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Paternal attachment patterns

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ABSTRACT.

This study aimed to investigate the Raphael-Leff model of paternal orientation and to assess whether fathers could be meaningfully distinguished in terms of attachment style, early bonding experiences and sex-role identity. A 19 question attitudinal survey was administered to a sample of 101 first-time expectant fathers (age range 16-41 years) recruited from the early parenting classes and antenatal clinics within two public hospitals in the Illawarra. Fathers also filled in the Parental Bonding Instrument (PBI; Parker, Tupling & Brown 1979), the Relationship Questionnaire (RQ; Bartholomew & Horowitz 1991) and the Personal Description Questionnaire (Antill, Cunningham, Russell & Thompson 1981). Findings of this study supported the Raphael-Leff model and added to it. According to a new instrument designed to classify fathers according to the Raphael-Leff model, 55% of the sample classified as participators (n=50), 44% as reciprocators (n=44) and 1% as renouncers (n=1). The participator group were more likely to have a secure attachment style and positive internal working models of others. The reciprocator group in contrast, were more likely to have an insecure and avoidant attachment style and negative internal working models of others. Fathers with secure attachment were more likely than fathers with insecure attachment to have a positive sex-role identity (ie. masculine, feminine or androgynous) than a negative sex-role identity (ie. undifferentiated). Androgynous men were significantly more likely to intend to nurture their baby and to feel competent with a newborn than masculine men and men who did not strongly identify with any sex-role orientation. No significant relationship was found between early bonding or sex-role identity and fathering styles. However, a relationship was found between early bonding and the expectant father's current relationship with his own father. The implications of
this research are that fathers with secure attachment and positive internal working models of others are more likely to be participators, and fathers with insecure attachment and negative internal working models of others are more likely to be reciprocators. Recommendation is made that the instrument is refined and tested on more samples of expectant fathers. This research suggests that the reciprocator group may be predisposed to prenatal and postnatal distress and find the transition to parenthood more difficult because of insecure attachment and negative internal working models, a hypothesis that requires testing in future studies. Midwives need to be sensitive to the different paternal orientations and the significance this has for fathers participating in the perinatal period and to early parenting. The current practice of midwives, which often neglects the dyadic relationship in which most women give birth, may not be addressing the psychological needs of the father.
Chapter One

A Review of Paternal Attachment Theory
1.1 Introduction.

Research in medicine, nursing, psychology, and sociology over the past 15 years has increasingly focused on the changing roles, needs and expectations of men who are going through the transition to fatherhood. The period which precedes the birth of a man's first child is an important developmental transition during which preparations for fatherhood and the establishment of a paternal identity are taking place. The move from being someone's son to someone's father is part of a major developmental task. From a psychodynamic perspective expectant fathers are said to experience reactivated oedipal conflicts, as well as disrupted dependency needs and rearoused sibling rivalry. First-time expectant fathers are said to be going through the most psychologically turbulent period in the development of their paternal identity (Zayas 1988). The first time a man faces the transition to fatherhood a greater change in identity and lifestyle will result than when experienced fathers go through the same period (Ferketich & Mercer 1995). The issues and conflicts that are uncovered during pregnancy may reappear with each successive child (Zalk 1980).

In order to promote a father's involvement in pregnancy and to support him in his transition to parenthood, health carers need to better understand the experience of expectant fatherhood (Jordan 1990). The link between an expectant father and his unborn baby is primarily psychological and clinicians need to be aware of the issues and conflicts related to pregnancy, childbirth and fatherhood (Zayas 1988). This paper will examine the literature on expectant fatherhood which relates to the psychodynamic experience of these men and sex role identity. It will include a summary of the literature on the development of a paternal identity and paternal-fetal attachment, and a brief overview of the physical and psychological health and stress of expectant fathers. The
literature reviewed was obtained by an online computer search of the data bases, medline, cinahl and psyclit over the period from 1982-1999. The citations in the bibliographies of located references were used to track additional references (ancestry approach). The central focus of the literature search has been the cohort of first-time expectant fathers.

During pregnancy the father is called upon to play a critical role in helping facilitate his partner's adjustment, which will involve him functioning as both a maternal and paternal object (Ballou 1978). Expectant mothers have shown a strong desire to be cared for and supported by their mothers and/or husbands. If a woman has a positive relationship with her husband, this may help reconcile conflicts that exist in her relationship with her mother. In fact women who have a difficult relationship with their mothers may still do well in pregnancy if they can draw on a relationship with a supportive, nurturant partner. A positive relationship with her husband has been said to enhance the facilitation of maternal-fetal attachment (Zachariah 1994).

