C.T. on The University of Leeds Doctor of Clinical Psychology Training Programme. The focus group with P.I.C.T.s was facilitated by myself and one of my research supervisors. In both groups the role of the facilitators, or moderators as they are commonly called in focus groups, was to maintain a focus on the research topic without closing down new avenues of information, to encourage all participants to contribute, and to ensure that the group environment remained a safe and reasonably comfortable place for all the participants. Up to one and a half hours was allocated for each of the focus groups, however, in practice they both ran for just over one hour. At this point, the participants seemed to have exhausted what they had to say. This may have been a consequence of the size of both focus groups (Focus Group with Father n=2, Focus Group with P.I.C.T.s n=4).

Transcription of Data

The audio-recorded data from each of the focus groups was transcribed into a word processing document for the purpose of analysis. The transcription was carried out by a secretary employed by The University of Leeds who signed a confidentiality agreement before being given the tapes. Identifying names and locations were changed to preserve anonymity. Pauses in speech, unless marked, were not recorded, though laughter was noted so that humour could be put into context. Line numbers were included in the transcripts as this allowed information to be easily identified during analysis. Transcripts were checked against the audio-tape to ensure accuracy and were corrected where necessary. A two page example of the transcribed data from each data set is provided in Appendix 4(a) and Appendix 4(b).

2.2.4 Main Study: The Qualitative Interviews

Interviews in Qualitative Research

The semi-structured interview is a tool commonly applied in qualitative research. It is a highly flexible method that is capable of producing data of great depth, and is one that most research participants feel comfortable with as they have an idea about what to expect (King, 1994). King (1994) describes the purpose of the qualitative interview as being '*to see the research topic from the perspective of the interviewee, and to understand how and why he or she comes to have this particular perspective*' (p.14). To achieve this goal, the research participant is encouraged to speak freely and openly. In qualitative interviews, the interviewee is not seen as a subject, but rather a participant who actively shapes the course of the interview.

The qualitative research interview, unlike its quantitative counterpart, does not consist of a formal schedule of fixed questions. Instead, the researcher follows a flexible interview guide that lists possible topics from any preliminary work, the research literature, and from the researchers experience (King, 1994). As there is no predetermined order in which topics should be broached, it is the role of the interviewer to address the topics contained within the interview guide where they fit naturally into the course of the interview. This style of interview is one that allows the topic under investigation to be redefined. That is, the researcher is free to formulate questions around new ideas that emerge, and to follow up interesting leads (Kvale, 1996). In addition to this, the interview may be modified as it is used in the research so that a topic that arises spontaneously in one interview may be included in the next (King, 1994).

A number of authors have suggested that semi-structured interviews are suitable where contradictions and complexities of views and experiences are likely to be explored (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998; Banister et al., 1994). I felt that the issues for a father deciding whether to attend an appointment with a Child Clinical Psychologist were likely to be of this nature. A semi-structured interview method would perhaps be less threatening for a father than a focus group environment, and would also mean that the timing of the data collection could be entirely of his choice. This seemed especially important given the difficulties in recruiting fathers made explicit within the research literature. In all, the qualitative interview was judged to be the most appropriate method to collect data from fathers who have not yet had any experience of Child Clinical Psychology. As it is customary to record and transcribe qualitative material, this method would also provide me with the textual data I needed in order to conduct analysis using Ground Theory (Glaser & Strauss, 1967).

Interviews in the Present Research

Following the analysis of the data derived from the two focus groups, a second stage in the research was to conduct individual interviews with two target populations within Leeds Teaching Hospitals Trust. Those were (a) fathers whose child had been referred to CAMHS, and who have been invited to attend a forthcoming appointment with a Clinical Psychologist, and (b) qualified Clinical Psychologists who were working with children and their families. The style in which these interviews were conducted, and the questions asked, was informed by several sources. My experience of the focus group, and the analysis of that data, was a strong influence. Topics were also drawn from the research literature, and from my own experience. In particular, I had learnt that fathers find it much easier to reflect on the behaviour of other fathers than on their own. Following conversations about other fathers, some then feel more able to bring their own personal reactions into the interview. I had also learnt that it is easiest to elicit the thoughts and ideas of Clinical Psychologists when asking them to recall specific examples.

The purpose of the interviews with fathers was to explore their experiences of deciding whether or not to attend their forthcoming appointment with a Child Clinical Psychologist. The purpose of the interviews with Clinical Psychologist was to elicit their thoughts, feelings and ideas about fathers attending their clinic appointments. The method of data collection will now be described.

Selection and Recruitment of Participants

Selection and recruitment of participants for the interviews with fathers took place through five CAMHS teams in Leeds Community Teaching Hospitals Trust. At least one Child Clinical Psychologist worked in each of the teams that took part in the research. The research population consisted of the fathers of all referrals to the CAMHS teams that had been allocated to a Child Clinical Psychologist and who met the following inclusion criteria: (a) the referred child lives with their biological father, (b) the parents have not been involved with a Child Clinical Psychologist in the past, and (c) the father is English speaking. It was felt that the study should focus on biological fathers as this made it possible to provide the potential participants with clear inclusion criteria and avoid confusion. It would also have been difficult to define more open inclusion criteria as some judgement would have to have been made about when and how someone becomes equivalent to a father. The specification that parents should not have had previous experience of seeing a Child Clinical Psychologist reflects the aim of the research to look at fathers expectations and beliefs about seeing a psychologist before this actually occurs. It was unfortunately not possible to interview participants who were not English speaking as the evolving and exploratory nature of the interviews, and the importance of using the fathers exact words, meant that recruiting another interviewer or an interpreter would not have been ideal.

Participants were selected and recruited from the population in the following way. Firstly, all referrals that were allocated to a Clinical Psychologist in the CAMHS referral meeting were examined to see whether they met the research criteria. All those considered to be part of the research population were invited to participate. The fathers were each sent an information booklet about the research, and a consent form that they were asked to return. The inclusion criteria for the study were clearly stated. If there was no reply from participants after three weeks, a follow-up letter enquiring whether a decision has been reached and a further recruitment pack was sent out where time allowed it. All research participants were interviewed before their first appointment with a Child Clinical Psychologist.

The selection and recruitment of participants for the interviews with Child Clinical Psychologists took place from the same five CAMHS teams from which the fathers were recruited. There were seven Child Clinical Psychologists working in the teams at the time of recruitment, and the entirety of this population were invited to participate in the research. Each Child Clinical Psychologist was sent an information booklet about the research, and a consent form that they were asked to return if they wished to participate. If there was no reply from potential participants after three weeks, a follow-up recruitment pack was sent out.

Interview Setting

Every effort was made to offer the research participants a time and place to meet that was convenient for them. Woollett, White and Lyon (1982) suggest that convenient timing and direct invitation increases success in recruiting fathers. Options given included the participant's home, their work, or in a local clinic where rooms could be booked. If participants chose to travel to an interview, their expenses were reimbursed.

Interview Procedure

As consent forms were returned, one-hour qualitative interviews with the participants were arranged. An interview guide was prepared prior to the meeting, and included topics derived from the research literature, my own experience, and the focus group data (see Appendix 3a, 3b). The guide was used flexibly, like most qualitative interviews there was a low degree of structure, and a preponderance of open questions to encourage the participant to follow their own agenda. The gathering of interview data was conducted hand-in-hand with the process of data analysis. The purpose of this approach was that, as themes or ideas arise in the course of the interviews, they are incorporated into those that follow and further explored.

In conducting the interviews, I felt that time keeping was important and the interviews were kept to a maximum of one hour. This was both for the benefit of those who had agreed to give up one hour of their time, and also for the purposes of transcribing and analysis. In practice research participants did not seem to want to talk for longer than this allocated time. All the interviews were audio-recorded and transcribed into a word processing document (see 2.2.3 Transcription of Data).

2.3 Method of Data Analysis

The method of qualitative analysis chosen for the purpose of this study was Grounded Theory, an approach originally developed by sociologists Glaser and Strauss (1967). In this section I will begin by discussing the reasons for my choice of methodology. Following this I will provide a brief explanation of the theoretical background of Grounded Theory, and specify the school of thought to which I subscribe. Finally, I will describe the process of coding and theory development that has been adopted for this piece of research.

2.3.1 A Background to Grounded Theory

The choice of Grounded Theory for this study was influenced by a number of factors. Firstly, Grounded Theory as a method has been well established in other disciplines, and has been used more frequently in psychological research in recent years (Henwood & Pigeon, 1992). This has meant that there has been a wide range of publications by which I could be guided. Secondly, its analytic techniques are rigorous and systematic, and are supported by several computer packages. I felt that this would be useful to me as a novice qualitative researcher, as my approach could be more structured than if I had opted for a more interpretative methodology. Thirdly, in using Grounded Theory, there would be several sources of support and guidance available to me. Two of my supervisors had experience in using this method, and several of my peers were also attempting to follow this approach for the first time. Finally, and perhaps most importantly, Grounded Theory is an inductive process in which theory is formed from, and grounded in the data. Rather than testing specific hypotheses, or comparing and fitting the data into an existing model or theory, the aim of Grounded Theory is to build bottom-upwards from the data itself into theoretical understanding. As Grounded Theory is conducted on textual data, this approach was compatible with the products of my data collection (the transcripts), and also the aim of my study to build up theory about how fathers decide whether to attend appointments with a Clinical Psychologist.

Having decided that Grounded Theory was a useful methodology through which to approach my research question, a decision then had to be made about which version of Grounded Theory I was going to subscribe to. Since Glaser and Strauss (1967) published 'The Discovery of Grounded Theory' the two have proposed different ideas regarding how Grounded Theory should be practised (Willig, 2001). Whilst Glaser (1978, 1992) proposes that Grounded Theory should be a purely inductive process, Strauss and Corbin (1990) argue that researchers actively construct the data and suggest the addition of a more prescriptive and deductive element to the methodology: the use of a coding paradigm (Willig, 2001). For the purpose of this piece of research I have decided to be guided more by the structured approach of Strauss and Corbin (1990, 1998). This is the approach that is compatible with my decision to take a social constructionist stance in relation to my research and accept that, as the researcher, I am unable to truly separate myself from the world of objects which I am part of and which I study.

The social constructionist approach to which I subscribe is that advocated by authors such as Charmaz (1990, 1995), Dey (1999), and Pidgeon and Henwood (1997) who have challenged the traditional and positivism-compatible epistemology of Grounded Theory. Willig (2001) notes that subscription to positivist epistemology has been one of the most widely raised criticisms of Grounded Theory in that it allows researchers to side step the question of reflexivity. By approaching Grounded Theory from a social constructionist stance these concerns can be addressed (Willig, 2001). The objectivist currents running through the original Grounded Theory (Glaser & Strauss, 1967) are evident in the way that it is described as a process that involves *discovering* theory from data as it *emerges*. This description implies that the representations of the research phenomena are already in existence and can be directly perceived by the researcher. Authors such as Charmaz (1990), Dey (1999) and Pidgeon and Henwood, (1997) have argued that Grounded Theory does not capture social reality; categories do not simply emerge from the data because they do not exist before the process of categorisation. Instead categories and theories are actively constructed by the researcher through their interaction with the data, the resultant theory is better described as a social construction of reality (Willig, 2001). As Dey (1999) argues '*Even if we accept the (doubtful) proposition that categories are discovered, what we discover will depend in some degree on what we are looking for*' (p.104). That is, whatever emerges from observation depends upon the observer's position within it (Willig, 2001).

2.3.2 Grounded Theory Method

The Coding Process

Grounded Theory is conducted on textual data. To begin the process, the transcript is read carefully a number of times in order that the researcher becomes familiar with the content

(Charmaz, 1995). In the margins of the transcript, the researcher notes what they see to be the emerging² themes in each meaning unit. A meaning unit refers to a unit of dialogue that is defined by its content rather than the length of utterance (Henwood & Pigeon, 1994). It could be one word, a few words, a sentence, or short paragraph, that in itself could be said to have meaning (Willig, 2001).

The next stage is to group together meaning units that describe the same, similar or related phenomena to form codes. If a meaning unit appears to fit into more than one code, it is usual to place it in each during this process of open coding. If a meaning unit is ambiguous it is kept separate for further examination later in the process of analysis. Open coding is usually achieved either manually by using index cards or by using a computer software package. In the present study, the option of using computer software was explored and rejected because it felt like the programme did not allowed enough flexibility in the evolving coding process. Instead, the coding was conducted manually. Rather than employing the standard method of grouping meaning units by copying them verbatim onto index cards, in this case the copy and paste functions within my word processing package were used to group them in documents on my computer. This meant that it was easy to locate and organise the data and also saved time because the meaning units did not have to be copied out in handwriting each time they were grouped. As would be the case when using index cards, the computer documents were labelled with the name of the code, and each meaning unit was labelled with the transcript and line number for identification. This is useful as it is often necessary to return later to the transcript for contextual information that could clarify meaning. This initial open coding process produces a large number of codes that require further analysis.

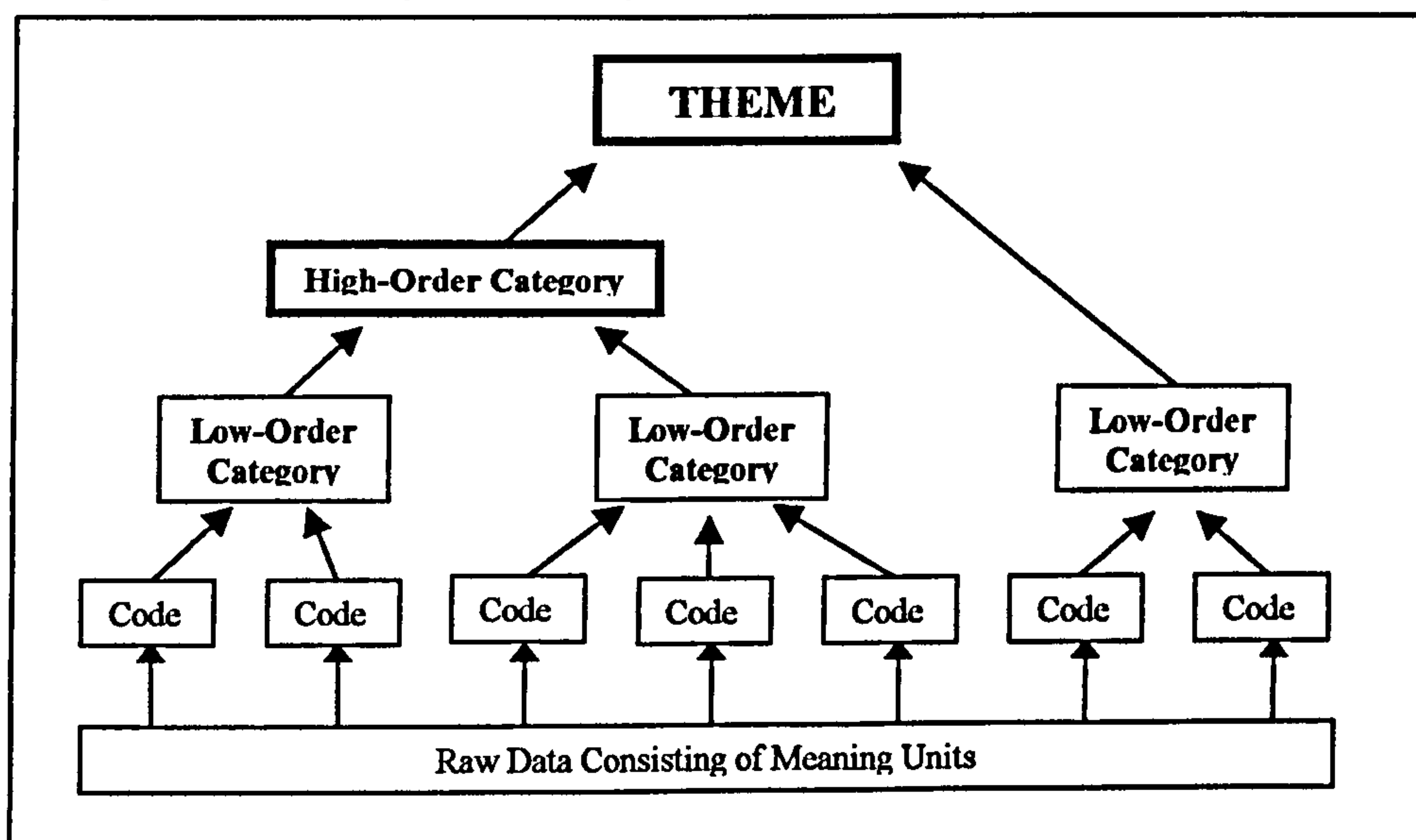
Axial coding is defined by Strauss and Corbin (1998) as *'the process of relating categories to their sub-categories'* (p.123). In axial coding, the codes developed in the initial open coding process are grouped together to form low-order categories that are in turn grouped together to form high-order categories. This occurs as the researcher becomes aware of overarching thematic similarities that could draw them together. As low and high-order categories are developed, they are then scrutinised in order to see whether they can be combined into themes that represent a higher still level of abstraction. It is this axial coding that helps define categories by their properties and dimensions and identifies links between them, and from this that the researcher constructs theory.

² I have chosen to use the word *emerging* because it seems to me to fit my experience of data analysis. The more one immerses oneself in the data, the more meanings come to light. I acknowledge, however, that they do so in the context of my own position with regards to how I construe the world and this particular piece of research.

Strauss and Corbin (1998) recommend that data gathering and data analysis are conducted hand in hand. The purpose of this is so that emerging themes can be explored in subsequent interviews. As data is gathered from a number of interviews, it becomes possible to assign meaning units to categories that have already been identified. It also becomes possible to move meaning units that have already been placed into a category into one of the new categories if it explains the phenomena better. Sometimes, two or more categories are similar and, to reduce the data to manageable proportions, they can be collapsed together. In this situation the new category is given an amended label that describes conceptually the categories subsumed within it and each individual meaning unit is re-checked to ensure good fit. Forcing meaning units into categories is avoided. As with the open coding, the copy and paste functions in my word processing package were used to build up and relate the categories and themes throughout this process.

The figure below illustrates the hierarchical manner in which the data is represented through Grounded Theory analysis. The codes are the product of open coding, and consist of meaning units that have been grouped together. These are closest to the data. Low-order categories represent a higher level of abstraction and encompass two or more codes. High-order categories draw together different low-order categories, and occasionally individual codes. Finally the theme represents the highest level of abstraction, and is furthest from the data. Themes may subsume a number of low and high-order categories and also individual codes that are not subsumed by any of the categories.