Men frequently have problems around issues of dependency and sexual identity during their wives' pregnancies (Ballou 1978). An association has been found between the stress of pregnancy and antisocial behaviour in some expectant fathers. It is of interest that of ninety one sex offenders examined by a court psychiatrist, 41 were expectant fathers, and 16 of these had wives in their first pregnancy (Hartman & Nicolay 1996).

The first pregnancy is believed to be a particularly stressful period for the husband and several conscious and unconscious themes appear in the literature to explain elements of that stress (Gerzi & Berman 1981). Although the vast majority of research has focused on mothers, expectant fathers make up a vulnerable population that
may be 'at risk' for a variety of both physical and emotional health problems (Clinton 1986).

1.2 Psychodynamic and developmental aspects of expectant and new fatherhood.

The prospect of becoming a father will bring with it a realignment and redefinement of major roles and responsibilities for the man. The psychosexual issues confronted in childhood will resurface as the elements within the marriage change, and childhood memories are revived. The man is moving from the position of son to father and adjusting to marriage to a mother and the increased dependency needs of others. This reemergence of psychosexual conflicts in expectant fathers may be seen as a developmental step in itself (Rosenberg-Zalk 1980).

Both male and female children probably experience a normal 'emotional symbiosis' with the mother during the hypothesised oral-dependent stage of early development, and identify with the mother's nurturance. The boy then goes on to identify with his father who is often seen as protector and provider. The evolution of nurturance and generativity in males leads to the foundation of a paternal identity during a boy's first decade. Identification with a loving father and not a tyrannical rival, aids the resolution of the 'oedipal conflict' contributing to a positive paternal identity later in life (Zayas 1987). It is the successful identification with a 'good enough male mentor', and mastery of sibling rivalry conflicts that are thought by some to be the two most important determinants of how a man will relate to his own children. Brazleton & Kramer (1990) state that the solution a boy adopts for integrating his core maternal identification with his growing identification with masculine behaviour will shape both his gender identity and future fatherhood. A balanced resolution will enable him to
function as a father in both a nurturing and providing role. However, many resolutions are possible, including a rigid refusal to acknowledge any feminine attributes as in stereotypical masculinity (Brazleton & Kramer 1990).

The attainment of a paternal identity can be seen as a succession of identifications with the nurturing and generative functions of the man's mother and father. Fatherhood is achieved gradually and the relinquishment of a boy's desire to emulate his reproductive mother will be a major developmental task. Those men who remain locked in a cycle of envy at the woman's childbearing capacities may compete with their wives, and resent their exclusion from the process (Zayas 1987).

A father acts as a mentor to his son thus facilitating his development of concrete and specific skills and a sense of competence. First-time expectant fathers do not usually have a clear sense of themselves in the paternal role. Men may initiate efforts at providing, engage in nesting behaviour, and attempt to ensure the security of the expanding family as part of establishing their paternal identity and role (Zayas 1987).

When the dreams of two first-time expectant fathers were examined in the three weeks prior to the expected arrival of their child, analysts found that images of the men's fathers filled their dreams revealing the presence of an unconscious process that revived and reworked perceptions of the father-son relationship. The subconscious process which meant both taking on and discarding aspects of their father's style of fathering is seen as part of the initiation and consolidation of their paternal identity (Zayas 1987). Also evident in these dreams were elements of uncertainty and self doubt as to their own capacity to protect, care and provide for a fragile child.

The findings of a subsequent study by Zayas substantiate the theory that during the period preceding birth, the psychological issues that are dealt with through dreams
will fluctuate in accordance with the progression of the pregnancy (Zayas 1988). The author expanded his sample to ten first-time expectant fathers, and analysed their dreams at several intervals during their wife's pregnancies. A control group of men who were not fathers was also examined over a two week period for the purpose of comparison. Early in the pregnancy, images of the womb and enclosed spaces were prevalent in the expectant fathers' dreams. Feelings of loneliness and exclusion which may have resulted from a disruption of dependency needs were also common. The middle trimester of pregnancy saw a move to images of water and the theme of nurturance was more implied than explicit. In the period immediately before delivery, images of the birth and transversing the birth canal are common. The sense of themselves as fathers grew as the pregnancy progressed.

Conflicts may arise during pregnancy as the expectant father relives and revives his identification with his mother and father (Zalk 1980). Both men and women hope to recapture in their marriage some of the lost moments with their own mother, and when a woman becomes pregnant, the part of attachment that each partner lives out in marriage will be shaken. The baby will be an intruder into this dependent relationship, and men whose dependency needs were insufficiently or ambivalently satisfied in childhood and who are looking to their wives to meet those needs may view the fetus as a rival (Zalk 1980).
1.3 The Raphael-Leff Theory of Paternal Orientation: Participators, Renouncers and Reciprocators.