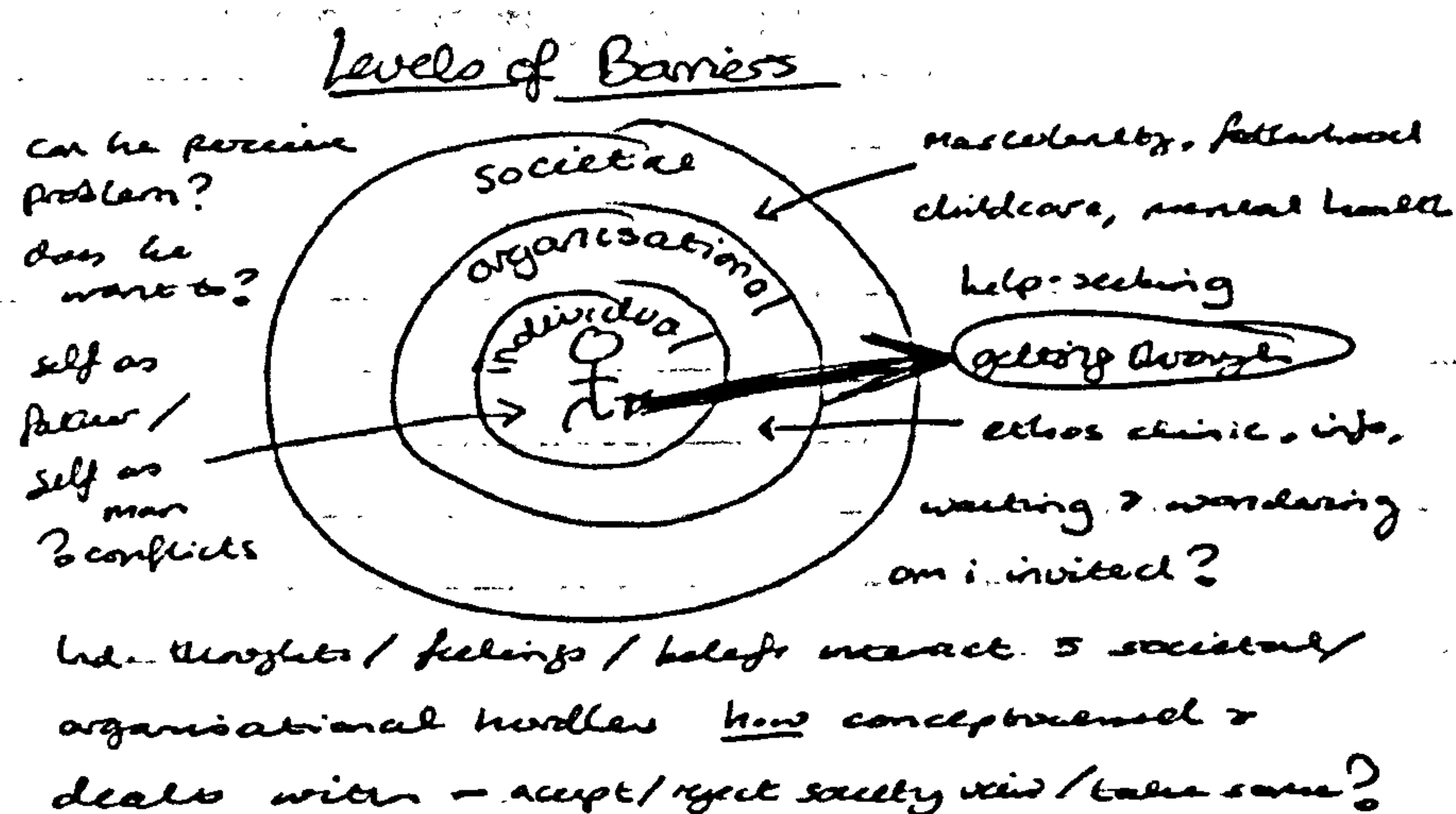
Figure 1: The Building of Data Using Grounded Theory



The Writing of Memos

Data analysis is aided by the use of memos, written aids that serve to remind the researcher of thoughts and ideas that they had during the analysis of their data (Strauss & Corbin, 1998). The process of recording and re-reading the memos is thought to be fundamental to the process of reflexive analysis. The use of memos helps the researcher to become more conscious of the processes involved in their thinking about the data, and helps them to remain grounded in the data. The emerging definitions of categories, the justification of category labels, and the explanations of relationships between categories, are all documented in the research memos. A memo can be of any length, and can be in written or diagrammatical form. Each memo is linked to the data through a reference to the interview and line number and as such provides a record of theory development. In the present studies, memos that referred globally to the process of analysis or that related to a number of links between codes or categories, were written in a log book. Memos that referred to specific decisions about where code or categories were placed, or specific definitions, were written within the relevant computer document. An example of a memo from the log book can be seen below.

Figure 2: Example of Memo



Credibility Check

Elliot, Fischer, and Rennie (1999) argue that it is important to include a credibility check measuring the extent to which the researcher and an independent reviewer draw the same meanings from the data. Robson (2002) recommends the use of a 'confusion matrix' and the calculation of Cohen's Kappa to measure concordance. Construction of the confusion matrix has the advantage that it shows very clearly where the two observers are differing in their judgements. If the two observers of the data reach good or excellent levels of agreement, this indicates that the coding has been conducted in a systematic rather than idiosyncratic fashion, and goes some way towards showing validity.

In the current study the credibility check is carried out by a fellow P.I.C.T. who has experience of using qualitative methods. The P.I.C.T. was asked to randomly choose, by number, one meaning unit from each code arising from the analysis (fathers: n=69, psychologists n=87). The selected meaning units were then presented to the P.I.C.T. along with definitions of the high-order categories, or in some cases the themes. The P.I.C.T. was then asked to place the meaning units where they felt they belonged. This process was conducted separately for the father and psychologist data sets and is reported on in the next chapter. The credibility check measures to what extent the independent reviewer of the data placed the same meaning units in the same categories or themes as had the researcher. I chose this method in preference to checking the emerging analysis with the participants themselves. I felt that because fathers are notoriously difficult to recruit, any additional imposition on their time might inhibit their participation in the first place.

2.4 Summary of Chapter

The current research study aims to explore how fathers decide whether or not to attend an appointment with a Child Clinical Psychologist, and how Clinical Psychologists working with children and their families perceive the fathers' decisions. In the preceding chapter, an argument was made for the use of a qualitative approach that could be used to understand and represent the experiences and views of the research participants. The importance of maintaining awareness of self in conducting qualitative research was considered and a section was included about the researchers own background, views, and experiences that may be relevant to the research. The use of guidelines for qualitative research as a means of maintaining reflexivity in the research was also discussed.

The second section of the chapter outlined the research design, and more specifically the methods of data collection: focus groups and individual interviews. An overview of the use of each of these techniques in qualitative research was followed by a detailed description of their use in the present study. The final section contains information about the method of data analysis. I chose Grounded Theory because it seemed to not only to be an appropriate choice given the aims of my research and the type of data that my methods would produce, but also because, I would have access to several sources of support and advice in using this method. An explanation of Grounded Theory was then followed by a detailed description of how this was put into practice in the analysis of my data. The results of the data analysis will now be discussed in the following chapter.

CHAPTER THREE

RESULTS

3.1 Overview of the Results Section

In the following chapter, the data from the focus groups and interviews that were conducted with fathers and with psychologists will be presented. In the course of analysis it was observed that the data from each of the focus groups overlapped substantially with that from the corresponding interviews. The decision was therefore made to present the two sources of data together, highlighting and discussing any major differences between them. Beginning with the data collected from fathers, details of response and participation rates, and background information about the participants, will be presented. Following this there will be a discussion of the main themes that arose from the data analysis. Taking each of the themes in turn, the codes and categories that were significant within the analysis will be described and similarities and differences between each of the participants will be highlighted. Verbatim extracts from the transcripts will be used to illustrate and add to the analysis throughout. Finally, having provided a summary of the data from fathers, the data that was collected from psychologists will be presented in the same manner. The chapter will end by pulling together the codes, categories and themes from the two data sets and building these up into a final model that represents the overall findings of the research project.

3.2 Quotation Conventions in the Results Section

All quotations from the transcripts will be presented in italics and placed between speech marks. The speaker, and location of the excerpt within the transcript, is shown in brackets after each quotation. The letters 'F' and 'P' followed by the interview number will be used to indicate whether the speaker is a father or a psychologist, and at what point they were interviewed. A second number indicating the location of the quotation within the transcript will follow the interview number. If the data is from one of the focus group participants this will be indicated by the additional letters 'FG'.

3.3 Descriptive Data: Fathers

3.3.1 Response Rate and Participation

Five fathers responded to the invitation to participate in the focus group. One of these fathers later withdrew because of family circumstances, two other fathers did not attend and the reason for this is not known. In total, two fathers attended the group. Despite the drop-out rate, the two

participants were able to discuss in depth their thoughts and feelings about why fathers might or might not attend appointments with a Child Clinical Psychologist. The focus group therefore met its purpose of providing a starting point from which to think about topics to introduce in the later interviews. In addition to this, the group also provided interesting data in its own right that will be discussed alongside that collected from the individual interviews.

Attempts were made to recruit fathers to individual interviews from the caseloads of seven Clinical Psychologists working with children and their families in Leeds between the dates of 1st July 2002 and 31st March 2003. Twenty-seven fathers met the recruitment criteria and were invited to participate. A total of eight fathers returned the consent form, five declined to participate, and a total of three were recruited to interview. The participation rate of the fathers who were contacted was therefore only eleven percent.

3.3.2 Background Information About Participants

Background information about marital status, age, number of children, and occupation was collected. The fathers were not asked to disclose any information about their child including the nature of the problem for which their child had been referred to the CAMHS. This maintained the emphasis of the study on the fathers, and my own role as a researcher rather than a clinician.

All participants in the focus group and in the individual interviews were married and lived at home with the referred child. Three of the fathers described themselves as managers, one a teacher, and one a electrician. The average age of the focus group participants was 46 years, and the average age of the interview participants was 44. The overall age range across the two samples was 39 – 51 years (separate ranges not included to protect confidentiality). Across the whole sample the fathers had, on average, two children (range 1-3 children).

3.4 Analysis of Data from Fathers

The analysis of the data collected from fathers resulted in four key themes through which the data is represented. The four themes (1) 'Family Involvement and Commitment', (2) 'Multi-Level Barriers to Help-Seeking', (3) '[Mis]Perceptions of Psychology', and (4) 'Positive and Negative Reinforcers of Help-Seeking' describe and explain the factors that the focus group and interview participants perceived to be central and important in fathers' decisions of whether to attend a forthcoming appointment with a Child Clinical Psychologist. An additional theme 'Self Vs Others' also ran through the entire data set. This fifth theme did not in itself provide explanation or understanding of the factors that affect fathers' decisions, however, the 'self versus others' distinction did provide useful insight into how the participants viewed the world.

In particular a polarised conceptualisation of the self as a ‘good or involved father’, and other fathers as ‘bad or uninvolved’ was evident.

In the following section each of the four themes, and their constituent components, will be discussed in turn. Where the theme ‘Self Vs Others’ was evident in relation to a specific category or code, this will be highlighted. Located in the Appendices (Appendix 5a) is a pull out diagram mapping all of the components that were constructed from the father data. It may be useful to refer to this diagram whilst reading this section. Although the themes are written about and described separately, they all exist in relation to one another. It can be seen from the diagram that each of these themes is closely linked in a direct sense or indirectly through connecting categories. The relationships between the themes and the most significant higher-order categories are shown on the diagram using arrows and coloured coding. The two themes ‘Positive and Negative Reinforcers of Help-Seeking’ and ‘Multi-Level Barriers to Help-Seeking’ are represented as antagonistic forces that are mediated through two other themes ‘Perceptions of Psychology’ and ‘Family Involvement and Commitment’ and their underlying codes and categories. Marked in red on the diagram (Appendix 5a) are the connecting factors that work as incentives for the fathers to seek help, marked in blue are the connections that inhibit help-seeking.

3.4.1 Theme 1: Family Involvement and Commitment

The theme ‘Family Involvement and Commitment’ describes the relationship between a fathers’ level of active interest in, and devotion to, his family and how he responds to the difficulties that they encounter and the subsequent referral to CAMHS. ‘Family Involvement and Commitment’ is composed of two low-order categories, ‘Perceived Responsibility’ and ‘Parenting and Partnership’, and one high-order category ‘Terms of Work’. One individual code, ‘Seeing Self in Child’, did not fit into any of the categories and was therefore subsumed directly by the theme. Each of the categories will now be discussed in turn.

Category 1: ‘Perceived Responsibility in Family’

‘Perceived Responsibility in Family’ refers to a father’s sense of accountability within his family. Two participants spoke of a sense of responsibility for the problem itself, and one explained how this made him feel that he should be actively involved in finding a solution. *‘I want to help my wife and my son, I feel it is my duty as a father. I suppose in some way I have failed them for things to get this far and it is up to me now to make up for it.’* (F2: 69). The participating fathers portrayed themselves as being highly involved and committed to their families and children, and contrasted this to their perception of other fathers who they perceived

to be uninvolved. Two of the participants conceptualised other fathers as being ‘distant breadwinners’ who provide financially for the family and leave the childcare duties to their wives. *‘I think it’s a lot of dads might think oh well you know what I mean they’ve got to go to work. The wife looks after the family, looks after the house, whatever, they should look after the kids’* (F1: 27). It was also suggested that fathers who are involved with their children do not necessarily perceive themselves as responsible for the more mundane or serious aspects of childcare. *‘Like some of the dads who boast of how involved they are, you know the ‘new man’ 21st Century thing. They do that and really all they do are the fun things and none of the stuff that mothers get stressed over.’* (F2: 63). The third participant reported less distinction between himself and others and acknowledged that his wife carried most of the responsibility for the children. *‘I suppose she is the boss when it comes to her kids.’* (F3: 57). This was explained as a practical arrangement reflecting the division of labour within the household.

Category 2: ‘Parenting and Partnership’

‘Parenting and Partnership’ describes the relationship between the father and his family and how this might impact on his reaction to difficulties. This category evolved through the joining of the codes ‘Pulling Together Vs Pulling Apart’, ‘Global Level of Involvement’, and ‘Time Spent with Child’. Here the participants all described their own families in terms that emphasised the equality and mutual support between themselves and their wives, and their interest in their children. In contrast, other families were described as divided in terms of childcare and emotional involvement, with mothers taking on the role of care-giver. *‘You must see that don’t you when the mum turns up and her kids a mess and you ask where the dad is and they’ve got no answer. Or maybe they just tell you do they – oh he’s at the pub, or he couldn’t be bothered.’* (F2: 93). The belief here is that non-involvement of fathers in psychology appointments is part of a more global pattern of non-involvement with their child or family. This links into the amount of time spent with the child. Two of the participants made a link between the extent to which a father is exposed to the difficulties and his motivation to become involved in their solution. *‘Like if the father is not around to be affected by the problems then maybe he sees no need to involve the mental health people’* (F2: 41). This was the case for one participant who described how his wife had noticed the difficulties their child was experiencing before he did because he was often out at work.

Category 3: ‘Terms of Work’

The ‘Terms of Work’ high-order category considers how the employment of fathers and mothers impacts on their ability to attend appointments. Interestingly, the majority of talk regarding working hours was centred around the belief that work was not a valid reason for not attending

appointments but was actually used as an excuse. *'Well the way I see it is if you wanted to go you'd get there like. No-one is that stuck in their jobs that they can't leave for summat that's important.'* (F2: 18). The timing of appointments was not seen as an important factor. *'I don't think it would make much difference you know what – what sort of time your appointments were. I think some dads would still stay away.'* (F1: 183). It is because of this that 'Terms of Work' became part of the theme 'Family Involvement and Commitment' rather than 'Multi-Level Barriers to Help-Seeking'. Each of the participants illustrated how they were different to other fathers by explaining how they would make sure they got time off work for family commitments when it was needed. Despite the emphasis on the ease with which fathers should be able to get away from their jobs to attend appointments, it was pointed out by one participant that many women work full time hours and might themselves find it difficult to take time away from their jobs. It was also suggested that some fathers might not want to ask for time off because this could mean telling their employer about the difficulties in their family. *'Your children are like a younger – a younger version of yourself and if you're admitting that there's something wrong with erm you know it's – they might think that er – or somebody might that think that you're bringing 'em up wrong or something else'* (F1: 167). Overall, the participants perceived work as a factor that could get in the way of fathers attending appointments if they chose to let it. According to the participating fathers, if dads are sufficiently motivated, and perceive the appointment as being important, work should be a surmountable problem.

3.4.2 Theme 2: Multi-Level Barriers to Help-Seeking

This theme describes the range of barriers, physical and psychological, which the participants perceived fathers as facing when deciding whether to attend their forthcoming appointment with a Child Clinical Psychologist. The barriers are perceived to exist on individual, organisational, and socio-cultural levels. 'Multi-Level Barriers to Help-Seeking' was constructed by bringing together three high-order categories: 'Socio-Cultural Barriers to Help-Seeking', 'Organisational Barriers to Help-Seeking', and 'Intra-Personal Barriers to Help-Seeking'. Each of these will now be described in turn.

High-Order Category 1: 'Socio-Cultural Barriers to Help Seeking'

'Socio-Cultural Barriers to Help-Seeking' describes how cultural ideas and beliefs about men, masculinity, and fatherhood, which are prominent in society impact upon fathers' willingness to seek help when difficulties in his family are encountered. This high-order category is comprised of two low-order categories 'The Females' Psychologist' and 'Preserving Masculinity', and one individual code 'Gender of Child'. The two participants who talked about the gender of the referred child did not perceive this to be a factor influencing fathers' attendance.

'The Females' Psychologist' is a low-order category that describes the belief that psychology services are run by women for women. *'And it is mainly women psychologists isn't it? They like listening to problems because they're women and women can go to them.'* (F2: 47). One participant emphasised self-other differences through his assertion that the gender of the psychologist would make no difference to himself, but that a female psychologist would be off-putting to other men. However, another participant indicated an explicit preference to see a male psychologist. *'To some extent yes, going to see another man is like knowing you will see someone of your wavelength.'* (F2: 48). It was suggested that he would feel better understood by another man.

The low-order category 'Preserving Masculinity' encapsulates dialogue that highlights perceived differences between men and women in terms of how they deal with emotions and difficulties, and their capacity to care for children. For example, the participants cited the societal understandings that men aren't supposed to show feelings, talk about problems, or allow others to help them deal with their problems. *'I think it's a macho thing isn't it really. You know, a man's a man and they're not supposed to have feelings.'* (F1: 61-62). Male reluctance to accept help from others was construed as global rather than specific to psychology. *'I am quite a private person like most men and I'd prefer to deal with things myself. Like I don't want to be told what to do or have someone else solve my problems. I like to do it myself.'* (F2: 33). There was also evidence of a belief that men are responsible for work rather than childcare because this is an area where women naturally excel. *'It's a mother-thing y'know.....To know what is best for the kids, like a natural ability to do it that fathers have to practise with.'* (F2: 59-60). The participants implied through these conversations that fathers find it difficult to become involved in what they perceive to be feminine activities. The data suggests that not becoming involved with psychology services could be part of an attempt on the part of the father to preserve his masculinity.

High-Order Category 2: 'Organisational Barriers to Help-Seeking'

'Organisational Barriers to Help-Seeking' refers to the ways in which the organisational set-up of the CAMHS (or the NHS more globally) might discourage fathers from attending appointments. This high-order category is made up from two low-order categories 'Struggles to Get Services', and 'Information and Understanding'.

Looking first at 'Struggles to Get Services', two of the participants were concerned by the extent to which they felt they had to push to get the services they needed. It was felt that this could deter some families from ever getting to the point where they are seen. *'Oh yes, that would put*

some people off I tell you.’ (F3: 37). Extended waiting times were also perceived to be unhelpful, it was felt that some families would get fed up of waiting. *‘I don’t know but I bet there are some people yeah who think oh it’s been so long you know why bother.’* (F1: 99). However, it seems that in the case of at least one participant having to pursue services with dogged determination, and having to wait for a long time, increased his anticipation and hope for what is to come. *‘And you know to wait for so long and then it to come up so quickly. It’s not excitement. There’s a bit of apprehension I suppose but it’s erm just glad that he’s erm – hopefully he’s getting the help he needs.’* (F1: 186).

‘Information and Understanding’ is a category that seems particularly significant to the participants as they each revisited this topic throughout their interviews. Participants reported a lack of information about the service to which their child had been referred, and that any information they did receive was of poor quality. *‘No very little erm well nothing. We knew coz we were told we were going to the mental health side of things and that we’d be seen by someone there. They said about psychologists but not much, just that that was our destination like. Unprepared for it really.’* (F2: 53). The importance of information was emphasised by the participants. One participant illustrated this from his own experience having sought further information from a contact in the NHS; *‘And no, if somebody hadn’t explained it to me properly then I wouldn’t have been quite as aux fait with it or as happy with it as I am now.’* (F3: 72). Another participant suggested that information would be important to other fathers *‘But if you had it explained properly. You know what I mean they might be a bit different about it.’* (F1: 146-147). It was felt that some fathers’ reluctance to engage with services stemmed from their lack of understanding of what it entailed. The participants all felt they had some understanding of the role of psychology, yet still felt unprepared and uncertain about the appointment. It was suggested that other fathers might be even less informed and that misperceptions of the service, and of the role of psychologists, could reduce fathers’ motivation to attend. This is discussed further in section 3.4.3.

High-Order Category 3: ‘Intra-Personal Barriers to Help-Seeking’

The high-order category ‘Intra-Personal Barriers to Help-Seeking’ refers to barriers that are perceived to be specific to the individual father as opposed to being related to socio-cultural constructs or arising from the set-up of organisations. This category encompasses one other high-order category ‘Fears of Psychology’ and one low-order category ‘Psychological Defences’. The category ‘Fears of Psychology’ is shared with the theme ‘Perceptions of Psychology’ and is discussed in section 3.4.3. Two other categories ‘Emotional Response to Difficulties’ and ‘Perception of Problem Status’ are partially subsumed by ‘Intra-Personal Barrier to Help-Seeking’. These two categories explain how a father’s emotional reactions and

his perception of the problem could either inhibit his attendance at an appointment or indeed act as an incentive to attend according to their specific qualities. It is because of this that they are identified as being both potentially part of 'Intra-Personal Barriers to Help-Seeking' and 'Positive and Negative Reinforcers of Help-Seeking'.

'Emotional Responses to Difficulties' describes how fathers might experience feelings of guilt and failure as a result of the difficulties in their families. In the category 'Psychological Defences', two of the participants suggested that these painful feelings might result in other fathers concealing the problem from themselves and others through denial of its' existence. *'Because it would be like admitting failure, like putting on show everything you've done wrong. I think a lot of fathers would want to conceal all that and pretend it is not there'* (F2: 71). Some consideration was also given to the involvement of the father in his family and whether the father may begin to distance himself from the family as a further means of avoiding difficult feelings. *'If the child has a problem and the father doesn't know what to do, maybe it is then that he starts to come away from the family like.'* (F2: 77). However, one of the participants suggested that his own feelings of guilt and failure were part of what motivated him to become involved in a solution to the difficulties. This suggests that a father's emotional response can act to either inhibit or motivate attendance.

The high-order category 'Perception of Problem Status' encompasses dialogue relating to the way in which a father perceives and rationalises the problem and how this might affect his willingness to attend an appointment. 'Perception of Problem Status' is comprised of the categories 'Perception of Need for Help' and 'Perception of Problem'. Together these categories describe the fathers' recognition and acknowledgement of a problem, his assessment of whether outside help is needed and of what kind of help this should be, and the perceived consequences of not seeking help, as factors that mitigate his attitudes towards the forthcoming appointment. The participants all indicated that they felt help was needed and had a rationale for involving CAMHS. *'I think you know the occupational side he's alright with now, it's just er – it's just this erm – it's a stupid word to use – but the mental side of it.'* (F1: 50). In contrast to this, it was suggested that a father who denies the existence of the problem, believes that the family should deal with it themselves, or does not perceive there to be psychological aspects to the problem, is unlikely to want to engage with psychology services. Additionally, all the participants described how their own families had reached a breaking point. That is, the duration and severity of the problem, and the impact on the family, was perceived to be great enough to necessitate help-seeking. *'If things have gone on so long or if they keep getting bad like, more than they have been, then it looks like help is something that would be a good thing for everyone.'* (F2: 34). Links were also drawn between the fathers' perception of the problem and their involvement with their families. It was suggested that perhaps some fathers are not around to be affected by the

difficulties so that they do not perceived the problem to be severe, or the need for assistance to be great.

3.4.3 Theme 3: [Mis]Perceptions of Psychology

The central premise of the theme '[Mis]Perceptions of Psychology' is that the way in which fathers view the psychology service to which their child has been referred has important consequences for whether or not they decide to become involved with that service. This theme is comprised of the two high-order categories 'Perceived Benefits of Attendance' and 'Fears of Psychology' and one low-order category 'Positive Expectations of Appointment'. A single code 'Set at Ease' that arose solely from the focus group data is also linked to the category 'Fears of Psychology'. The theme was originally named 'Perceptions of Psychology' and later renamed to '[Mis]Perceptions of Psychology' reflecting an emphasis in the dialogue on the potential inaccuracy of fathers expectations. As one father stated: *'It's er .. could be people's perceptions.... Could be 'cos it's people's perceptions on it, lack of understanding basically isn't it really?'* (F3: 204-205).

High-Order Category 1: 'Fears of Psychology'

The high-order category 'Fears of Psychology' pertains to aspects of an appointment with a Child Clinical Psychologist that either the participating fathers feared, or that they felt that would be feared by other fathers. It is interesting to observe that there is a large self-other distinction made by the research participants; whilst these fathers reported that they had a number of fears and apprehensions, they felt that other fathers would have more extreme and significant anxieties about attending their appointment. One major fear shared by all the participants was labelled 'The Unknown' as it stemmed from the uncertainty about what the appointment might entail. It was also felt that other fathers would share this fear. *'It's a grey area for a lot of people.'* (F3: 77). Although the importance of being given information was emphasised, one father suggested that there would always be an element of anxiety in anything new *'I think there is always a fear of new things though'* (F2: 55). In addition to fear of the unknown, a number of fears relating to either specific aspects of the appointment and of psychology more generally, were suggested by the participants. These fears are defined by the categories 'Feeling Devalued', 'Power of the Psychologist', 'Incrimination', 'Not Meeting Needs' and 'Psycho-Analysing', and the individual code 'Experiencing Pain'. Each of these will now be discussed in turn.

'Feeling Devalued' is a category about the fathers' sense of uncertainty about how welcome they would be, and how they would be treated if they were to attend the appointment. *'I was thinking that it is usually the mothers who are supposed to go to things like that and you wouldn't want*

them to think what you doing here or that' (F2: 46). There is a fear of being an unwanted guest, feeling uncomfortable and devalued. It was suggested that many fathers might share this sentiment. *'You know they might not – you know I think a lot of fathers might not feel that it's – includes them as well'* (F1: 134). The fathers' feelings of non-importance are perhaps exacerbated through their perception of psychologists as holding power. In the category 'Power of the Psychologist', psychologists are described as intimidating, dominating, and as having the authority to take children away from their parents. One participant takes this idea further suggesting that fathers might be fearful of 'Incrimination', that is, blame, judgement and criticism. *'It is just a bit like being on trial – they want you there to check you're not beating on your kid and you've made him go wrong. Like Social Worker as well y'see everybody is looking out and looking to point at Dads.'* (F2: 10). It is clear that this participant's expectations of a blaming and persecutory atmosphere make him feel uncomfortable about attending his appointment. *'Well yeh, I mean for me coz I not done nothing wrong, but I still feel like I'm gonna be told off'* (F2: 22). Participant F3, on the other hand, holds a very different view: *'It's the whole idea about going to see a psychologist is to find out what the problem is not to apportion blame'* (F3: 183).

'Not Meeting Needs' includes the codes 'Adverse Affects' and 'Service Doubts'. 'Adverse Affects' refers to one participants concern that the appointment could actually be detrimental. *'Don't get me wrong I think they all do a grand job like, but, well it is just that I am not sure if it could all lead to worse y'know'* (F2: 5). This poses the important question of what the potential costs and benefits of attending the appointment are likely to be and whether the involvement of a psychologist could have negative side effects. 'Service Doubts' refers to the fear of one participant that his family would not get the kind of help that they were needing. *'Well I suppose you often don't get what you need and you think what's the point of going, or of waiting.'* (F3: 39). The fear in this case was fed by previous negative experiences with other child professionals.

The final category encompassed within 'Fears of Psychology' is 'Psycho-Analysing'. This category relates to participants' expectations that psychologists want to delve into private thoughts and read alternative meanings into what is said. One participant explained that;

'It is the whole analysing thing, hanging onto everything you say and digging into it like does it mean this or that and what are all your secrets. You feel like you're going to have to watch what you say and mind how you say it that's gonna make anybody nervous whether they've done something wrong or not.' (F2: 62).

Another participant referred to psychology as a *'Bit like big brother type thing'* (F3: 14), although he did not qualify what he meant by this. One individual code 'Experiencing Pain' that was not subsumed under any of the categories has similarities with the data in the category 'Psycho-Analysing' in that they both refer to exposure of unwanted realities. This code describes one participant's fear that the appointment could be emotionally painful, for example he referred to facing 'home truths' and drew analogies between the psychology appointment and medical interventions that are feared because of pain such as the dentist and operations. It seems that whilst 'Psycho-Analysing' refers to the fear of having ones secrets exposed to someone else, experiencing pain refers to them being exposed to oneself.

Additional Code: 'Set at Ease'

Within the focus group data, one code was generated that did not arise from the individual interviews; 'Set at Ease'. This code lends support to the notion that some fathers have misperceptions about the role and nature of Child Clinical Psychologists that inhibit their attendance. 'Set at Ease' describes the release of tension that the two focus group participants experienced when they actually attended the first appointment. *'So yes, your set at ease straight away, you know.'* (F1FG: 73). These two fathers placed emphasis on their fears and anxieties that they had felt before attending and drew a sharp contrast between their emotions and apprehensions before, during and after the appointment. *'Just the way K (female's name) was, the way she spoke you know. The atmosphere. It just felt like how she acted with my kids, you know it just changed it all, just (clicks fingers) went like that.'* (F2FG: 63). It would seem that the appointment the fathers had experienced was far from what they had imagined and feared. *'But you expect, you know, coz they're over there, the doctors are over there and you come in and you sit and answer all their questions. But it was just like a group situation and it was – all seemed so much informal yet you were getting more out of it being in the informal situation rather than being formal.'* (F1FG: 65). The focus group participants spoke about the difficulties that services might face in trying to engage fathers. The fathers explained how their own anxieties about the appointment had nearly led to them abstaining. *'I was very on tender hooks whether to go or not'* (F2FG: 61). Yet when they did attend, their experience was very positive. The difficulty is that fathers have to attend to find out what the service is like, yet if they are very anxious they may be unlikely to do this. As one father explained: *'It's a catch situation isn't it? Because if they're not going to get involved they're not going to learn.'* (F2FG: 49).

High-Order Category 2: 'Perceived Benefits of Psychology'

The high-order category 'Perceived Benefits of Psychology' contains dialogue referring to the gains that participants hope that they will make by seeing a psychologist. This category provides

important insight into how these participants understand and conceptualise the role and purpose of Child Clinical Psychologists working in CAMHS. 'Perceived Benefits of Psychology' subsumes two categories 'Exploration and Discovery' and 'Therapeutic Input', and two individual codes 'Making Changes from Own Childhood' and 'Keeping an Eye on Things'.

'Exploration and Discovery' describes the participants' hopes that input from a psychologist will help to clarify the difficulties that the family encounter, and to increase their understanding of how these difficulties came about. One participant was particularly systemic in his thinking, suggesting that psychology was also about exploring the perspectives of different members of the family, and looking at how the parents might play a role in the presenting problem. *'I think it's good to know how everybody feels, not just one you know.'* (F1: 143). Two participants qualified the importance of understanding explaining their belief that increased insight would lead on to means of managing the difficulties. For example, one father said: *'If you know why you are half way there to knowing what to do aren't you?'* (F2: 38). The hope of understanding was followed by the hope for 'Therapeutic Input'. This was conceptualised non-specifically as 'help' for both the parents and the child. *'And that's why you say oh yeah you look forward to the appointment 'coz hopefully something will come of it to help him. Help us to help him.'* (F1: 207). The form that this 'help' would take or the specific gains that were hoped for were not articulated, although it was implied that the psychologist would be the active agent of change. For example F3 stated *'Well they look and see what's going on in the kids head and sort them out I suppose.'* (F3: 13) and F2 thought the psychologist would *'see (the child) and sort him out a bit'* (F2: 37).

The first individual code, 'Making Changes from Own Childhood', describes one father's commitment to providing his child with a more nurturing experience than he had encountered in his own childhood. *'I vowed when I got married that I'd be different you know what I mean 'coz all I'd get is a good telling off or sommat like that.'* (F1: 216). This participant felt that becoming involved with a Child Clinical Psychologist could help him to meet his parental aspirations. The second code, 'Keeping an Eye on Things', contrasts with all the other codes subsumed under the category 'Perceived Benefits of Psychology' in that it describes negative as opposed to a positive reinforcement. Participant F2 indicates that he is motivated to attend the appointment partly because if he doesn't he will not know what happened or what was said. *'Mmmm yeh I'll be going like I want to keep an eye on what goes on'* (F2: 16). Reflecting on this, he suggests that monitoring of the appointment is more likely to be important to fathers when there is family conflict. *'I think as well that sometimes when everything is fine you don't have to worry what the other one is saying like. So if they are fighting they might want to make sure they are there to give their side and that.'* (F2: 84). This perhaps represents a slightly different slant on the ideas of participant F1 who felt it was important to see different sides of the problem.

Category 3: 'Positive Expectations Re: Appointment'

The final category making up 'Perceptions of Psychology' is 'Positive Expectations Re: Appointment'. This lower-order category subsumes the codes 'Expectation of Child-Friendly Atmosphere', 'Easy to Talk at Interview', and 'Own Feelings Being Understood' which are self-explanatory. These codes originally formed part of the 'Perceived Benefits of Attending Category' but were later separated because they seemed to refer more specifically to the expected atmosphere of the first appointment rather than the ongoing benefits of psychological input. It is interesting to note a significant difference in size between this category and that of 'Fears of Psychology'. Whilst participants reported many negative expectations that they and fathers in general might have of the appointment, very few positive expectations were voiced. However, there was a self-other discrepancy within this category. The participants all defined themselves as having positive expectations, but expected that other fathers would have more negative expectations.

3.4.4 Theme 4: Positive and Negative Reinforcers of Help-Seeking

The theme 'Positive and Negative Reinforcers of Help-Seeking' describes those factors that were perceived to increase fathers' motivation to attend an appointment with a Child Clinical Psychologist. Most of the factors described by participants as motivating them to attend were those that provided positive reinforcement. That is, the fathers' felt that their attendance would result in direct gains or benefits. In addition to this, the fathers also mentioned a number of undesirable consequences that might result from their non-attendance, such as the problem continuing to get worse, them not knowing what was said at the appointment, and feelings of guilt or failure. These factors were perceived to provide negative reinforcement of their attendance.

Subsumed under this theme are all the components that are marked in red in the diagram that is located in Appendix 5a. The high-order category 'Perceived Benefits of Attending' and the low order category 'Positive Expectations of Appointment' are both included in their entirety. Positive expectations about the appointment, and about gains that may be made as a consequence of therapeutic input, were described by the participants as providing them with motivation to attend. *'If I thought it was gonna be torture erm I wouldn't be going, but I think the appointment will be relaxed like so I am you see.'* (F2: 99). A single code 'Organisational Incentive' also contributes to the theme. This code contains dialogue referring to the participants' experience of being invited to the appointment. All five fathers stated that one reason why they had engaged

with services, or intended to in the future, was that the appointment letter requested their presence.

Two other categories 'Emotional Response to Difficulties' and 'Perception of Problem Status' are partially encompassed by 'Positive and Negative Reinforcers of Help-Seeking' as well as contributing to the theme 'Multi-Level Barriers to Help-Seeking' through the high-order category 'Intra-Personal Barriers to Help-Seeking'. A father's emotional reactions and perceptions of the problem are represented in the data as factors that can either inhibit or drive a father's willingness to attend an appointment. In relevance to this theme, it is suggested that a father who experiences concern for his child and perceives the problem to be significant and warranting outside help will be motivated to attend the appointment. Feelings of guilt and failure were also revealed as motivating factors for one participating father who felt that he should be 'sorting things out'.

3.4.6 Summary of Father Data

In summary, the participating fathers provided information about their own reactions to the referral of their child to a Child Clinical Psychologist, and the factors that they felt were influencing their decision of whether or not to attend. In addition to this they also hypothesised about the factors that might be important in other father's decisions. In portraying themselves and others, the fathers talked a lot about their own keenness to become involved whilst depicting other fathers as highly resistant to engagement with services. However, despite voicing their enthusiasm to attend their forthcoming appointment, the fathers were all able to reflect on some of the factors that discouraged them from attending. As a whole the data set provides a balanced view of factors that might drive or inhibit attendance, each being equally represented in terms of volume.

Within the data set, there were several factors upon which particular emphasis was placed. In terms of inhibiting factors, the fears that fathers might have about psychology were accentuated. Many fears and anxieties were perceived to arise from misunderstanding of the role of psychology in healthcare, a perceived consequence of lack of information about services. Socio-cultural constructions of masculinity and fatherhood that conceptualise childcare as women's work, and emotional expression as non-masculine, were also described as key barriers to attendance. In terms of factors that increase motivation to attend, the participating fathers emphasised the importance of family commitment. Each of the fathers emphasised their own involvement in family life and their perception of the problem as being the shared responsibility of both parents. It was suggested that fathers who do not attend appointments are distant and

uninvolved in family life and, as a consequence of this, are unlikely to feel that they have a role in responding to the difficulties.

3.5 Descriptive Data: Psychologists

3.5.1 Response Rate and Participation

The focus group consisted of four P.I.C.T.s who had responded to the invitation to participate. Two of the P.I.C.T.s were female and two were male. These participants appeared to work well together in the focus group as they were able to explore in depth their thoughts and feelings about why fathers might or might not attend appointments with a Child Clinical Psychologist.

Seven Clinical Psychologists working with children and their families in Tier Three CAMHS in Leeds were invited to participate in individual interviews. A total of five psychologists returned the consent form agreeing to participate, and they were interviewed between the dates 1st November 2002 and 1st February 2003. At this point it was decided that sufficient data had been collected given the size of this study so no further efforts were made to recruit the remaining two Child Clinical Psychologists.

3.5.2 Background Information About Participants and Departments

All the Clinical Psychologists who participated in the research were currently working in a Tier Three CAMHS team in Leeds. Three participants were female, and two were male. The participants described having held their current posts for between one and a half and eighteen years. Two of the participants were at consultant level, two at Grade B level, and one at Grade A. Two of the participants worked in specialised areas: nocturnal enuresis and paediatric development, and the other three participants worked with a wide range of children of different ages and different presenting problems.

The participants reported that, in each of the CAMHS settings, families are invited to attend the clinic for their first appointment. All participants noted that mothers tended to attend appointments as a rule whereas fathers would attend more rarely. Four of the participants reported that fathers are more likely to attend the first appointment or other appointments that are particularly significant (for example assessment clinics or reviews), than they are likely to become involved on a continuous basis. The participants were asked to estimate the percentage of fathers currently attending their initial appointments. One participant reported that fathers attend the initial appointment in around 15% of cases, three participants reported attendance rates of between 30-50%, and one participant reported that between 70-80% of fathers attend

initial appointments. Exact data on fathers' attendance was not available from any of the CAMHS teams.

3.6 Analysis of Psychologist Data

3.6.1 Analytic Process and Reflexivity

The initial open coding of each psychologist interview was conducted hand-in-hand with the data collection at the same time as the data from the father interviews was undergoing the same analytic process. Throughout this coding, my thoughts, ideas, and questions, about each interview naturally had an effect on what I brought to the next. Although the data arising from the father and psychologist interviews was kept physically separate, on a cognitive level there was much interaction. It is also important to acknowledge that the data from the interviews with Clinical Psychologists was brought together in the final stage of analysis at a point when the data from the fathers had already been analysed. I therefore began building up a model of the psychologist data with one conceptualisation of how the data might fit together at the back of my mind.

In analysing the data it became clear that the two populations shared many ideas about the factors that are important to fathers' decisions of whether to attend an appointment with a Child Clinical Psychologist. There were many instances of shared language across the two groups, and of shared constructs used to explain the participant's perspectives. Partly because of the similarities across the two sources of data, I felt it was particularly important to maintain a sense of openness to differences between the psychologist and father perspectives. I felt it would be all too easy to push-fit the psychologist data into the already established model, defeating the purpose of a grounded approach. At this stage I relied particularly heavily on my narrative of the evolving analysis, studying each memo in depth and questioning and exploring my reasons for the coding of each part of the data.

In analysing the data collected from the psychologists it became clear that the differences between the fathers' and psychologists' perceptions lies mainly at the level of individual codes and lower-order categories. As a result of this, both sets of data can be represented through many of the same themes and high-order categories, and could be displayed using a similar structure. At this point I considered that, as with any building work, there is no single right way to construct. To a large extent the finished design is a product of the individual involved and the way they see the world. The models that I had constructed represent one way of displaying and conceptualising the data, and each of the models could be reconstructed differently many times over. Using the same model outline for both the father and psychologist data is helpful in that it aids direct comparison between the two groups.

3.6.2 Introduction to Psychologist Data Analysis

The analysis of the data collected from the psychologists resulted in the same four themes as that collected from the fathers; (1) 'Family Involvement and Commitment', (2) 'Multi-Level Barriers to Help-Seeking', (3) '[Mis]Perceptions of Psychology', and (4) 'Positive and Negative Reinforcers of Help-Seeking'. Again, these themes describe and explain the factors that the participating psychologist perceived to be important in fathers' decisions of whether to attend a forthcoming appointment with a Child Clinical Psychologist. Located in the Appendices (Appendix 5b) is a pull out diagram mapping all of the components that emerged from the father data. The interested reader might find it useful to refer to this diagram whilst reading this section.

The aim of the following section is to describe the similarities and differences between the psychologists' and the fathers' perspectives. This will be achieved by discussing each theme in turn, highlighting areas where the data sets diverge. Where the same codes or categories are present in both the father and the psychologist data these will not be described or explained for a second time in this section. Instead the focus will remain on any new codes or categories that have arisen in the psychologist data, and any differences of emphasis between the two sources of data. Finally, at the end of this section, the psychologist data will be summarised.

3.6.3 Theme One: Family Involvement and Commitment

In common with the participating fathers, the Clinical Psychologists spoke of a father's investment in his family as being an important determinant of his involvement with services. The consensus amongst the participants was that the greater the father's emotional investment and contact with the child, the greater his motivation to become engaged with a Child Clinical Psychologist. The two categories 'Perceived Responsibilities in Family' and 'Parenting and Partnership' that had arisen from the father data were both corroborated and expanded on in this analysis. An additional code that did not arise in analysis of the father data, 'Polarisation of Father Involvement', was also developed.