Joan Raphael-Leff's theory of maternal and paternal orientation has made a significant contribution to the area of psychodynamic research of pregnancy and child bearing since it was first proposed in the early 1980's. This theory has formed the basis of several cross cultural studies on postnatal depression (Sharpe 1992, Scher & Blumberg 1992). The model of parenting that is proposed describes two distinct styles of mothering and fathering: mothers being either facilitators or regulators, and fathers either participators or renouncers. These orientations are said to be detectable during pregnancy and remain consistent with each child (Raphael-Leff 1985). Although there are very few 'pure' types, individuals will show a predominance of one style over the other. This theory is both complex and comprehensive, drawing on the individual's conscious and unconscious approaches to pregnancy, birth, bonding and parenting (Sharpe 1992).

More recently Raphael-Leff has identified a third category of parent which she describes as a reciprocator (Raphael-Leff 1993) and Scher & Blumberg have isolated a bipolar group which Raphael-Leff had labelled 'mixed mothers' (Scher & Blumberg). The three paternal orientations of fathers, namely, participators, renouncers and reciprocators will be outlined.

1.4 Participators

As the name suggests this man is eager to participate as fully as possible with the pregnancy and primary child care. He has a flexible male gender identity which allows him to draw on both maternal and paternal aspects. In practical terms his involvement
will result in him reading books on childcare, attending antenatal classes and interacting with health care professionals.

On an emotional level he may feel either exuberant or anxious depending on how far he can trust his wife's capacity to 'grow the baby' (Raphael-Leff 1985). He may also feel frustration that he lacks social recognition and the visible body changes of pregnancy experienced by his partner. As a result of his overidentification with his wife's pregnant state he may seek control through constantly monitoring the pregnancy. He may even make changes to his own diet and exercise and monopolise the conversation about the pregnancy. If he becomes overly enmeshed with the baby this may result in feelings of helplessness and need within himself. He will see the baby as helpless and vulnerable and feel that his role is to be its spokesman.

A feeling of envy at the female capacity to create life may be close to the surface of the participator and an extreme participator may develop 'couvade symptoms' mirroring those of his wife. This represents his deep seated desire to experience pregnancy (Raphael-Leff 1991). The participator will long for active involvement in labour which will enable him to be the one to draw his baby out of the mother's belly and to cut the cord. Although he may be jealous of the instant relationship between the mother and infant he will appreciate that his relationship with his child will gradually build up.

As the participator is in touch with the feminine, maternal aspects of his personality, his challenge will be to resolve his early identification with a nurturant mother and to channel his maternal instincts into protectively mothering his wife, rather than competing with her and, to father his baby. How he resolves this challenge will be influenced by his own conscious and unconscious needs as well as those of his partner.
He can either compete with his wife as a rival in 'mothering' the baby, 'father' it or share care (Raphael-Leff 1993).

1.5 Renouncers.

The renouncer has engaged a strong concept of masculinity, having rejected femininity and not identifying with his mother. He has a rather rigid concept of masculinity that is separate from, and often the reverse of femininity, and pregnancy will highlight for the renouncer the differences between male and female. As his archaic identification with his mother is aroused he may be forced to reimpose old solutions to restore his inner chaos. The result of this will be his seeking to reinforce masculine attributes and identifying strongly with his father and the paternal role (Raphael-Leff 1985).

This expectant father, although proud of the pregnancy will avoid involvement in antenatal clinics, childcare classes and where possible the labour ward. Beneath the surface he will dread being exposed to the powerful primitive emotions and the fear of death and morbidity which the prospect of birth arouses in him. Some fathers may either faint or bolt if too overcome with this 'ultimate female experience'. When compared to the participator father, the renouncer will be lacking in empathy for his pregnant wife.

The prospect of a new baby will also bring fear of exposure to raw emotions, and 'messy infantile experiences.' It may be difficult for him to tolerate echoes within himself of his own helplessness, vulnerability and dependency during infancy. However the renouncer father often feels that he will come into his own with an older child. Breast feeding may not be easily tolerated by this man. Some renouncers who may be unable to mother their wives may nevertheless be supportive. Others may experience a
Chapter Two

Sex-Role Identity: Masculinity, Femininity and Androgyny
Sex-role identity refers to an individual's arrangement of sex-typed traits, attitudes and interests which will ideally be congruent with, and affirming of his or her biological sex (Kaplan 1979). Where these traits, attitudes and interests are not congruent with the biological sex of the individual, that person's sex role identity is said to be inadequate, disturbed or insecure.