Absent from 'Family Involvement and Commitment' in the psychologist data, but subsumed under that theme in the father data is the high-order category 'Terms of Work'. In the analysis of the psychologist data many codes arose that referred to fathers' employment, and these were used to construct the category 'Constraints of Employment' which contributes to the theme 'Multi-Level Barriers to Help-Seeking'. The different category labels and locations, highlight a

contrast between the fathers' perception of work as a barrier that fathers place between themselves and the appointment when they are not motivated to attend, and the psychologists' perception of work as an organisational barrier to help-seeking.

Category One: Perceived Responsibilities in Family.

The category 'Perceived Responsibilities in Family' arose from both the psychologist and father data. The most significant code in each of these datasets is 'Perceived Responsibility for Child', although the volume of data subsumed under this code in the analysis of the psychologist interviews is substantially greater. Overall, there was a consensus between the psychologists and the fathers that the attendance of family members is likely to reflect the way roles within the family are organised. *'I suppose it is more – it must be more reflective of their general involvement. I mean in their family life, or their perceived role of fatherhood or parenthood maybe.'* (P4: 102). The fathers who were interviewed suggested that those who do not attend appointments are likely to be those who do not see childcare as part of their role. The psychologists shared this perception, suggesting that when parents organise their family so that there is a clear division of labour, with roles as either breadwinner or care-giver, the care-giver tends to attend alone. Whilst it was perceived that mothers are most likely to be nominated as the care-giver, one psychologist gave several examples of fathers who had attended appointments because they obviously perceived their child's care to be their responsibility. In one of these cases the father was a single parent, and in another his partner was the main breadwinner of the family. It was suggested that where separate roles are not so clearly established and both parents have taken on substantial responsibility for childcare, both parents are likely to get involved when their child is referred. *'And of course there are families where you think there's a shared responsibility and they both have erm an equal, if that can ever be the case, concern for the child'* (P2: 23).

In the father data, the code 'Perceived Responsibility for Problem' was subsumed under 'Perceived Responsibility in Family' representing one father's feeling that he was in part responsible for the problem and therefore responsible for the solution. In the psychologist data, the perception that some fathers might feel responsible for the family's difficulties is instead found under 'Perception of Problem Status' reflecting the fact that no explicit link is made between the feeling of responsibility and motivation to attend the appointment.

Category Two: Parenting and Partnership.

'Parenting and Partnership' is again a category that arose in both data sets. Psychologists and fathers perceive the degree to which the parents 'pull-together' or 'pull-apart' over the problem

as important. *'The ones where it's 'pull tighter you know we're gonna get' they say that to each other 'we're gonna get through this love' you know and work together for his or her problem. And they do so.'* (P1: 86). There was an emphasis in the psychologist data on the significance of marital difficulties, or the pulling-apart aspect of this code, whereas the fathers emphasised their own experiences of pulling together with their partner. It was suggested by the psychologists that problems between the mother and father might lead to a lack of cooperation between them and reluctance to attend an appointment together. Linking into this idea, the global level of father involvement in family life was also considered significant by both groups. Fathers who spend little time actively engaged with their family are seen as least likely to attend an appointment.

In the psychologist data, an additional code 'Investment in Partnership' develops the category further. 'Investment in Partnership' is built from examples given by two participants of fathers they had worked with who had been very committed to their partners and had attended because of this level of investment in that relationship. One participant felt that this was often the case where there is a new partner taking on the role of a non-biological father. *'I suspect that sometimes they're very committed because they've then got, you know, the mother of the child is the new partner and they've got a lot of investment in making the marriage or partnership work'* (P1: 68). Whilst this code was not present in the father data, the general concept of commitment to the mother-father relationship was perhaps alluded to through the emphasis on 'pulling together', and through the code 'Support to Family' in which one father spoke of his perceived duty towards his wife to support her through the difficulties, and of the value his wife placed on his support.

Code: Polarisation of Father Involvement.

'Polarisation of Father Involvement' is a code that arose from the observations of two of the participating psychologists. These psychologists reported that many of their clinical experiences were of particularly committed and particularly uncommitted fathers. The middle ground in between these polarities was perceived to be lacking. *'I wonder if there is a kind of dimension that they're either for it or not for it.'* (P1: 67). For example, one psychologist felt that when fathers are involved they are overly involved. *'I do have a lot of families where you know there is a dad involved erm and the – as I'm talking to you now it almost seems as if they're overly involved you know rather than just being an erm equal partner'* (P3: 70). However, despite this perceived polarity, it was acknowledged by one participant that perhaps these were the cases that were particularly memorable, perhaps because of their extremity. *'The ones that stick in my mind, you know, that occupy this position, you know, polarised as either extremely involved or not.'* (P3: 114).

3.6.4 Theme 2: Multi-Level Barriers to Help-Seeking

High-Order Category 1: Socio-Cultural Barriers to Help-Seeking.

In the psychologist data, 'Gender Barriers to Help-Seeking' is the category that is perceived as most significant, followed by socio-cultural barriers to do with class and ethnicity. As in the father data 'Media Portrayal of Psychology' is a small code that also contributes to the high-order category. Although the father data that refers to 'Socio-Cultural Barriers' is organised and labelled differently to the psychologist data, there is a huge amount of overlap between the perceptions of the psychologists and fathers. This will be discussed below.

Gender Barriers to Help-Seeking: Within the psychologist data there is reference to three types of gender bias; (a) in perceived responsibility for childcare, (b) in beliefs about help-seeking, and (c) within the health service settings. Each of these biases is perceived to be a significant barrier to fathers attending appointments with a Child Clinical Psychologist.

'Gender Bias in Perceived Responsibility for Childcare' contains dialogue about how mothers, fathers, and society as a whole, tends to perceive childcare as 'woman's work' and childcare appointments as 'woman's business'. One psychologist suggested that women are socialised into this role early on because they are the one physically carrying the baby. *'Dads aren't socialised, I think, in to it as much as maybe mums - you know I'm just thinking of when you've got a newborn you might be taking the baby to get weighed weekly or you might be having contact with the health visitor, it's much more likely to be seen as your role.'* (P4: 129). Both the fathers and the psychologists felt that, when mothers and fathers subscribe to these gender stereotypes, fathers do not see attending appointments as part of their role. Further to gender stereotypes about childcare, talk about gender biases in help-seeking beliefs and behaviours was present in both sets of data. Like the fathers, the psychologists perceive men as being more dismissive of psychology and other health services than woman. *'I wonder if there's also some kind of other dynamic which is that psychology for dads is harder to digest than it is for mums er or the female gender I should say.'* (P2: 42). Possible reasons given for this were that showing feelings, or needing someone else's help, is not considered to be masculine behaviour. *'It is er something of a soft, maybe whimpy, uncool kind of option.'* (P2: 45). In the father data this emphasis in the data built the category 'Preserving Masculinity' to represent the idea that fathers might avoid psychology appointment because the showing of emotions, involvement with childcare, or asking for help, could make them feel less of a man. *'It maybe that it's just uncool in the sense of you know it tackles issue which are personal and emotional erm and I know it's a kind of old view of males in many ways but – but many males are more interested in other issues.'* (P2:47).

In considering the perception of psychology as 'non-masculine', three of the psychologists noted that there was a sense in which health care settings confirm and perpetuate this understanding. One psychologist considered what it might be like for a father attending an appointment. *'If I went to a child development team and they were all women all the times, it's like, yeah, it IS a women's world. So there's an actually down to earth real life er sort of feel to it that it's not a men's area this.'* (P1: 104-5). Another participant considered the messages that the female orientated magazines in their waiting room might give out about who the service is for. In the father data there was a strong sense that child psychology is perceived as being run by women for women, hence the category label 'The Females' Psychologist'. However, despite this perception, each of the fathers was adamant that they were happy to attend their forthcoming appointment. One psychologist suggested that the gender of the psychologist was perhaps one factor amongst many. *'I don't think it's (gender as a factor) any bigger than any of the others. I think it's definitely in there but I don't think it's necessary the thing that keeps them all away.'* (P4: 117).

Class Barriers to Help-Seeking: In the father data, a single code 'Class and Education' referred to one father's perception of social class as a barrier to help seeking. It was suggested by this participant that low education level may be related to a lack of understanding of psychology, and subsequent feelings of intimidation. In the psychologist data, four codes make up the category 'Class Barriers to Help Seeking', each of which refers to a mechanism by which social class might affect whether or not a father attends an appointment. The code 'Class Culture' consists of the perceptions of two participants who felt that a father's social class might effect how he perceives psychology and his role as a father. One psychologist suggested that lower class families were more likely to subscribe to gender stereotypes where the mother cares for the children and the father acts as the breadwinner and does not see attending his child's appointments as his role. *'I wonder if families in lower kind of socio-economic status, very deprived – sort of generations of deprivation – the kind of the model is that parenting or childcare is a female role.'* (P4: 62). It was further suggested that middle-class fathers would be more likely to think that they ought to be involved in their child's care, regardless of whether they actually are, and would be more likely to modify their behaviour in light of this and attend appointments.

'The families that we do get that are from sort of more professional or middle class I think whether the fathers come more because they think they ought to and therefore – you know what I mean, they don't want to be seen in a bad light.' (P4: 60).

The effect of social deprivation in lower class families, and negative experiences of being parented, was also considered. It was suggested that fathers who had grown up without access to

a good model of parenting, especially by their own fathers, might have difficult in becoming positively involved in their own children. *'You know I think a lot of it depends on what their experiences are of being parented. And how involved their fathers were which is probably even less than what fathers are now.'* (P4: 110).

Ethnicity as a Barrier to Help-Seeking: The fathers who were interviewed did not talk about the ethnicity, of the father or of the therapist. In the psychologist data, two participants talked about how members of ethnic minority groups might find it more difficult to access healthcare because they might be attempting to communicate in a second language in which they are not completely fluent, or perhaps because they are illiterate in English. Alternatively, it was suggested that there might be a reluctance to engage with a therapist who is a different race or religion. These barriers were not seen as being specific to fathers, rather they were seen as affecting the whole family.

High-Order Category 2: Organisational Barriers to Help Seeking

'Organisation Barriers to Help-Seeking' describes the barriers that an individual father is perceived to face from organisations that he is involved with, namely the NHS and his workplace. Within the psychologist data, 'Organisational Barriers' is made up of three lower-order categories, 'Constraints of Employment', 'Non-Inclusion of Fathers', and 'Service Changes and Father Inclusion'. The categories 'Struggles to Get Services' and 'Information and Understanding' that arose from the father data did not emerge from the psychologist data. However, two individual codes 'Waiting Time' and 'Ability to Travel to Appointment' do allude to difficulties faced by families in accessing service provision, and 'Information About Psychology' is represented as one individual code. One additional code 'Negative Past Experiences of Services' that is unique to the psychologist data is also subsumed under 'Organisational Barriers to Help Seeking'.

Constraints of Employment: The category 'Constraints of Employment' describes how working arrangements could make it difficult for some fathers to attend clinic appointments. Whilst the participating fathers perceived others to be using work as an excuse for not attending when they were actually uncommitted to their family, the psychologists talked more about how difficult it could be for some fathers to take time out. For example, one psychologist described how some fathers are committed to providing much needed financial support to their family and are therefore unable to attend appointments in working hours. *'I don't think people necessarily appreciate – professionals necessarily appreciate really some of the poverty that some children and families are living in, and it really is, you know, a major difference to them if they get that income from that day.'* (P4: 151). The nature of the father's work including; the geographical

location of the workplace, the security of employment, and the specific demands of the father's work role and the degree of flexibility this affords, were all considered by the psychologists to be important factors. Like one of the fathers, one psychologist considered how difficult it might be for some fathers to ask for time off work for family commitments.

'I've had quite a few dads say things like well it's awfully difficult to go into work erm and if they work in some industry and so on where's quite a kind of up front erm you know tough minded jocular er teasing type approach the they find it quite difficult to expose the side that's really concerned about their child.' (P1: 45).

However, despite this emphasis on the constraints of employment, two of the psychologists considered that work might not always be the problem. *'Mum will say no he won't accept that, and the dad won't come along to that. And usually it isn't to do with work, it's to do with erm – it is to do with – with some of the kind of issues we've already talked about.'* (P2: 90). One psychologist clearly reiterated the sentiment expressed by the participating fathers; *'I think most fathers that are committed tend to work around it.'* (P4: 146).

Non-Inclusion of Fathers: The category 'Non-Inclusion of Fathers' refers to the ways in which fathers might be excluded from attending appointments. One psychologist suggested that there might be a bias in terms of contact sought with mothers and fathers in both clinical practice and in research. The reasons for this were felt to be largely pragmatic, mothers who take on the role of care-giver tend to be easier to access than fathers who are out at work. Two other participants wondered whether mothers always give the fathers an opportunity to be included. One psychologist also gave an example of a mother who wanted to control what information the service was given, and did not want the father present. *'I suspect it's also about mum's controlling, you know, information and – and only allowing us to know what they would like us to know'* (P3: 101). It was also considered that some mothers might perceive attendance as their role and not even think to tell the father about the appointment, or ask if he would like to attend. *'Some mothers come and they sort of think 'oh I didn't even think to ask him' you know.'* (P4: 104). This idea that fathers might not feel or realise that the invitation to the appointment does include them was also strongly represented in the father data.

Service Changes and Father Inclusion: 'Service Changes and Father Inclusion' describes the views of the focus group participants and four of the interviewees that there is a lot that could be done to increase the number of fathers engaging with services. *'Yeah. I'm sure there's stacks of stuff we could be doing actually. Erm .. I'll have a think about that (ha).'* (P5: 55). The category consists of three codes 'Provision of Information', 'Increasing Service Accessibility', and 'Messages at Work'. 'Provision of Information' describes the view that more information

should be given to families when a child is referred. It was suggested that clear information about the role of a Child Clinical Psychologist and the rationale for father involvement, and information emphasising the importance of his attendance would help fathers to understand the service better and hopefully feel less threatened. One psychologist also suggested that a leaflet aimed at normalising the fears that fathers might have about attending could be useful. 'Increasing Service Accessibility' refers to the perception that increasing the accessibility of services to fathers could lead to their increased engagement. It was suggested that services might need to be more accommodating in terms of appointment times and that they could even offer individual time for fathers. Finally, the code 'Messages at Work' refers to the perception that services might be giving out signals that inhibit father involvement, and that by changing these messages fathers could be encouraged to attend. For example, one psychologist suggested that waiting room magazines that appeal to men as well as women should be readily available, and another felt that increasing the number of men employed in health service settings would help fathers to feel that services are provided for them as well as their partners and children.

Information About Psychology: The participating fathers talked at length about the information that families received when their child is referred to CAMHS. The fathers all felt that they had received little information, or poor quality information, and suggested that, if fathers had a better understanding of services, they would feel less threatened and be more likely to engage. In comparison just two of the psychologists talked about the information fathers currently receive about psychology as a potential barrier to their attendance. However, as the category 'Service Changes and Father Inclusion' indicates, the psychologists did suggest that the provision of more information for families might improve attendance rates. Three of the participants also spoke about members of the public having inaccurate perceptions of the role of psychologists. It was suggested by two psychologists that some misperceptions might be a result of information given by referrers. *'Erm we're not sure what they get from their GPs 'coz we worry sometimes that what they get isn't quite accurate.'* (P3: 17). Whilst the psychologists emphasised the role of the referrer in providing information for families, the fathers felt that the responsibility lies within the CAMHS team.

Negative Experiences of Services: A factor that one psychologist felt could inhibit fathers from attending appointments made up the single code 'Previous Negative Experience of Services'. *'Lots of the parents we see had experiences of child mental health services when they were children and you know a lot of them were in local authority accommodation, in care, and that colours their perceptions of what it's gonna be like. They think it's gonna be the same.'* (P4: 49). It was suggested that fathers who had unhelpful experiences of services in their childhood were unlikely to relish the prospect of a present day referral of their own child. A link was drawn between this code and the category 'Class as a Barrier to Help-Seeking'. One psychologist

suggested that lower class families who have experienced social deprivation are more likely to have previous and negative experiences with services.

High-Order Category 3: Intra-Personal Barriers to Help-Seeking.

The high-order category 'Intra-Personal Barriers to Help-Seeking' refers to obstructions to attendance at appointments that were perceived to come from within the individual father as opposed to from cultural constructions of masculinity or fatherhood, or from the set-up of organisations. Encompassed by this category in both the father and psychologist data are two high-order categories 'Fears of Psychology' and 'Perception of Problem Status', and one lower-order category 'Psychological Defences'. 'Fears of Psychology' also contributes to the theme '[Mis]perceptions of Psychology' because it describes how the father perceives psychology. The psychologist data does not include the category 'Emotional Response to Difficulties' that formed part of the fathers' model.

Perception of Problem Status: 'Perception of Problem Status' is a high-order category present in both the father and psychologist data sets. In common there is the lower-order category 'Perception of Need' which contains dialogue about whether the existence of the problem is acknowledged and whether a need for outside help is recognised. Two of the psychologists felt that paternal perceptions of the problem are often very different to the maternal perceptions, with fathers being less likely to perceive the difficulties as being significant. *'Sometime erm I think fathers don't see the difficulties as much you know.'* (P4: 57). The possible reasons given for this were that fathers might be less exposed to the problem at home, and that they might have psychological problems of their own that prevent full awareness of their child's difficulties. Fathers were also perceived to be less likely to feel the need for outside help either because they want to solve problems within the family, or because they believe their child will 'grow out of' the problem. *'I remember coming across a dad who just felt that, you know, there was no need for his daughter to be there....He just said she needed to kind of pull herself together.'* (P5: 29). Three participants suggested that, in cases where a father is genuinely concerned for his child, he would be likely to become involved in helping them. One psychologist reported having observed that fathers do seem to attend more frequently when the problem is particularly severe. Overall, it would seem that both psychologists and fathers concede that the way in which a problem is conceptualised and perceived by a father has important consequences for whether he will want to involve himself with a Child Clinical Psychologist. The father data adds to this the importance of a rationale for psychological input, and also the effect of perceived consequences of not attending the appointment.

In the psychologist data the lower-order category 'Not My Problem' is also subsumed under 'Perception of Problem Status'. Four of the participants suggested that fathers tend to hold beliefs that the cause or ownership of the problem belongs to other family members. Three psychologists felt that problems are often perceived as belonging to the mother. This may be because it is the mother who is at home and struggling to cope, or because the father believes that the problem has arisen because of how the mother parents the child. In both of these cases the father might perceive the mother to be responsible for a solution. *'It may well be perceived that parenting itself has some- some role in that and that erm – and sometimes dads may opt out of wanting to – to think they have a part in that or perceive that it's the mum's responsibility in some way to solve it.'* (P1: 45). Two of the psychologists also considered that fathers might perceive the child as being the sole cause of the problem and therefore see no need for his own involvement.

'A dad in that situation might perceive that the child in some ways has to take responsibility for it because with that annoyance and anger is often a kind of attribution of blame. So that the child is – is kind of blamed for this. Er and therefore the child can in some - the dad can in some way kind of opt out of that as like taking any responsibility for the solution.' (P2: 32).

Although this 'Not My Problem' category does not exist in the father data, similar ideas were voiced about in the category 'Psychological Defences'.

Psychological Defences: Both the psychologists and the fathers suggested that a father might try to avoid facing the difficulties that his family are encountering as a defence against painful feelings of guilt or failure, or other threats to psychological functioning. *'Not only do they have a responsibility which I think most of them have already – but they are perhaps implicated in as to why this child is struggling. Then that probably is a threat to their erm – to their own psychological functioning.'* (P2: 90). Strategies that the two research populations thought fathers might develop include denying the existence of a problem, or their part or responsibility for it, distancing oneself from the problem or the family, and refusing to engage with services or solutions. The psychologist data expands on this with the suggestion that fathers might be less able to accommodate to the difficulties their child is experiencing than are mothers. *'But I still think that men find it harder to accommodate than women who have resources to come to terms with their – problem their child faces.'* (P1: 107). One psychologist wondered if the involvement that women have with their children, particularly in the early years, makes them more able to face the difficulties. It was also suggested that cultural expectations of men make it harder for fathers to process their difficult emotions. *'I think the male culture find it harder to show concern and upset and distress and therefore they find it harder to cope with. And it's a bit of a generalisation but I'm sure there's something in there about it.'* (P1: 47).

3.6.5 Theme 3: [Mis]perceptions of Psychology

In the psychologist model, the theme '[Mis]perceptions of Psychology' is comprised of two high-order categories 'Fears of Psychology' and 'Perceived Benefits of Attending'. The lower-order category 'Positive Expectations re: Appointment' that formed part of the father model did not emerge from the psychologist data.

High-Order Category One: Fears of Psychology.

In common with the participating fathers, the psychologists suggested that dads might find the prospect of contact with a Child Clinical Psychologist anxiety provoking. Many of the codes and categories that had arisen from the father data emerged also from the psychologist interviews indicating that there is an awareness of the fears fathers might have amongst practising Child Clinical Psychologists. In line with the fathers, the psychologists suggested that some of the fears and negative assumptions about psychology arise from misperceptions or misunderstandings of the way in which psychologists practice. *'Erm and er you know he might be just making the kind of assumptions that – that are inappropriate and are missing the point.'* (P2: 98). Exemplifying this, three psychologists suggested that misperceptions of the role of Child Clinical Psychologists as being medically orientated are particularly common amongst the public. *'I think 99% of the families that I see couldn't tell you what a psychologist, how a psychologist was different from erm a psychiatrist or a CPN.'* (P4: 75). Overall, the psychologists considered fathers' fears of incrimination, disempowerment, and stigmatisation, to be most important.

Fear of Incrimination: 'Fear of Incrimination' is a category that arose out of both the psychologist and the father data. Three of the psychologists contributed to this category suggesting that fathers might fear blame and judgement. This echoes the views of one father who feared that attending the appointment would be like being on trial, and thought that many fathers will fear that they will be blamed for their child's difficulties. An additional dimension in the father data was a perceived fear of actual punishment in the form of being told off, or even having children taken away. It seems that whilst psychologists and fathers perceive one fear to be what the psychologist might think, the father who spoke about fears of incrimination felt that other fathers might also fear what the psychologist might actually do.

Disempowerment /Violation of Self: The category 'Disempowerment', that arose from the psychologist data, describes how fathers might feel devalued or powerless either within their family or in contact with health services. One psychologist gave an example of a father who felt so overwhelmed and powerless as a result of the involvement of health professionals that he became very defensive about the involvement of a psychologist. It was suggested that many

fathers feel that they are not important or that their ideas or opinions will not be heard in their contact with health professionals, and that there is therefore no point to them attending. *'Yeah, I think if they feel involved or if they feel listened to. If they feel, oh it doesn't matter what I say anyway, why should they – why should it be any different, why should I listen to them, so you know.'* (P4: 184). Linked closely with 'Disempowerment' is a second category 'Violation of Self' which describes a fear of being forced to open up and having privacy removed. Three psychologists talked about how fathers might fear that a psychologist would aim to probe their minds to reach their private thoughts through mind reading or invasive interviewing. *'They think, you know, you're gonna delve into their inner most psyches and so on.'* (P2: 71). Here there is also a sense that fathers' are perceived as feeling fearful of powerlessness and of not being respected.

It can be seen that there are strong parallels between the categories described above and similar categories that arose in the father data. 'Feeling / Being Devalued', 'Power of the Psychologist', and 'Psycho-Analysing' each overlap aspects of 'Disempowerment' and 'Violation of Self'. It would seem that both the psychologists and the fathers who took part in the research agree that some fathers might perceive psychologists as powerful and intrusive, and expect that they will not be valued or respected. Unsurprisingly, it was suggested that these perceptions might lead them to resist attempts by psychologists to engage them.

Fear of Stigmatisation: A category arising uniquely from the psychologist data is 'Fear of Stigmatisation'. Three psychologists reported that fathers might fear being labelled mad. *'I can imagine that some people might have anxieties and concerns that psychology means mental health and madness, and instability and family problems or whatever, and they might fight shy of it.'* (P1: 58). There was also a sense of perceived discomfort about a hospital environment. *'I suspect that some dads may just not feel comfortable coming – I mean this so called this – the hospital, not feel comfortable in that kind of environment.'* (P1: 101). One psychologist went on to explain a historical connection between the hospital and severe mental illness, and felt that this might be why some fathers feel that the hospital setting is stigmatising. A fourth code 'Problem in Public Domain' refers to a fear of the way others will act if they become aware that a father is in contact with a psychologist. In particular, it was felt by one psychologist that parents worry that someone that they know will see them in the waiting room, and then tell others what they have seen. *'And then they might see their mates in the waiting room, that spells a problem.'* (P4: 137). It is assumed here that seeing a psychologist is somehow embarrassing and stigmatising.

Fear of Opening Up: A single code that was not subsumed by any category and therefore fed directly into 'Fear of Psychology' emerged from the psychologist data. 'Opening Up' describes

one psychologist's experience of working with a father who was fearful about talking about difficulties he had had as a child and because of this had initially avoided becoming engaged with the psychologist. This fear of facing one's own past was not mentioned by the fathers who were interviewed, although one father expressed the worry that he would hear painful 'home truths' which may be a related concept.

High-Order Category Two: Perceived Benefits of Attending.

The high-order category 'Perceived Benefits of Attending' describes the psychologists' perceptions of how fathers might be expecting to benefit from attending an appointment with a Child Clinical Psychologist. 'Perceived Benefits of Attending' is comprised of two lower-order categories 'Exploration and Discovery' and 'Access to Therapeutic Medium', and one individual code 'Alternative Agenda'. An individual code 'Previous Positive Experience with Services' also feeds into the category because of one psychologist's suggestion that previous experiences might inform the fathers' expectations of what he might gain from attending.

Exploration and Discovery: The low-order category 'Exploration and Discovery' broadly describes the gaining of knowledge about the presenting problem as a benefit of attendance in both the psychologist and father data sets. However, a difference in emphasis between the two populations was noted. Four of the psychologists placed emphasis on the perceived importance of formal assessment and diagnostic labels. It was reported by these participants that fathers are more likely to attend assessment clinics than other appointments because of their motivation for a medical diagnosis of their child's difficulties. *'I think they have a motive – a lot of them are motivated to get a positive diagnosis.'* (P4: 85). One psychologist linked this wish to 'medicalise' the problem with male discomfort with emotions and emotional issues. In contrast to this perspective, the emphasis in the father data remained on the need or wish for deeper understanding and insight into the nature or causes of the presenting problem. This perspective was voiced within the psychologist data by two participants who suggested that some fathers are motivated by a wish for greater insight. *'Many of the dads I've met over the years have been extremely kind of thoughtful and insightful and they are wanting to know, wanting the best for the child and working on the problem.'* (P1: 58). One psychologist also gave examples of fathers who had attended appointments because of their wish to understand how their own issues related to those of the child. *'I can think of several dads who've – who've been I suppose you could say motivated by self – need for self insight and self awareness as part of the work with the child.'* (P1: 70). Other examples included fathers who wanted the space to tell their own story, and who felt that their perspective might be important to understanding the difficulties.

Access to Therapeutic Medium: The category 'Access to Therapeutic Medium' parallels the category 'Therapeutic Input' in the father data with the different labels reflecting a difference in emphasis between the two populations. In the analysis of the father data it was noted that all the participants had referred to accessing help for the child and help for the parents as being one of the main benefits of attending the appointment. In the psychologist data only one participant contributed to this category suggesting in line with the fathers that the psychologist would be perceived as being the active agent of change who would 'sort-out' the child, or somehow find a solution to the problem. *'They really just want the idea that we sort out, you know, the child out and everything will be fine again.'* (P3: 34). However, one psychologist suggested that medication for their child's condition is the main therapeutic medium that fathers are motivated to obtain.

Alternative Agenda: One psychologist felt that fathers might attend appointments for reasons other than to help the child. This idea was illustrated with an example of a father who wished to gain custody of his children following a marital breakdown.

'There's some examples of when dads – dads actually arrive erm and they have an agenda which is, you know, and the main – and the family are sort of erm split and a dad would er – and I've had one particular experience where the dad turned up because he wanted to erm demonstrate that the mum was incompetent.' (P2: 20).

This notion of an alternative agenda was also suggested by one father who felt it was important to attend to 'keep an eye' on what is going on and check what is being said.

3.6.6 Theme 4: Positive and Negative Reinforcers of Help-Seeking

The theme 'Positive and Negative Reinforcers of Help-Seeking' encompasses the high-order category 'Perceived Benefits of Attendance', and is contributed to by the theme 'Family Involvement and Commitment', and the high-order category 'Perception of Problem Status' as in the father data. Like the participating fathers, the psychologists suggest that fathers who are likely to attend are those who believe psychology input will be beneficial, who are highly involved with and committed to their families and who perceive the problem as severe, or as partially belonging to them. One low-order category that is unique to the psychologist data 'Pressure to Attend', and the code 'Organisational Incentives', also contribute to "Positive and Negative Reinforcers of Help-Seeking'.

Pressure to Attend: The low order category 'Pressure to Attend' refers to ways in which fathers might be persuaded or coerced into attending by others. Two psychologists gave examples

where the CAMHS service itself exerted pressure on the father, in one case because it was felt that marital difficulties were preventing effective work with the mother and child, and in one case because attendance was part of a child protection plan. One psychologist suggested that mothers often put pressure on their husbands or partners to attend. In some cases this is seen to occur because the mother either does not want, or is unable, to attend herself, or because she needs the fathers assistance for pragmatic reasons such as transport. In other cases it is suggested that mothers feel the need for the father's support at the appointment. *'The clinic where we do get a lot of fathers and whether it's mothers sort of nagging saying you'll have to come with me and you tell her that, you tell her how so and so is.'* (P3: 46). This psychologist also hypothesised that the pressure from the mother is a major factor in attendance. *'And I suspect that if a dad never comes it's because mum doesn't put sufficient pressure on him to come.'* (P3: 101).

Organisational Incentives: Four of the participating psychologists spoke about ways in which the organisation they worked for made efforts to help fathers to feel invited to appointments. Specific invitations to fathers, emphasis on the flexibility of appointment times, and emphasis on a non-judgemental environment, were all felt to be important ways of increasing the likelihood that father will attend. The psychologists clearly perceived that whilst organisations can produce barriers that inhibit the attendance of fathers, they might also emphasise the potential benefits of attendance and provide conditions that motivate fathers to become involved.

3.6.7 Summary of Psychologist Data

The emphasis in the psychologist data was placed on the reasons why fathers might not attend appointments, although a variety of reasons why fathers might be motivated to attend were given. It is perhaps because the fathers who were interviewed were all keen to attend that they placed greater emphasis on reasons for attending. Like the fathers, the psychologists felt that the involvement of the father in the family, and his perceptions of the problem, are both factors that have major influence over whether he is likely to attend an appointment. Gender barriers in the form of tradition stereotypes of mothers and fathers, and masculine and non-masculine activities were also emphasised. Fears of psychology were talked about less than in the father data but were still particularly significant in the analysis. The constraints of employment were felt to be a major reason for non-attendance.

3.7 Results of Credibility Check

A credibility check of the results of the analysis was conducted as described in Chapter Two (2.3.2). The Cohen's Kappa value was found to be 0.85 (nine disagreements) in the case of the

father data set, and 0.89 (eight disagreements) in the case of the psychologist data sets (Appendix 6a, 6b). According to Robson (2002) any Cohen's Kappa value above 0.75 indicates an 'excellent' level of agreement between two sources. This level of concordance between the researcher and the independent reviewer indicates that the coding has been conducted in a systematic fashion as, in the majority of cases, the independent reviewer placed the same meaning units in the same categories or themes as had the researcher. Where differences were encountered, many of these arose because different categories within the data focus on similar and inter-related issues. My own judgement of where the meaning units belong often required knowledge of the wider interview context to which the reviewer did not originally have access. The reviewer also felt that context could have been important, and voiced agreement with many of the discriminations I had made after studying the extract within its immediate location in the transcript. The placing of four meaning units remained contested.

Three disagreements were about meaning units that I had placed in the category 'Intra-Personal Barriers to Help-Seeking'. Whilst I had interpreted talk about avoidance, denial, and distancing as the action of psychological defences, the reviewer had interpreted these in terms of their consequences. For example, I perceived the following quote to be about how fathers defend themselves from the difficulties through avoidance: *'Just the threat of insecurity and having to actually rationalise and look at it straight in the face...Not all – people don't always want to face things.'* (F3: 127). The reviewer, however, felt that the statement illustrated how 'not facing things' leads to failure to perceive the problem and placed the extract in the category 'Perception of Problem Status'. It is not felt that this difference in coding actions versus consequences points to problems with the analysis and resultant model because the links between factors are emphasised and it is recognised that factors within 'Intra-Personal Barriers' can impact on those in 'Perception of Problem Status'.

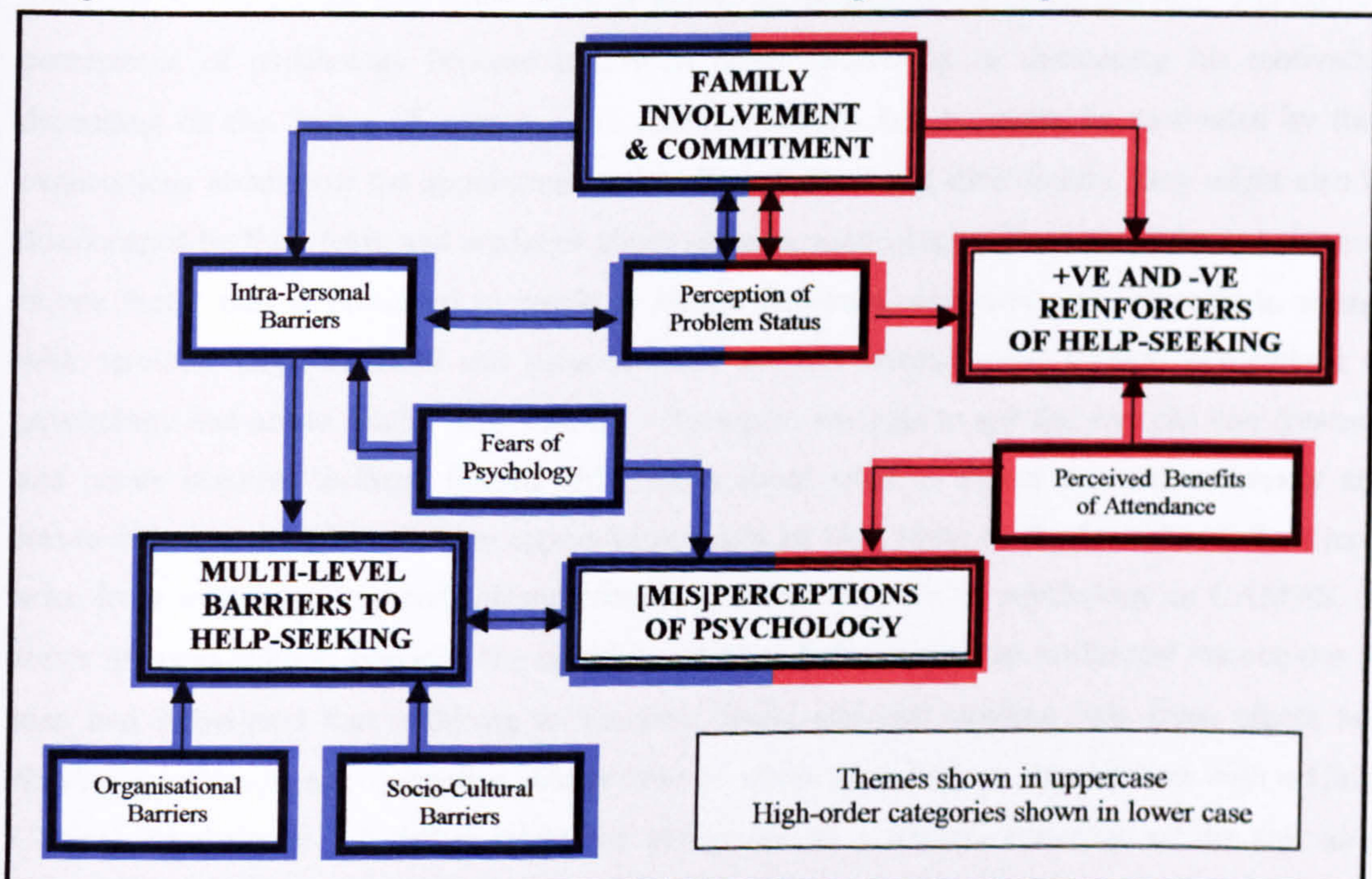
The remaining disagreement represented a subtle difference in interpretation of dialogue. The following meaning unit had been coded as 'Pragmatic Pressure' and subsumed under the theme 'Positive and Negative Reinforcers of Help-Seeking' as I felt this psychologist perceived the fathers' attendance to be for purely practical reasons. *'I mean dad turned up because – probably because of transport because they came from quite a distance and mum didn't have transport'* (P2: 21). The reviewer, however, placed the extract in the theme 'Family Involvement and Commitment' as it was felt that this father perceived getting his wife and child to the appointment as his responsibility. With this example I felt that my own coding was more grounded in the content of the extract, and that the reviewer's was more interpretative as the psychologist did not mention whether or not the father felt responsible.

3.8 Model of Interaction Between Themes

Having discussed the content of the two sets of data, a model of the relationships between the most significant high-order categories and themes will now be presented and discussed. The extent of similarity between the psychologist and father data has meant that one model captures the essence of both data sets. These will therefore be discussed together to avoid unnecessary repetition.

The model below represents the relationships between the themes and main high-order categories that emerged from the two sets of data. It can be seen that all the components of the model are linked, either directly, or indirectly through one of the themes or categories. Shown in red are the factors that are perceived to increase motivation to attend an appointment, and shown in blue are the factors that are perceived to inhibit attendance. Essentially, a father's decision is perceived to be the result of whether the perceived benefits of attending, his sense of responsibility towards his family, and the potential consequences of not attending, are enough to outweigh his fears and doubts, and to overcome organisation and socio-cultural barriers to help-seeking.

Figure 3: Model of Interaction Between Themes and Main High-Order Categories



Within this cost-benefit analysis, there is a hierarchical relationship with some components of the model taking greater loading than others. 'Family Involvement and Commitment' is a pivotal factor in the decision making process, influencing and influenced by 'Perception of Problem Status'. A father's perception of the problem might affect his relationship and involvement with

his family, whether they pull together or apart. Fathers might increase their involvement with their family in order to provide support or to help find solutions, fathers might also begin to withdraw from their family to avoid or distance themselves from the difficulties. The level of a father's involvement in his family can vary from high to low and a father's perception of the problem can vary in terms of the perceived ownership and severity of the difficulties and the perceived need for help. Whether these two components increase or decrease motivation to attend an appointment is determined by how they co-vary within an individual father. However, if the level of involvement and/or perception of the problem in an individual case inhibit attendance, the other factors that make up the model become relatively unimportant. This is because an uninvolved father who either doesn't recognise the existence of a significant problem that requires outside help, or who doesn't perceive the problem or its solution as anything to do with him, is unlikely to get as far as considering the costs and benefits of his attendance. Uninvolved fathers are perceived to be as distanced from the problem and its solution as they are their families. More involved fathers, who are perhaps more exposed to the problem, or feel that they share some joint responsibility for their child's health, might go on to consider whether they want to attend the appointment.

At this point in the model, when a father is actually considering the appointment, a variety of obstacles and incentives that either drive or inhibit his motivation to attend are met. The father's perceptions of psychology become influential either increasing or decreasing his motivation depending on the degree of negative and positive. Whilst fathers might be motivated by their expectations about how the appointment might benefit them and their family, they might also be discouraged by their fears and anxieties about seeing a psychologist. Fear about the appointment is one factor that is perceived to result in fathers becoming defensive and reluctant to engage with services. Organisational and socio-cultural barriers interact with fathers' perceptions of psychology and act to inhibit help seeking. Having to struggle to get the services can frustrate and create negative feelings, limited information about what to expect can create anxiety and leaves fathers to imagine what the appointment might be like. Many of the fears that fathers have arise from misperceptions and misunderstandings about the role of psychology in CAMHS. In terms of socio-cultural barriers, the extent to which a father buys into traditional stereotypes of men and fatherhood that childcare is women's work, and that needing help from others and sharing emotions is non-masculine shapes how he views attending an appointment with a Child Clinical Psychologist. A father might see attendance as a natural extension of his role as a father, or he might perceive it to be at odds with his perceived role as a hegemonic male.

In conclusion, of the myriad of factors that are perceived to affect the attendance of fathers at initial appointments with a Child Clinical Psychologist, it is difficult to determine the most significant. This is because the weighting of each variable is unique for every father and the

relative importance of factors therefore varies on a case by case basis. However, it is suggested by those who participated in this study, that the level of a father's involvement with his family in interaction with his perception of the problem are key factors in whether the pros and cons of attendance are considered by the father at all.