2.1 Background of Sex-Role Identity.

There has been some debate among psychologists as to how the male sex role identity develops. Doyle (1983) identifies three theoretical positions which are: the psychoanalytical - identification theory of sex role identity, the social learning theory of sex-typed behaviours and the cognitive developmental theory of sex-role identity. The later has been proposed by Kohlberg and has applied the views of Jean Piaget to sex role development. The cognitive developmental theory stresses the active interaction between a child's thoughts and his organisation of his role perceptions and role learning around his basic conceptions of his body and his world. Male gender identity will therefore result from his labelling himself a 'boy'. Others will also teach him that he is a boy and as he grows older he will learn to associate more complex behaviour with his sex (Doyle 1983). There is a consensus among theorists that there is a connection between age and the development a child's gender identity, therefore it follows that once a child adopts a sex-specific gender identity, behaviour will be consistent with this regardless of external forces.

For several decades a sex role model was used that specified the ways in which biological males and females became socialised as men and women in a particular culture. Research was based on the assumption that masculinity and femininity were two opposite characteristics on a bipolar continuum (Kimmel 1987). This sex-role paradigm
forces biological males and females to fit into a model, a process which is called 'socialisation'. When sex-role constructs become static they may have nothing to do with the way in which these roles are enacted in everyday life. Recent research suggests that although masculinity and femininity are socially constructed within the historical context of gender relations; definitions of masculinity have changed historically according to changing definitions of femininity. However although masculinity is always constructed in relation to femininity this will vary across class, age, race and ethnic lines.

Studies of trait stereotypes have demonstrated consistently that the typical male and female are perceived as differing in a number of personality attributes. Males are reported to be higher than females in a cluster of characteristics that reflect personal competencies and goal orientation, whereas women are reported higher in a cluster of characteristics that reflect social-emotional sensitivity and an interpersonal orientation. Bakan identified two fundamental properties that characterise living organisms, namely agency and communion. Agency has been identified as a male principle and is manifested in self assertion, and self aggrandisement among other things. Communion which is manifested in selflessness and a desire to be at one with others, has been identified as a female principle, that is stronger in females than in males. Spence et al (1979) propose that "masculine" instrumental characteristics and "feminine" expressive characteristics form separate dimensions that vary independently and contribute positively to the effective functioning of both sexes. Therefore "androgynous" individuals tend to be more socially effective than those who are sex typed. However it has been observed that within the category of agentic and communal traits there are a number of both masculine and feminine traits that are socially undesirable. The
fundamental task of all human beings is to balance agency and communion as either unchecked will be destructive to the individual or society. Either a strong sense of agency that is unmitigated by some sense of communion or communion that is unmitigated by agency will result in an individual who cannot effectively function (Spence et al 1979).

Therefore the challenge for males is to temper self interest with concern for the welfare of others, whereas for women it is to develop a sense of an effective actualised self rather than to have an identity reflected only in the service of others. Individuals of either sex who do fail to develop or to integrate successfully into their sense of self both agentic and communal attributes will not reach the higher stages of ego development with all that it imports. Individuals at the higher level of ego development will have a greater sense of self and individuality and may define their masculinity and femininity not in terms of conformity to the behavioural standards of their sex but in terms of inner characteristics (Spence & Helmreich, 1978).

2.2 The Bem Sex-Role Inventory (BSRI).

The development of a new type of sex-role inventory by Bem proposed that it was possible for an individual to be both masculine and feminine, both assertive and yielding, both instrumental and expressive depending on what was appropriate in a given situation (Bem 1974). The Bem Sex-Role Inventory (BSRI) includes both a masculinity and femininity scale which each consist of 20 characteristics selected on the basis of sex-typed social desirability. A scale is included which lists characteristics which are completely neutral with respect to sex but are considered socially desirable for both sexes. Participants are asked to rate themselves on these scales in regard to each characteristic. The BSRI does not automatically build in an inverse relationship between
masculinity and femininity but establishes them as two independent dimensions, therefore making it possible to characterise individuals as masculine (high masculine, low feminine), feminine (high feminine, low masculine) or androgynous (high masculine, high feminine) (Bem 1974).

Bem suggests that strongly sex-typed individuals may be seriously limited in the range of behaviours available to them as they move from one situation to another. If this individual is motivated to keep his or her behaviour consistent with an internalised sex-role standard, this may be achieved by the suppression of any behaviour that might not be desirable for his/her sex (Bem 1974). Psychological androgyny has not only been accepted as a reliable concept but it has been nominated as a new criterion of healthy and adaptive personality development.