CHAPTER FOUR

DISCUSSION

4.1 Introduction

The aim of this study was to employ the method of Grounded Theory to explore the factors that influence fathers' decisions of whether to attend an initial appointment with a Child Clinical Psychologist when their child is referred. This topic was addressed from both the perspective of the fathers who were potential service users, and from that of the service providers: Clinical Psychologists working with children and their families. In the first chapter, a review of the relevant literature was conducted. A need for qualitative research aimed at generating new understandings regarding fathers' attendance, and at highlighting important areas that may have been neglected in previous research, was identified. The research question was posed. The second chapter detailed the methodology chosen to explore this topic and provided a rationale for the use of the qualitative approach of Grounded Theory. The third chapter presents the results of the study, looking first at the fathers' perspectives then turning to a comparison of the data collected from fathers and that from the psychologists. A theoretical model describing the factors that are perceived to influence fathers' decisions was presented. This fourth and final chapter aims to draw together the key points raised in this study and to relate these to the relevant literature and current policy and practice. Following this, the methodological limitations of the study will be considered and, in light of these, recommendations for future research will be offered. Finally, as is the tradition in qualitative research, the chapter will finish with reflections on the research process and a brief conclusion.

4.2 Review of the Main Findings

Analysis of the father and psychologist data revealed five factors that were perceived by both populations to influence fathers' decisions of whether or not to attend an appointment with a Child Clinical Psychologist. The themes and categories that arose from the analysis, and that point to these five factors, fit with the vast majority of the data collected indicating that they can be described as addressing those factors that are central rather than peripheral to an understanding of fathers' decisions. The five factors are outlined below:

- (1) The level of a father's involvement with, and commitment to, his family.
- (2) A father's positive and negative perceptions of, and expectations about, the appointment and child psychology services in general.

- (3) The extent to which factors are experienced or perceived by a father to positively and negatively reinforce help-seeking behaviour.
- (4) The individual, organisational, and socio-cultural barriers to help-seeking that fathers perceive and experience.
- (5) A father's perception of the problem, including whom he perceives is responsible for the problem and/or solution and his assessment of whether outside help is required.

In the previous chapter, these factors were linked together to form a conceptual understanding and representation of the data. Within this model, a father's decision is perceived to be the result of whether the perceived benefits of attending, his sense of responsibility towards his family, and the potential consequences of not attending, are enough to outweigh his fears and doubts, and to overcome barriers to help-seeking on individual, organisation, and socio-cultural levels. The model describes no single factor as being most important across all fathers' decisions as the participants considered that a unique combination of factor characteristics would arise in the case of each individual father. One participant explained this particularly concisely stating: *'It will be a pie chart with different bits of different things. They'll all have - they'll all have varying things, it's just being different levels. It will all be the same stuff, it will just be in different ratios.'* (F3: 142-143). However, the two factors 'Family Involvement and Commitment' and 'Perception of Problem Status' were perceived as being pivotal to whether other factors contribute to the decision. It was suggested that uninvolved fathers, particularly those who perceive the problem as unimportant or insignificant would, as a default, not consider the possibility of attending. *'Well it's like this, if a dad's not into realising it or getting into his family it is not like what he thinks of psychology or ought's gonna make a blind bit of difference. He's just not going y'know'* (F2: 98). The model therefore describes how, when a father begins considering attendance as a possibility, a host of factors other than his family involvement and perception of the problem become important in the decision making process.

4.3 Discussion of the Main Findings

In relating the current findings to the wider literature, there are three significant areas that require discussion. The first of these is the relationship between the father's involvement in his family and his involvement with the clinic. The second concerns issues of gender and masculinity, and the third considers the role of organisations, and the individual clinicians within them, in engaging fathers. These will be discussed in turn and the implications for future policy and practice will be considered.

4.3.1 Fathers in the Family and in the Clinic

The participating fathers and psychologists suggested that if a father is generally uninvolved with his child on a practical and emotional level and/or generally uncommitted to a relationship with the mother, he is unlikely to become actively involved with mental health services when that child is referred. All the fathers who participated in this study referred to their commitment to their families and their involvement and responsibility in parenting their child as being key reasons behind their intention to attend. The psychologists also referred to concepts of emotional investment and attachment, levels of family participation, and feelings of family inclusion and responsibility. In this way a father's participation at the clinic was perceived by the participants of this study to mirror his participation at home.

Although it would perhaps seem logical that the greater a father's emotional investment in his child the more likely he would be to attend, in one recent study this pattern was not born out by statistics. Walters and her colleagues (Walters et al., 2001) found no significant correlations between fathers' attendance at appointments and their emotional involvement with their child, the expressed warmth towards child, the quality of fathering, or the level of involvement with their child through play. However, fathers in the same study suggested that close relationships between mothers and their children was one reason why mothers rather than fathers might attend (Walters et al., 2001). Interestingly, whilst measures of the quality of the father-child relationship did not correlate with attendance, measures of father involvement in terms of 'parental load taking' revealed a positive correlation. This would concur with the suggestion of authors such as Carr (1995) who perceive problems of father involvement to be embedded in the context of Western culture that tends to separate fathers from their children. This distinction between practical involvement in childcare and emotional involvement with the child was also found in an earlier study (Deater-Deckard et al., 1994). Deater-Deckard and his colleagues (Deater-Deckard et al., 1994) reported that fathers who spent time away from their family at work experienced similar levels of separation anxiety to the mothers, and argued that this indicated a high-level of emotional involvement. Clearly, the presumption made by fathers and psychologists in this study that parental load taking is an indicator of emotional investment requires further clarification.

Walters and her colleagues (Walters et al., 2001) found that the most important predictor of a father's attendance is the quality of that father's relationship with his own father. There was no statistically significant correlation between attendance and fathers' relationships with their mothers (Walters et al., 2001). In the current study, fathers' experiences of being parented was an issue highlighted briefly by one of the psychologist participants who suggested that some fathers do not have an internal model of how to parent because it was lacking in their own

childhood. *'I think a lot of it depends on what their experiences are of being parented. And how involved their fathers were.'* (P4: 110). One of the participating fathers also linked his experiences of being parented with his own behaviour as a father indicating that his determination to provide his children with a better experience provided him with motivation to attend. Together these findings imply that the impact of parental relationships may be important. However, this subject matter arose spontaneously in only two interviews and was not specifically explored with the other participants. It is therefore difficult to draw conclusions about the extent to which the current findings support or refute those of Walters, Tasker and Bichard (2001).

4.3.2 Masculinity, Gender, and Help-Seeking

The current research indicates that perceived incompatibility between acting and feeling like a 'real man' and attending a child mental health appointment produces a key barrier to fathers' attendance. As Lee and Owens (2002) purport, individuals behave and contribute to relationships in ways that reflect their personal and gender identity. In this way, fathers choose not to become involved in activities such as CAMHS appointments when doing so would be incongruent to their sense of self. It was interesting that each of the fathers emphasised the ways in which other men subscribed to the traditional, patriarchal view of maleness and appropriate male behaviour often described in the sociology literature as 'hegemonic masculinity' (Connell, 1987). It was perceived that the importance of being successful, infallible, independent, and invincible (central tenets of hegemonic masculinity), constrict men's abilities to seek and accept help. When talking about their own beliefs and behaviours, the fathers tended to portray themselves as being what has been dubbed a 'new man' (Morgan, 2001). The 'new man' is a modern conceptualisation of masculinity that represents a contrast to the hegemonic stereotype and, according to Morgan (2001) has received considerable publicity in Britain. The 'new man' is characterised as one who renegotiates his relationships with employment and family to achieve increased equity between himself and his partner. Unlike his hegemonic counterpart, the new man shares power and intimacy with his wife, is caring and emotionally available, and willing to pull his weight when it comes to childcare and domestic chores (Silverstein, Auerbach & Levant, 2002; Lewis & O'Brien, 1987).

Whilst the fathers in the study were defining themselves as family-dedicated 'new men' and openly criticising the 'macho' tendencies of others, at the same time their discourse suggested that they had not completely rejected hegemonic ideology. For example, one father referred to the mother as being 'the childcare boss' and referred to the children as 'her children' regardless of the fact he was their biological father, and another father stated that he was private 'like most men' and wanted to solve his own problems. All the fathers also described their families as

conforming to traditional divisions of labour. Within sociological literature, many authors are suggesting that, despite much interest in more egalitarian conceptualisations of masculinity, there is little evidence of real change (Morgan, 2001; Edley & Wetherell, 1995). It is argued that the competing and mutually exclusive hegemonic and new man ideals present individual men with a complex ideological dilemma of how to reconcile the traditional and modern notions and define themselves as a man (Lee & Owens, 2002; Morgan, 2001; Connell, 1995). Perhaps this is the position of the participating fathers who did appear to be experiencing conflict between the two polarised identities of the hegemonic macho male and the more sensitive new man.

Returning to the recent study by Walters, Tasker, and Bichard (2001) the reasons that fathers gave for non-attendance echo those expressed by fathers in the current study. These authors (Walters et al., 2001) report that fathers referred to men being unable to discuss feelings, being more secretive than women, and 'too macho', and that they described the appointment as not being their responsibility or business. Concerns about the clinic atmosphere being controlled by women and fears that they would feel awkward or redundant and that their masculinity would be attacked were also voiced (Walters et al., 2001). It would seem that these fathers, like those in the current study, were reporting ways in which attendance at child mental health appointments is fundamentally at odds with a hegemonic male identity. Whilst psychologists and fathers in the present study felt that increasing the number of male mental health workers would result in clinics being perceived as less feminine and attract more fathers, Walters, Tasker, and Bichard (2001) report that fifteen percentage of their participating fathers stated a preference for a female therapist and the other eighty five percent indicated no preference. As Walters and her colleagues (Walters et al., 2001) point out, there is little known about gender and therapeutic relationships. It is therefore difficult for health services to know how to respond to issues that appear to be gender related.

The findings of the present study also draw our attention towards the ways in which fathers construe the difficulties in their families. It was suggested that many fathers become defensive about the problem and deny its existence or distance themselves from their family. The difficulty that fathers face in acknowledging the problem appears to arise from the hegemonic ideal that a 'real man' is strong and infallible, and able to cope independently. It was felt that fathers tend to resist the notion that a problem is significant, that it requires outside help, or that they have a role in responding to that which is perceived to be 'woman's business'. The fathers who participated in the study reported that they had overcome their own resistance and planned to attend having acknowledged the problem and become concerned for their child. They suggested that fathers who are able to realise the significance of their child's problem, perhaps because of the severity or impact, then become concerned and are more likely to attend. This concurs with the findings of Kerr and McKee (1981) who reported that fathers only become involved in child health care

when they perceive the problem as being important enough to warrant their participation. However, more recently Walters, Tasker, and Bichard, (2001) found no correlation between fathers attendance and their reported level of concern for their child or the reported extent or severity of the problems. Somewhat at odds with this, the same fathers reported one reason for non-attendance being the belief that the problem would sort itself out (Walters et al., 2001) which would seem to suggest low levels of concern.

A further barrier that was felt by fathers to be mediated by socio-cultural beliefs is that of employment. In line with the findings of an earlier study (Walters, 1997) it was suggested that fathers are easily excused from attendance, by their partners, the psychologist, and most importantly themselves, because appointments take place in office hours. It was argued, particularly by the fathers, that men tend to see their role as the 'bread-winner' and prioritise work over their families when they might actually be able to take time away from work should they want to. In this way work *per se* was not perceived to be a major reason for non-attendance. One recent study lends support to this supposition. Walters, Tasker, and Bichard (2001) report that fathers frequently stated work as a reason for non-attendance yet no statistical relationship was found between the fathers attendance and either parents' employment situation. However, as the psychologists in this study pointed out, in some cases work is a very genuine reason that should not be discounted. This is a feeling reflected in a paper by Hecker (1991) in which she states that: *'Therapists may view some of the fathers who give work as an excuse for not attending therapy as 'resistant', but as the psychoanalysts say 'Sometimes a cigar is just a cigar'.'* (p.38). It would seem that it is important not to completely discount the constraints that working arrangements may place on fathers, and for services to accommodate flexibility to these. However, as Walters (1997) suggests, it is also important to consider how factors other than working hours impact on fathers ability and willingness to participate in their families contact with CAMHS.

4.3.3 Service Organisation Issues

Organisational barriers such as lack of information about the service, uncertainty about fathers' role and inclusion in the process, long waiting lists, and difficulties in getting referred in the first place were all cited as important factors influencing fathers' willingness to attend appointments. In particular, it was suggested that uncertainty or misperceptions about what to expect create anxiety about the appointment and lead to avoidance. Equally it was suggested that fathers do not perceive that they will be welcomed and valued, and therefore choose not to become engaged with services. As Streaan (1997) has argued, therapy is often equated with a 'women's world' in which fathers may not feel wanted. In line with this and suggestions in earlier papers (Heubeck et al., 1986; Hecker, 1991), Foote and colleagues (Foote, Schuhmann, Jones, &

Eyberg, 1998) reported that fathers often feel they have little to contribute and doubt their own value in the therapeutic process. Herbert and Carpenter (1994) also reported that many fathers, in this case fathers of children with Down's syndrome, often feel like a secondary partner and feel excluded from hospital appointments.

The current literature supports the notion that the way a father perceives the service to which his child is referred is of great importance. Fathers' perceptions of their therapists have been linked to their family's decision to continue or terminate therapy (Berg & Rosenbaum, 1977; Shapiro & Budman, 1973) as well as to clinical outcomes (Bennun, 1989). In the current study, the fathers reported being motivated by what they perceived to be benefits of attending, in particular increased understanding of the problem and access to therapeutic interventions. However, these fathers also described how their own motivation, and most probably that of others, was curbed by their fears and anxieties about what the appointment might entail. The views of the psychologists matched closely with those of the fathers suggesting that there is awareness within these services of the positive and negative feelings and expectations that fathers might hold. Importantly, both the fathers and the psychologists felt that misperceptions about the role and nature of psychology and psychologists are common amongst fathers. This suggestion was confirmed by the group of fathers who recalled an experience of relief and being 'set at ease' when their first appointment was not as unpleasant or threatening as they had imagined.

Clearly, the findings indicate that there is a large disparity between fathers' expectations and their experiences, their expectations being largely negative and tending to inhibit attendance. The participants of this study propose that providing fathers with information aimed at altering their perceptions of services could be effective in recruiting some of the absent population. This is a view shared by Hecker (1991) who advocates giving fathers information about the nature and purpose of therapy, what it might involve, and how long it might last. Further strategies such as providing rationale for the fathers' involvement, emphasising his importance in his family, extolling his capabilities as an expert in regard to his son or daughter, and acknowledging and normalising some of the reasons why fathers find it difficult to attend appointments, also mirrored Hecker's (1991) earlier recommendations.

In addition to their focus on the reluctance of fathers to attend appointments in therapeutic settings, a number of authors (Lee & Owens, 2002; Walters et al., 2001; Flynn, 1998; Streat, 1997) have also referred to an apparent counter-resistance within mental health services. This topic was briefly encountered during the psychologist interviews as they reflected on the process of the interview. Each of the participants felt that the interview had prompted them to think about their own services, and their work with fathers, in a way that they might not have otherwise done.

As one psychologist explained:

'I mean it's erm just the fact that you know - not a fact - but that you were coming along made me kind of sit down and think a little bit about it. That I'd probably not thought too much about it before erm .. I just you know - you know - I suppose your trains of thoughts and the way that you're trying to think are - are along kind of well groomed lines in some ways.' (P2: 124).

Two of the participating psychologists indicated that the interview had aroused their interest in the phenomena of the absent father. *'But I'm gonna keep an eye on it now. I'm gonna be a lot more aware of it.'* (P5: 152). The same two participants also considered that it is all too easy for clinicians to get caught up in day-to-day practice seeing whoever comes through the door without necessarily reflecting on who isn't attending and why that might be. This is perhaps one reason for previous findings that verbal enthusiasm for including fathers is often not reflected in the behaviour of clinicians (Flynn, 1998; Robertson & Fitzgerald, 1990). One participating psychologist also acknowledged that psychologists generally have more experience and therefore skills in working with mothers, and that many psychologists are mothers themselves and can draw on their own experiences. Robertson and Fitzgerald (1990) have previously speculated along the same lines suggesting that clinicians may not feel skilled in working with fathers and therefore do not tend to actively seek out this experience.

4.3.4 Summary

The findings of the current study resonate with those in the wider field of literature and point to a variety of factors as impacting on fathers' willingness to attend appointments. The supposition that the global level of a fathers' practical involvement with the referred child would reflect his involvement with the clinic found support in one recent study (Walters et al., 2001). However, the same study challenged the belief that a relationship between the level of a father's emotional involvement and attendance also exists. Further research is needed to clarify this matter. Other factors implicated in this research such as the fathers' perceptions of CAMHS, the way he conceptualises the problem, and the ethos of the clinics, found some support in the limited body of literature that the relevant field provides. Within this, and the present study, many of the reasons that are used to account for the non-attendance of fathers at appointments appear to relate to and arise from internalised values associated with hegemonic conceptualisations of masculinity. This suggests that, in order to understand and tackle the difficulties in engaging fathers, their resistance needs to be understood within the wider socio-cultural context in which it occurs.

4.4 Implications for Policy and Practice

As research begins to point to the fathers as the most pivotal member of the family in terms of their engagement and subsequent clinical outcome, interest is turning to means of engaging the absent fathers. Berg & Rosenbaum, (1977) argued that the father should be involved as early as possible in the process of therapy as failure to involve him may only confirm his assumption that he is not very important and make later attempts to engage him more difficult. Since this time, authors such as Carr (1991, 1995), Hecker (1991), Littlejohn & Bruggen (1994), and Walters, Tasker and Bichard (2001), have all emphasised the importance of fathers and have advocated early and active inclusion of fathers in CAMHS. However, there is little in the literature that suggests how services can encourage fathers to attend initial appointments, as well as a notable scarcity of therapeutic strategies and tools specifically designed for working with men once they get there (Robertson & Fitzgerald, 1990).

The current research points to the importance of making fathers feel invited to attend appointments, and of offering them an understanding of what the appointment is likely to entail and a rationale for becoming involved. These ideas are also found within earlier literature. Heubeck, Watson, and Russell (1986) and Hecker (1991) have both pointed specifically to the importance of the ethos of the clinic, suggesting that more could be done to make these places father-friendly. Hecker (1991) further advocates the provision of information and suggest that fathers will be encouraged and engaged by clarifying expectance of the father's involvement, normalising his lack of enthusiasm, and extolling the his capabilities as an expert with regard to his children. Walters, Tasker, and Bichard (2001) found that fathers were often positively engaged by participating in the research interview and in some cases began to attend appointments where they had not done previously. The authors (Walters et al., 2001) conclude from this that taking a special interest in the father and positively connoting his role can increase his willingness to engage.

In considering both the current findings and the wider literature, it seems that it would perhaps be beneficial for services to provide more explicit information for fathers and their families at the stage of referral. In particular, information that helps fathers to get a sense of how the service operates and that provides him with rationale for his attendance might be helpful. In addition to this, it seems important that CAMHS teams take the time to reflect on their work with fathers and to think about how fathers might perceive their service. In cases where there are difficulties in engaging fathers in therapeutic work, it may be useful for the clinician involved to consider how the model constructed in the present research might apply to explain and predict the factors involved. The model could also be useful in helping clinicians to remain mindful of the myriad

of factors that might be inhibiting fathers' attendance, as well as in exploring and understanding how the same or similar processes are operating within specific families.

4.5 Limitations of the Study

Throughout the research process a number of practical and theoretical limitations to my study became apparent. In terms of practical difficulties, I encountered significant problems in recruiting fathers, particularly to the individual interviews. In planning this study I had included methods that the literature suggested would increase response rates of fathers and I had hoped to recruit ten fathers to individual interview. Unfortunately, the response rate was a lot less than I had envisaged and as a result of this the sample size is smaller than was originally anticipated. This has meant that the data set did not reach the point of theoretical saturation. That is, the data collection did not reach a stage where no new material was arising with each subsequent interview. The fathers' focus group did however produce very similar material to that of the individual interviews allowing the two sources of data to be brought together in analysis. The overall model of the factors that influence fathers' decisions of whether to attend an appointment was therefore built from the discourse of five rather than three fathers. It is also the case that the difficulties in recruiting fathers afforded the time and resources to explore the perspectives of Clinical Psychologists working with children and their families.

The exploration of the psychologists' perspectives adds interesting and useful dimension and depth to the research. However, it is important to acknowledge the limitations that were encountered in attempting to analyse two sets of independent data through the process of Grounded Theory. The main difficulty was that it proved impossible to conduct the interviews and to analyse the two sets of data without bringing to each ideas that arose from the other. Throughout this research I have maintained a social constructionist position and have argued that no research is initiated and conducted without the influence of the researchers pre-existing theoretical ideas and assumptions. The difficulties I faced were therefore not incompatible with my philosophical stance. However, whilst acknowledging that researchers are unable to truly separate themselves from the world that they study, I believe that it is possible for researchers to be reflexive in their practice, and to acknowledge the impact of their own beliefs, position, and knowledge of the field. The level of my immersion in both sets of data within the same time frame reduced my conscious awareness of how I was drawing from each to understand the other. This lack of separation between the two analyses therefore limited my ability to introspect and reflect on what was intended to be two separate processes.

The surprising degree of agreement found between the population of fathers and that of psychologists is not felt to have arisen as a result of the way the data was analysed, a claim that finds support in the results of the credibility check as well as my own reflections on the process.

However, it is possible that the participants were all drawing on global cultural assumptions about the behaviour of fathers rather than their own unique experiences and ideas. If this is the case, then it would be a limitation of the study. Certainly, the participants were asked to speculate about the thoughts, behaviours, and experiences of others and they may have referred to dominant cultural beliefs in doing so. However, the participants were also encouraged to reflect on their own thoughts and feelings, and ground examples in their own experiences. Within the father data the majority of factors mentioned were cited as being of personal importance to the participants as well as other fathers. When the psychologists talked about the reasons for father attendance they were asked about specific examples that they had experienced in the course of their careers, and the reasons that mothers or children had given if the father was not in attendance. It therefore seems possible that the references to cultural assumptions were made largely because these assumptions reflect the behaviour of some fathers.

Qualitative research aims to provide richness and depth in its findings and does not attempt to approximate quantitative research methodologies with regard to issues of generalisability. However, the extent to which the research samples are representative of the research population, and the contextual settings of the study, are important in considering who the research might apply to. In terms of the psychologists recruited to the study, a range of ages, gender, experiences, backgrounds, and interests, were represented. The diversity of views that were accessed are therefore likely to be fairly representative of this professional population working in CAMHS teams in the N.H.S. in the UK. However, it is important to note that the data set as a whole did not reach the point of saturation. Further interviews or focus groups might have revealed some of the codes to be particular to this group of psychologists working within West Yorkshire.

In terms of the fathers recruited to the study, this sample were all aged between thirty-nine and fifty-one years. This indicates that younger and older fathers are either less well represented in the population invited to participate, or that they are less likely to agree to take part in research. Fathers with positive attitudes towards their child's referral to CAMHS and their own attendance also appear to be over-represented in the data. Whilst the participating psychologists reported father non-attendance rates of between 20-85%, and gave anecdotal evidence of fathers being generally resistant to the therapeutic process, this is not a view strongly represented in the data. This may mean that the population of fathers who are difficult to recruit to clinic are also difficult to recruit to research, and that the findings of this research may not necessarily apply to this group. The research therefore cannot claim to have privileged access to the views of those fathers who do not attend. It is also uncertain to what extent the model might apply to non-biological fathers, fathers from different cultural backgrounds, or fathers who are not living with the referred child.

In addition to the wider context of CAMHS teams with the N.H.S., the more immediate context of the interview itself is an important consideration. As with all qualitative interviews, each was a unique encounter. The flexibility of a topic guide results in participants being asked different questions, or the same questions in a different way. Despite genuine attempts not to lead participants and to frame questions in a neutral manner, undoubtedly the research agenda and the way questions were asked to some extent will have shaped the answers that were received. It is also the case that my own position as a white, middle class, female psychologist may have had implications for the matters that the fathers or psychologists felt comfortable discussing. In particular, the research topic implies that I am interested in working with and engaging fathers and in favour of them attending appointments. It may therefore have been difficult for participants to share beliefs that conflicted with these due to concern about causing offence or being seen in a bad light. However, as far as I could ascertain, all the participants appeared relaxed and open during the interviews.

4.6 Directions for Future Research

The exploratory nature of this piece of research, and some of the acknowledged limitations, give rise to further questions regarding the factors influencing fathers' attendance at initial appointments with a Child Clinical Psychologist. Given that the data sets did not reach the point of saturation, future research using larger samples is needed to clarify and establish the results. In particular, research recruiting greater numbers of fathers would be useful, although it seems likely that this would be a difficult task. Certainly, any research that identifies more successful methods of engaging fathers in research would make a valuable contribution to the field. The small sample size of the current study has also meant that some potentially important variables have not been explored in depth. In particular, it would be interesting to see whether the model varies with age and lifestyle and, following the recent findings of Walters, Tasker, and Bichard (2001), to further explore the influence of a father's relationship with his own father. It would also be of interest to investigate whether the same or different factors are important to populations of fathers that were not accessed in this study such as fathers from ethnic minority backgrounds, non-biological fathers, and fathers who do not live with their children. Given that in this study the resultant model was not discussed with participants to establish whether it fits with their experience, future research incorporating this into the design would be of great benefit to the field.

Given the multidisciplinary nature of CAMHS, it would be useful to explore whether different factors influence fathers' decisions to attend initial appointments according to the type of professional they are invited to see. The current findings suggest that fathers' perceptions of psychology, psychologists, and psychology services are important influences. It would be

particularly interesting to explore this area further and to address how different professions are perceived. Further exploration of organisational barriers to attendance is also needed. Whilst the fathers in this study felt that they did not have access to the right quantity and/or quality of information about CAMHS it was not clear what their specific information needs were. Research investigating this, and exploring how father-friendly information impacts on their perceptions of the service and willingness to attend would be a particularly useful contribution to the field.

Finally, it is important to note that this study has concentrated on one single member of a family when there are usually at least two more of importance when a referral to a Child Clinical Psychologist is made. Research examining the perspectives of different family members and how these impact on each other, perhaps longitudinally through the whole referral and attendance process, would certainly be illuminating and would add further depth to the research initiated in the present study. The current findings also highlight the significance of fathers' internalised values associated with masculinity. Given the predominance of hegemonic masculinity in Western culture, it would seem important that future research attempts to understand and locate the behaviour of fathers within a broad understanding of societal constructions of masculinity.

4.7 Reflections: The Research Process

As a novice qualitative researcher, I have found the research process to be both a challenging and thought-provoking journey. At times during the analysis I felt hesitant in my attempts to move from a purely descriptive account of the data to one more interpretive in nature. This hesitation arose largely from my anxiety about maintaining a good balance between staying close to the data and building up more general themes. My decision to compare two separate populations added to this difficulty. At times I was surprised by the similarity between the groups of fathers and between them and the psychologists and I worried that I was unintentionally mixing ideas and concepts between the sets of data. Having said that, I strove to maintain an openness to potential differences in the data and the results of the credibility check suggest that the similarities I uncovered were not a result of the data having been forced into categories. Overall I found Grounded Theory to be a powerful and useful tool for analysing and conceptualising the personal thoughts, opinions, and experiences of those who took part in the study.

Throughout the process I endeavoured to ensure the rigour and quality of my research and found some of the techniques that Grounded Theory prescribes, such as the use of memos and constant comparison, particularly useful. I also chose to implement the evaluative criteria set out by Elliot and colleagues (Elliot et al., 1999). I have aimed to own my own perspective, to situate the samples by providing basic descriptive data about the participants of this study (i.e. age,

occupation, number of children for the fathers and grade, experience and service set-up for the psychologists) and I have grounded examples with verbatim extracts throughout. I have also provided a separate credibility check for each set of data and have accomplished specific research tasks. One quality criterion that I found difficult to achieve was that of coherence. Having never before attempted to synthesise such a vast and complex web of data I found maintaining both depth and readability a challenge to which I hope I have risen. Finally, Elliot, Fischer, and Rennie (1999) suggest that the research should resonate with readers. This is a quality criterion that I have aimed to meet but cannot truly judge. Given my previous immersion in the data, and my knowledge of the wider field of literature, I cannot imagine myself in the shoes of a first time reader. I hope, however, that I have succeeded in bringing to life the thoughts, ideas, and experiences, of my participants, and that this does indeed resonate with readers.

4.8 Concluding Comments

The current study has produced findings that have widened the base of knowledge about the reasons why fathers do, or do not, attend appointments with Child Clinical Psychologists when their child is referred. A major strength of this thesis is that thoughts, ideas, and concerns about attendance are generated in the everyday language of the participants. The open-ended exploratory nature of this research unsurprisingly gave rise to a wide-ranging corpus of information and the findings suggest that there are many issues involved for fathers making decisions about whether or not to attend an initial appointment.

A main finding was that a lack of involvement in family life and, in relation to this, particular ways of construing the presenting problem, are perceived as being key reasons for non-attendance of fathers. In cases where absence in the clinic is a reflection of physical or emotional absence in the child's life, there is perhaps little that services can do about this, at least before the first appointment. However, further findings suggest that fathers frequently hold concerns about attending the first appointment that appeared to arise from uncertainty about what the service entails and their own role within it, and also from wider socio-cultural conceptualisations of masculinity that are incompatible with attendance. It is these findings that draw our attention to organisational issues within CAMHS. It is suggested by the participants that further information about what can be expected from services, and that emphasises and gives rationale for the attendance of fathers, would help to reduce anxiety and encourage fathers to attend. It is also felt that services need to examine the subtle messages that they give out and make efforts to project a more 'father-friendly' image. As Walters, Tasker, and Bichard (2001) have suggested, it would seem that there is indeed a need for the energies of therapists in child services to be directed to creative ways of encouraging the attendance of hesitant fathers.

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LIST OF APPENDICES

APPENDIX 1: Ethical Approval (a) Wakefield Health Authority

(b) The Leeds Teaching Hospitals NHS Trust

APPENDIX 2: Consent Forms (a) Example of Information Leaflet

(b) Example of Consent Form (Returned by Post)

(c) Example of Consent Form (Interview)

APPENDIX 3: Topic Guides (a) Fathers Focus Group and Father Interviews

(b) P.I.C.T. Focus Group and Clinical Psychologist Interviews

APPENDIX 4: Two Page Extracts from Transcripts

(a) Father Transcript (F2:1 – F2:18)

(b) Psychologist Transcript (P1:10 – P1: 24)

APPENDIX 5: Diagrams Presenting Codes, Categories, and Themes that Arose from Analysis

(a) Fathers Focus Group and Father Interviews

(b) P.I.C.T. Focus Group and Clinical Psychologist Interviews

APPENDIX 6: Validation Exercise: Confusion Matrices and Cohen's Kappa Calculations

(a) Father Data Set.

(b) Psychologist Data Set.

APPENDIX 1: (a) Ethical Approval, Wakefield Health Authority

Wakefield Health Authority Chairman: Lord Lothhouse of Pontefract
Acting Chief Executive: Janet A Fox**LREC/WYHA/W/02/04/003 – Please quote on all correspondence for ease of reference**

1 May 2002

Miss Elinor Dennison
 Psychologist in Clinical Training (PICT)
 Academic Unit of Psychiatry & Behavioural Sciences
 The University of Leeds
 15 Hyde Terrace
 LEEDS LS6 9LT

Dear Miss Dennison

TITLE OF PROJECT: Deciding whether to attend an initial appointment with a Child Clinical Psychologist: Fathers' discourses

On behalf of the District Research Ethics Committee, we would like to thank you for attending their meeting held on 16 April 2002 and presenting the above study for their consideration.

During discussions, the Members requested you design a separate patient consent form to be used by fathers participating in this study; provide a witness statement on the patient consent form and identify the use of a tape-recorder. They also requested information on the time and place where the focus groups were to be held and how long they were likely to last. Finally, they requested confirmation that you would comply with the data protection act. All these items have now been satisfactorily addressed and the Vice-Chairman is, therefore, prepared to extend approval for you to commence this study in line with the protocol presented and the above mentioned items. This decision will be ratified at the May meeting of the Ethics Committee.


In wishing you every success with this study, we would ask you to complete the appropriate Proformas as and when required during the course of your study and return them at the relevant time. A set of these is enclosed herewith.

We are delighted to have been of service on this occasion and wait to hear from you in due course. However, if you require any further advice or assistance, now or in the future, please do not hesitate to contact the undersigned.

With best wishes - Yours sincerely,



Cynthia M Whitehead (Mrs)
 Administrator – DREC
 (Signed for and on behalf of Dr Margaret L Faull, Chairman)
 Enc.

The Leeds Teaching Hospitals 
 Local Research Ethics Committee NHS Trust

Room 8.7, Clinical Sciences Building, St James's University Hospital
 Beckett Street, Leeds LS9 7TF
 e-mail: comdhfo@stjames.leeds.ac.uk

Miss E L Dennison
 Psychologist in Clinical Training
 Academic Unit of Psychiatry & Behavioural Sciences
 15 Hyde Terrace
 Leeds University

Enquiries to: Ann Prothero
 (Ethics Secretary)

Direct Line/Ext: 0113 (20) 65652

16 July 2002

Dear Miss Dennison

Project No 02/118: Deciding whether to attend with a child an initial appointment with a child clinical psychologist: Fathers' discourses

Thank you for your letter of 11 July clarifying the procedure for recruiting fathers into the above study. I am pleased to confirm that your study has now been approved by the Ethics Committee.

We would be very interested in receiving a report of your findings at some future date.

Yours sincerely

Ann Prothero

Dr P R F Dear
 Chairman
 Leeds Health Authority/St James's & Seacroft University Hospitals
 Clinical Research (Ethics) Committee

APPENDIX 2: (a) Example of Information Leaflet



**Deciding Whether to Attend an Appointment
With a Child Clinical Psychologist**

99

**Elinor Dennison
Psychologist In Clinical Training
C/o Child and Adolescent Mental Health Services
12A Clarendon Road
Leeds LS2 9NN**

**An Interview Study with Fathers
INFORMATION BOOKLET**

**Doctor of Clinical Psychology Programme
Secretaries: Carol Sloman/Helen Greenwood**

☎ 0113 233 2732

c.a.sloman@leeds.ac.uk

h.i.greenwood@leeds.ac.uk



An Interview Study with Fathers Your Invitation to Participate

Introduction

My name is Elinor Dennison and I am a Psychologist In Clinical Training (P.I.C.T.) with the University of Leeds and the Leeds Teaching Hospitals NHS Trust. As part of my training I am required to conduct a piece of original research that is of current clinical interest. I am writing to you to invite you to participate in this research. It is important that you read the following information carefully before making your decision.

What does this Research Involve?

The research involves conducting one hour interviews with fathers who have a child who has been referred to Leeds Child and Adolescent Mental Health Services and will be offered an appointment with a Child Clinical Psychologist.

I am looking to interview biological fathers who live in the same house as their child and have not attended an appointment with a Child Clinical Psychologist in the past.

What is the Purpose of the Research?

The research aims to explore the factors that influence fathers' decisions of whether or not to become involved with Child Psychology Services. This follows recent findings that a large proportion of fathers do not get involved with Child Clinical Psychology Services when their child is referred. The findings of this research are intended to be used in the future planning and development of Child and Adolescent Mental Health Services.

Why Have I Been Chosen?

I am writing to you because you are a father of a child who has been referred to Leeds Child and Adolescent Mental Health Service. The member of the team who will be inviting you and your child to an assessment appointment is a Child Clinical Psychologist. I am interested in hearing about how you feel about this forthcoming appointment and whether you feel you would like to attend it with your child. All fathers who are being invited to Child Clinical Psychology appointments are also being invited to participate in this research.

What Would the Interview Involve?

The interview would be with myself and would last for one hour. In this time, you would be asked a series of questions and given time and space to discuss your thoughts and opinions. The questions are not intended to cause you to feel uncomfortable in any way, if you did not wish to comment on particular issues for whatever reason then this would be fully respected.

These will all be focussing on the topics below:

- Factors that influence your decision to attend psychology appointments
- What you think seeing a psychologist might be like
- If you have thought about whether to attend the appointment
- Why you think other fathers might choose not to attend appointments

The interview would be arranged with you at a time and place of your convenience. This might be daytime or evening, at you work, home, or a local health centre, it would really be up to you! If you chose to travel to the interview, any expenses occurred on public transport or in petrol would be reimbursed.

How will the Information from the Interview be Recorded?

The interview will be audio-recorded as this is the most reliable way of recording what you have to say. The recording will be transcribed into a word processing package after which the tape will be wiped. The material will be treated with full confidentiality. Great care will be taken not to include any information that could potentially reveal your identity in the write-up of the research.

What will Happen to the Information Collected?

The data from the interview will be analysed and written up as part of the Doctor of Clinical Psychology qualification. The result may also be published in relevant clinical journals.

What will Happen Next if I Decide to Take Part?

If you decide to take part, you need to fill in your details on the consent form return it in the pre-paid envelope provided. I will then be able to contact you to arrange the date, time, and venue of your interview.

What will Happen if I Don't Take Part?

Your decision of whether or not to participate in this research will not affect the future service that you, or your family, receive in the NHS. I would be grateful if you could return the consent form stating your decision in the pre-paid envelope provided.

Can I Get Further Information?

If you would like more information about any aspect of the research before making your decision, then please feel free to contact either Carol Sloman or Helen Greenwood (Course Secretaries) on (0113) 233 2732. You will need to leave your name and a contact number and state that you are ringing about the Fathers Interview. I will return your call as soon as possible. Please specify if there is a particular time that you would like to be called.

Thank you for taking the time to read this leaflet!



Elinor Dennison
Psychologist In Clinical Training

This research is conducted under the supervision of Dr Ann Worrall-Davies (Senior Lecturer in Child and Adolescent Psychiatry), Dr Brendan Gough (Lecturer in Qualitative Psychology), and Dr David Green (Clinical Psychologist).

APPENDIX 2: (b) Example of Consent Form (Returned by Post)

*Elinor Dennison
Psychologist In Clinical Training*

*C/o Child and Adolescent
Mental Health Services
12A Clarendon Road
Leeds LS2 9NN*

*Telephone: 0113 295 1760
Fax 0113 295 1761*

An Interview Study with Fathers Consent Form

I agree / I do not agree (delete as appropriate) to participate in the Interview Study with Fathers. I understand the nature and purpose of the research and the way in which the data collected will be used. I understand that I am free to withdraw at any point in time and that I would not be obliged to give a reason for doing so.

Full Name: _____

Signature: _____

Date: _____

If you have agreed to participate, please give details of how you would like to be contacted to arrange an interview. Please specify if there is a particular time that you would like to be called.

Phone Number(s): _____

Email Address: _____

Other Information: _____

This research is conducted under the supervision of Dr Ann Worrall-Davies (Senior Lecturer in Child and Adolescent Psychiatry), Dr Brendan Gough (Lecturer in Qualitative Psychology), and Dr David Green (Clinical Psychologist).

APPENDIX 2: (c) Example of Consent Form (Interview)

Fathers Interview Consent Form

Thank you very much for agreeing to take part in this interview today. The purpose of this form is to confirm that you are still happy to take part and that you are aware of what is involved. Please tick the boxes as appropriate and add your signature at the bottom of the page. Thank you once again!

- YES NO I have been given adequate information about the nature and purpose of the research.
- YES NO I have been offered the opportunity to ask questions and to discuss the study, and have been given satisfactory answers to any questions which I have asked.
- YES NO I understand that I am free to withdraw from the study at any time I wish and do not have to give a reason for my decision.
- YES NO I understand that I am free to choose whether I comment on any of the issues raised in the interview and do not have to give a reason for my choices.
- YES NO I understand that my decision of whether or not to participate in this research will not affect future service that I or my family receives from the NHS.
- YES NO I agree to the interview being audio-recorded.
- YES NO I give permission for extracts from the interview to be used in reports of the research on the understanding that anonymity will be maintained.

I _____ (NAME) agree to take part in this study.

SIGNATURE: _____ DATE: _____

Witnessed by Elinor Dennison (Researcher): _____

APPENDIX 3:**(a) Topic Guides for Fathers Focus Group and Father Interviews****Fathers Focus Group: Topics for Discussion**

Opening: Introductions, Research Aims, Confidentiality, Consent, Any Questions.

- How the decision to attend was made / who involved / what factors
- Expectations / Understanding of Service / Appointment
- What made it easy / difficult to decide and to attend
- Expectations and Experience: Same or Different
- Other fathers who attend / don't attend
- What would encourage fathers to attend

Closing: Any Important Points Missed / Any Questions

Father Interviews: Topics for Discussion

Opening: Introductions, Research Aims, Confidentiality, Consent, Any Questions.

- Thoughts and Feelings about Referral and Attendance
- Factors Important to Own Decision / Most Important
- Who Involved in Decision
- Fears / Hopes / Expectations
- Do Fathers Need to Attend / Why / Most Important Factor
- Difference Between Mothers and Fathers Attending
- Factors Important to Other Fathers' Decisions
- Does Anything Make it Particularly Difficult for Fathers to Attend

Closing: Any Important Points Missed / Any Questions

APPENDIX 3:**(b) Topic Guides for P.I.C.T. Focus Group and Clinical Psychologist Interviews****P.I.C.T. Focus Group: Topics for Discussion**

Opening: Introductions, Research Aims, Confidentiality, Consent, Any Questions.

- **Who Attends First Appointments**
- **Factors Influencing Father Attendance Non-Attendance**
- **Specific Examples of Own Experiences with Fathers**
- **Perceptions of Fathers Fears / Hopes / Expectations / Difficulties**
- **Clinic Ethos: Who is Invited / Worked With: Fathers Vs Mothers**
- **Are Fathers Needed at Appointments / Why**

Closing: Any Important Points Missed / Any Questions

Clinical Psychologist Interviews: Topics for Discussion

Opening: Introductions, Research Aims, Confidentiality, Consent, Any Questions.

- **Who Attends First Appointments**
- **Thoughts and Feelings about Working with Fathers**
- **Do Fathers Need to Attend / Why**
- **Factors Influencing Father Attendance / Non-Attendance**
- **Specific Examples of Own Experiences with Fathers / Mothers**
- **Perceptions of Fathers Fears / Hopes / Expectations**
- **Differences Between Mothers and Fathers Attending**
- **Main Difficulty for Fathers to Attend**

Closing: Any Important Points Missed / Any Questions

APPENDIX 4

(a) Example of Transcript from Father Interview

Father Interview 2:

F2(1): Right is that thing going now then hey?

ED: Yes, it seems to be working fine. It is ok if we make a start then?

F2(2): Ha Glad to hear it, don't know trust stuff like that you know.

ED: Mmmmm (laughs)

F2(3): So you want to know all about this psychology thing then, that right love?

ED: Yeh, I'm interested in how you feel about your child being referred to psychology, and how you how feel about whether you are going to the appointment or not?

F2(4): Well, to tell you the truth I am not so sure about it y'know like things like when they want to mess with your head.

ED: Mmmmm

F2(5): Don't get me wrong I think they all do a grand job like, but, well it is just that I am not sure if it could all lead to worse y'know.

ED: So you think the appointment might somehow make things worse than they are now?

F2(6): Well no, I suppose not. I don't know, I just think sometimes you do your best with your kid and no-one really knows how that is like well like they want to tell you how its done like and what would they know. If they've struggled on with problems for years they might be in a position to criticise mmmm yeh I suppose yeh

ED: Are you saying it is like you know your kid best but you think a psychologist might try and tell you what to do?

F2(7): Something like that

ED: Yeh?

F2(8): More that they'd think we were bad parents, like not doing our bit and that. Take one look at my son and tell me like its I'm not good when really whats up can't be helped it was never anything about me y'see or the wife. She does her best to, soft like, but more than me.

ED: So one of your worries is that you would be judged badly is that right?

F2(9): Not a worry really, just it concerns me that I don't want to be seen as a bad parent. If my son needs me I am there for him like not one of these dads who is never home or who takes a belt or ought like that. You sometimes wondering if that's what they are looking for. Some dads are bad, bad as bad and that's it. Me I am not one of those sorts.

ED: So you are thinking that maybe psychologists are especially looking out for Dads who mistreat their children?

F2(10): Yeh, and well that is sort of a good thing, I mean someone has to notice. It is just a bit like being on trial – they want you there to check your not beating on your kid and you've made him go wrong. Like social workers as well y'see everybody is looking out and looking to point at Dads.

ED: So in some ways you feel like Dads are being unfairly treated//

F2(11): (laughs) //the ones who haven't done ought are yeh.

ED:// and you see psychologists as being a bit like social workers maybe or//

F2(12): //That's true yeh, they both have to same bits of a job y'know like two sides of a coin. It's all for good though y'know, I am not saying it's wrong.

ED: What do you see as being the role of the psychologist – their side of the coin erm well what do you think they do?

F2(13): Well they look and see what's going on in the kids head and sort them out I suppose. They probably have to see how all the mums and dads are going wrong and make sure they sort it because if they don't sort it the kid'll have to go and that.

ED: So what do//

F2(14): That's not the case with me though because in our case like it is in my son, it is nothing us can do like being parents it is just something maybe that he was born with. Like my wife calls it a predisposition, he's emotional y'see and takes things on board like you shouldn't do too much y'see.

ED: So you are thinking that in some cases parents might have a role in the problem, but that in your case that isn't what is happening?

F2(15): Yeh, right.

ED: I am wondering whether you have decided whether to go or not?

F2(16): Mmmm yeh I'll be going like I want to keep an eye on what goes on and I suppose I will have to prove myself that I'm ok and stuff. I can always get time off work with working for myself and the wife likes it if I go with her to these things and like do the support things and them.

ED: Do you think being able to get time off work like that would be a factor for other dads?

F2(17): Which ones? The ones who smack their kids up, and probably their wives as well. In my opinion, and I hope you don't mind me saying this, but them dads won't give a shit love. I'd be surprised if they even had jobs anyhow, like in the pub wit their pints all day and taking it out of the family in the evening like.

ED: Ok, I see what you mean. But what about other dads..like maybe ones who aren't violent?

F2(18): Well the way I see it is if you wanted to go you'd get there like. No-one is that stuck in their job that they can't leave for summat that's important. Might means they need to do some arranging but I don't reckon that really stops many at all.

APPENDIX 4

(b) Example of Transcript from Psychologist Interview

Psychologist Interview 1:

P1(10): Erm and dads - dads do - hard to judge really. I'd say for the formal type of things and so on if there is a father they'll often come because it's quite a major event to have a child development team assessment so er we often get dads. It will be quite interesting to look at our records and see - we just have to look at all the reports and we could see how many dads were present at the assessments actually. Quite an interesting question. Not one we've asked ourselves oddly enough. Erm on the other hand for this young age of children my impression - or you may be coming on to that - but my impression is that er mums will always come. We've only had like two or three cases in a year where only the dad comes and that is for very particular reasons 'cos they're the only care giver usually for whatever reason.

ED: Right.

P1(11): So if there's both parents I'd have said it's either both mum and dad or just dad - or just mum comes, the mother comes. Erm for other types of cases some of the other ones (pause) if there is - if there is a dad then yeah they'll often be there if they can be erm or one will know why they're not there and that's usually to do with work they're actually saying. Okay?

ED: Okay. Have you ever had an appointment where the dad's turned up but not the mum where there has been a mum around?

P1(12): Oh yes. Erm we've had - had one recently with what we call the growth nutrition team erm and dad came to that and we'd noticed because he'd been to previous appointments with paediatric colleagues and then they came to the team, and people had noticed that the mother didn't tend to come to appointments, and we kind of - when we were thinking about the case we commented on that and wondered why.

ED: Right.

P(13): And actually when he came then to the Tuesday afternoon session erm we kind of enquired slightly sort of just gently (laugh), it's like the erm sideways enquiry about er the mother.

ED: Uh-huh.

P1(14): And he said that she really didn't like coming to appointments very much but and that he saw it as his role because he'd actually given up his work to look after this little girl who had a disability. And so he saw himself as the main carer.

ED: Yeah.

P1(15): So he regarded almost as his job I think. But also it did sound in that family situation as if he wasn't just the kind of the main carer because he was getting the disability living allowance looking after the little girl and the carers allowance but I think the dynamics were such that he did more of it any way at home.

ED: Right.

P1(16): And we did wonder whether the mum had an eating disorder and she didn't like coming to things about eating, which was what the problem was about. Erm I can think of another child development team one recently where the - you say where there are both parents but only the dad comes?

ED: Yeah.

P1(17): Yeah -no that was one where - where there wasn't a mother and the dad came. Erm.

ED: I suppose in those situations he's got no choice if there is only a dad?

P1(18): No, no, no, then it's him or nothing.

ED: Yeah.

P1(19): And they're always the main carer then. Erm I can think of other situations in the past if I kind of trawl where I may have seen both parents at some point but the dad has tended to bring the child for various reasons. And if I think - this is off the top of my head stuff isn't it but (ha) erm - that's how it's meant to be - when I think about it I can remember one and a dad was er a university lecturer and he was freer than his wife who was a solicitor erm\

ED: \Right.

P1(20): And so she could get less time so the dad tended to do the bringing 'cos he could presumably swing it with his job.

ED: Job .

P1(21): And he sat down there reading PhD theses and things or whatever (laugh). Erm so I can think of several situations where dads have come but it's as if one's always understood the reason why.

ED: And when mum's come do you want to know why the dad's aren't there? is it kind of accepted that the mum's turned up and that's fine?

P1(22): *(Pause)* If it's a first appointment I would always want to know, and I would always in some fashion ask about the dad.

ED: Uh-huh.

P1(23): And how involved he was and where he was. And you usually get an explanation then. Erm it's usually either er he's at work and he's you know out round the north of England on whatever you know depending on the work or else his firm don't let him have much time off.

ED: Yeah.

P1(24): Or more occasionally er they'll say well he doesn't take much part in the kid's stuff, it's like women's work this so they come. So there's usually an explanation. I then don't find it - I don't find it strange that both parents don't come all the time.

APPENDIX 5 (a):

Themes, High-Order Categories, Low-Order Categories, and Codes, from the Analysis of Father Data.

APPENDIX 5: (a) Themes, High-Order Categories, Low-Order Categories, and Codes, from the Analysis of Father Data.

KEY

THEME = UPPER CASE, BOLD

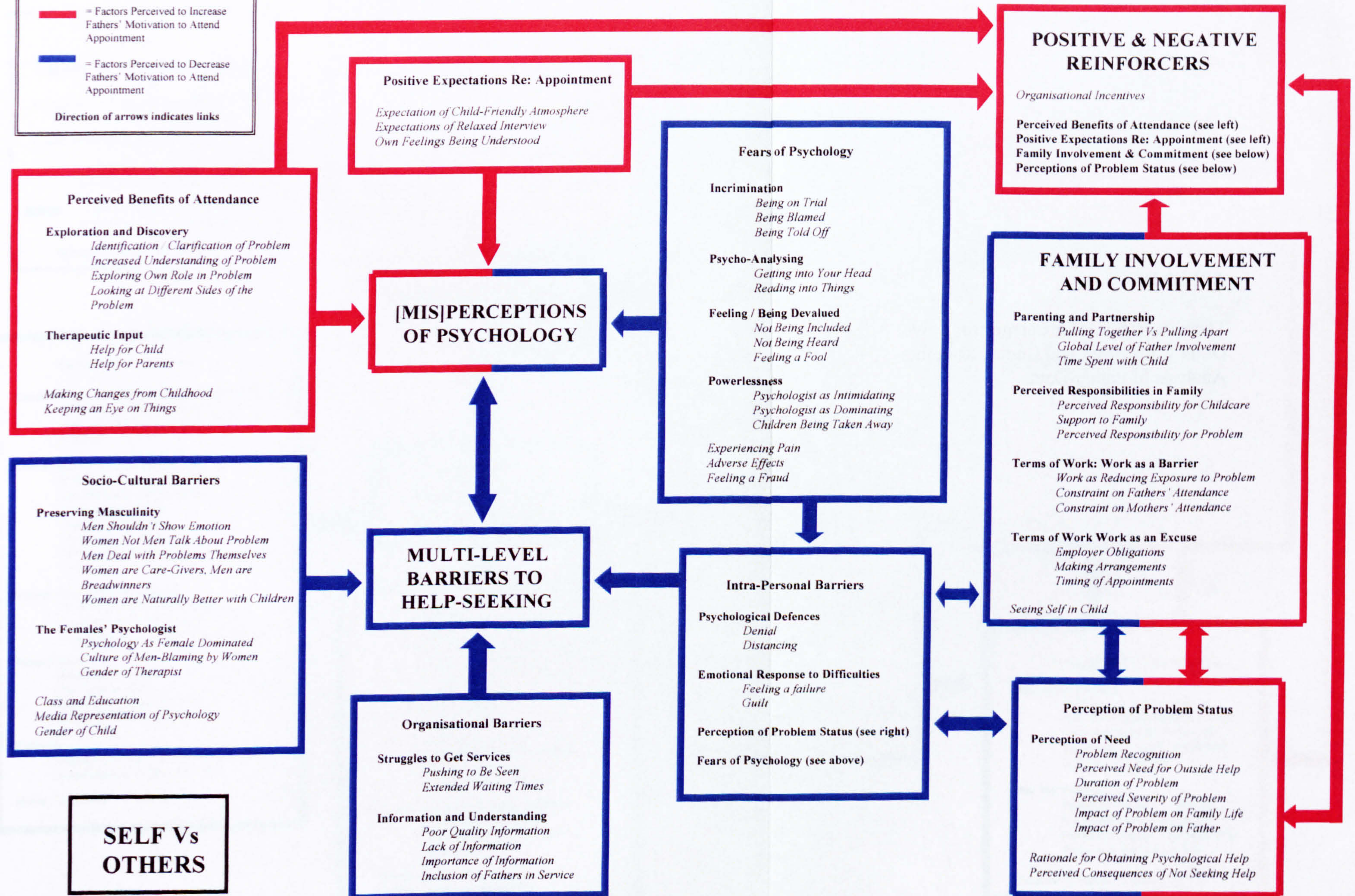
Category = Lower Case, Bold

Code = Lower Case, Italic

Red arrow = Factors Perceived to Increase Fathers' Motivation to Attend Appointment

Blue arrow = Factors Perceived to Decrease Fathers' Motivation to Attend Appointment

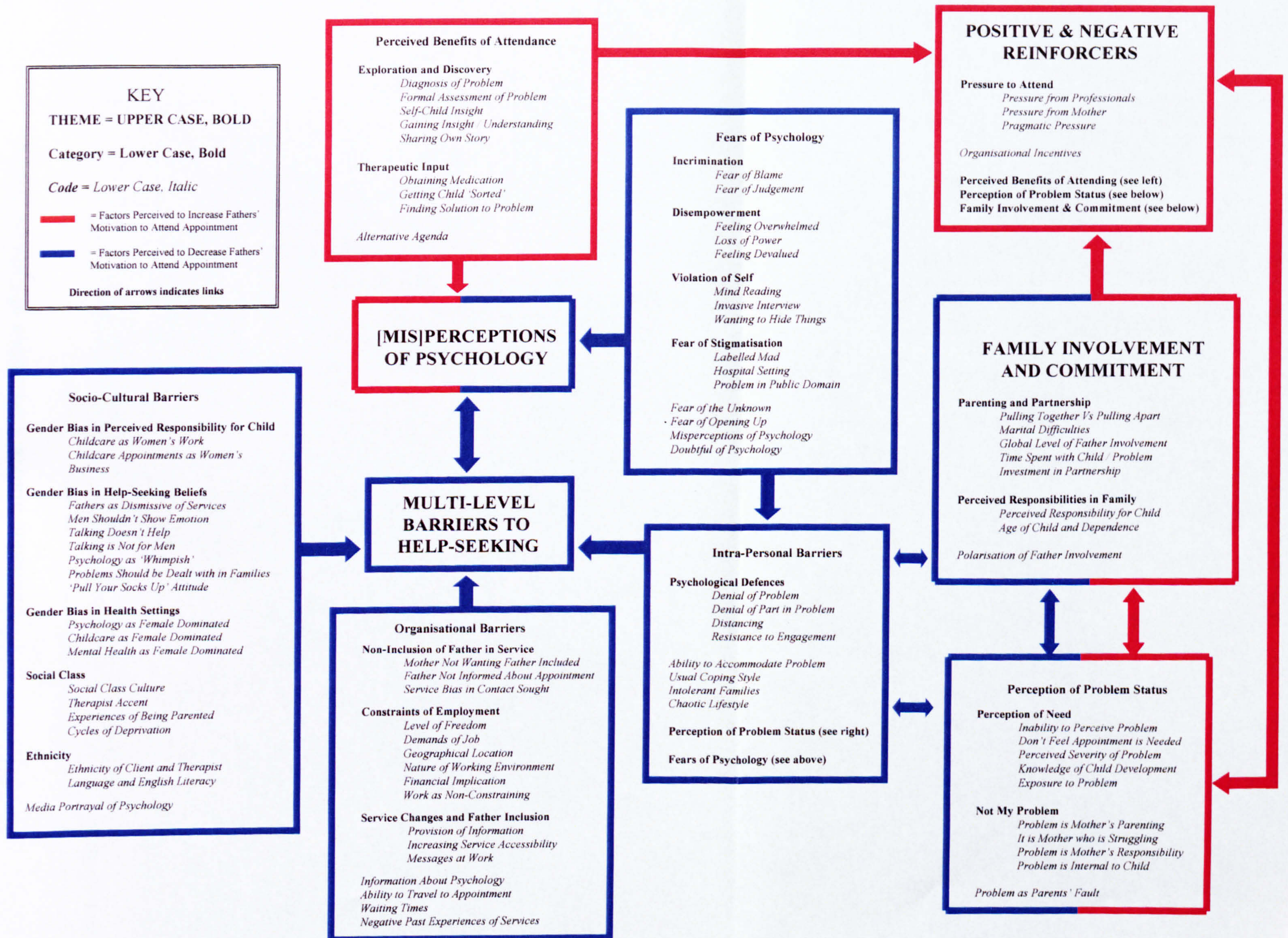
Direction of arrows indicates links



APPENDIX 5 (b):

Themes, High-Order Categories, Low-Order Categories, and Codes, from the Analysis of Psychologist Data.

APPENDIX 5: (b) Themes, High-Order Categories, Low-Order Categories, and Codes, from the Analysis of Psychologist Data.



APPENDIX 6: (a) Credibility Check Father Data

Confusion Matrix: Calculation of Cohen's Kappa

Categories / Themes	Fears of Psychology	Perceived Benefits of Attending	Organisational Barriers	Socio-Cultural Barriers	Perception of Problem Status	Intra-Personal Barriers	Family Involvement /Commitment	Incentives to Seek Help	Row Total (Reviewer)
Fears of Psychology	14	0	0	2	0	1	0	0	17
Perceived Benefits of Attendance	0	11	0	0	0	0	0	0	11
Organisational Barriers	0	0	6	0	0	0	0	0	6
Socio-Cultural Barriers	0	0	0	9	0	0	0	0	9
Perception of Problem Status	0	0	0	0	8	1	0	0	9
Intra-Personal Barriers	0	0	0	0	0	0	2	0	2
Family Involvement /Commitment	0	0	0	1	0	2	11	0	14
Incentives to Seek Help	0	0	0	0	0	0	0	1	1
Column Total (Researcher)	14	11	6	12	8	4	13	1	69

Percentage of Agreement =
(60 agreements / 69 total units) = 0.8696

Percentage Expected by Chance =
 $(\frac{14}{69} \times \frac{17}{69}) + (\frac{11}{69} \times \frac{11}{69}) + (\frac{6}{69} \times \frac{6}{69}) + (\frac{12}{69} \times \frac{9}{69}) + (\frac{8}{69} \times \frac{8}{69}) + (\frac{2}{69} \times \frac{2}{69}) + (\frac{1}{69} \times \frac{14}{69}) + (\frac{4}{69} \times \frac{1}{69}) = 0.160890569$

$K = \frac{Pa - Pc}{1 - Pc} = \frac{0.8696 - 0.1609}{1 - 0.1609} = \frac{0.7087}{0.8391} = 0.8446$ Kappa values above 0.75 are rated as 'excellent' (Robson, 2002)

APPENDIX 6: (b) Credibility Check Psychologist Data

Confusion Matrix: Calculation of Cohen's Kappa

Categories / Themes	Fears of Psychology	Perceived Benefits of Attending	Organisational Barriers	Socio-Cultural Barriers	Perception of Problem Status	Intra-Personal Barriers	Family Involvement /Commitment	Incentives to Seek Help	Row Total (Reviewer)
Fears of Psychology	15	0	0	0	1	0	0	0	16
Perceived Benefits of Attendance	0	9	0	0	0	0	0	0	9
Organisational Barriers	0	0	12	0	0	0	0	0	12
Socio-Cultural Barriers	0	0	1	16	0	0	0	0	17
Perception of Problem Status	0	0	0	1	9	1	0	0	11
Intra-Personal Barriers	0	0	0	0	0	7	0	0	7
Family Involvement /Commitment	0	0	0	0	0	0	8	1	9
Incentives to Seek Help	0	0	0	2	0	0	0	3	5
Column Total (Researcher)	15	9	13	19	10	8	8	4	86

* the independent reviewer was also not able to classify one code within this system

Percentage of Agreement =
(79 agreements / 87 total units) = 0.9080

Percentage Expected by Chance =
 $(\frac{15}{87} \times \frac{16}{87}) + (\frac{9}{87} \times \frac{9}{87}) + (\frac{13}{87} \times \frac{12}{87}) + (\frac{19}{87} \times \frac{17}{87}) + (\frac{10}{87} \times \frac{11}{87}) + (\frac{7}{87} \times \frac{7}{87}) + (\frac{8}{87} \times \frac{8}{87}) + (\frac{1}{87} \times \frac{5}{87}) = 0.139780684$

$K = \frac{Pa - Pc}{1 - Pc} = \frac{0.9080 - 0.1398}{1 - 0.1398} = 0.893$ Kappa values above 0.75 are rated as 'excellent' (Robson, 2002)