Bem proceeded to define a fourth group who scored low on both masculine and feminine scores which are classified as undifferentiated. This group were lower in self esteem and showed less self disclosure and responsiveness than the androgynous group (Bem 1977). The major findings reported by Bem were that the dimensions of masculinity and femininity are empirically as well as logically independent and that the concept of androgyny is a reliable one. Spence & Helmreich (1978) report that their studies consistently show that androgynous individuals of both sexes report the highest levels of self esteem followed by masculine, feminine and undifferentiated (Spence & Helmreich 1978, p.123).

Theorists propose that a state of sex role transcendence can exist which may be viewed as an ideal state of sex role development. Those who reach this level of sex role transcendence will not be affected in their development by having or not having sex role related traits, but will transcend the normal ways of organising and experiencing
masculinity and femininity as psychological traits. However as yet there does not exist a measure to differentiate these individuals from those who test as androgynous (Garnets & Pleck 1979).

An individual may be said to experience sex role strain when they devalue themselves because they perceive that they deviate from the sex role norms and standards that they attribute to their own sex. Sex role salience is said to exist when there is a high consistency between the individual's rating of the same sex ideal and the social, cultural constructs of masculinity, and femininity.

Garnets & Pleck (1979) warn that there may be pressure exerted on individuals by society to be androgynous, in the wake of both the women's and men's movement. This trend may merely shift the burden of sex role strain from one group to another, and a long term goal needs to be the development of strategies to reduce sex role salience.

2.3 The Development of an Australian Sex-Role Scale.

As the construction of the BSRI had drawn almost exclusively on samples of American college students it was therefore necessary to design an Australian scale that would be more appropriate for a variety of ages and social class groups within the Australian population. An Australian Sex-Role Scale was developed which consists of the Personal Description Questionnaire Forms A and B, each comprising 10 masculine positive, 10 masculine negative, 10 feminine positive, 10 feminine negative and 10 social desirability items (Antill et al 1981).

When Russell (1983) explored the relationship between parent-child interaction in Australian families, he found that androgynous men participated more extensively in childcare and displayed more nurturance. He states that men who score higher on the femininity scale of the BEM Sex-Role Inventory are more likely to perform what might
be considered cross sex behaviour, such as interacting with a baby. The more highly participant fathers were found to have an inherent belief in their own ability to take over the care giving role. Caution is given, however against assuming that the personality trait of androgyny causes these nurturant behaviours. It may be that shared caregiving behaviour grows out of an interaction between beliefs about parental roles, previous experiences, and the situational or structural factors within a family (Russell 1983). A review of the literature on fatherhood in North America would support this view whereby the trend toward 'father as child care provider' which has occurred over the last two decades was seen as a result of emotional or socio economic circumstances (Tiedje & Darling- Fisher 1996).

There has been very little research carried out on the psychological characteristics of the fathers who are highly participant in child care. Russell recommends that future studies consider both sex roles and personality factors as well as factors associated with the family situation, as his results support the possibility that a father's participation is influenced by the attitudes and behaviour of the mother. Future research should focus on the effects that different types of family situations have on parental behaviour. There is a dearth in the literature on fathers who have major or sole responsibility for child care (eg. lone fathers) (Russell 1978).
Chapter Three

Physical and Psychological Health of Expectant Fathers
3.1 'Couvade' Phenomenon.

There has been considerable coverage in the literature of the 'couvade phenomenon', and its occurrence has been reported widely in a number of cross cultural studies. The term 'couvade' has been used to describe the occurrence of symptoms during pregnancy and upon the birth of the child which mimic those natural and proper to the mother (Quill et al 1984). The 'couvade syndrome' has been described in medical literature since the 17th century, as a cultural ritual, facilitating the father's acknowledgment of paternity, and can be viewed as an identification with, and envy of the pregnant woman or even as a regressive reaction to oedipal feelings (Kimmel 1987).

The most frequently exhibited symptoms are alimentary and they imitate those experienced during pregnancy. These include nausea, vomiting, alterations in appetite, weight gain, abdominal pain, backache, leg cramps, elusive toothaches and other aches and pains in different parts of the body. 'Couvade' symptoms usually appear about the third month of pregnancy, ease up in the middle months and return again in the last trimester. 'Couvade syndrome' is not uncommon and its incidence in Western industrialised cultures has been reported as low as one in nine to as high as one in three, depending on the definition used (Strickland 1986).

The psychodynamic explanation for 'couvade' proposes that because of his identification with and envy of the pregnant woman, and her ability to give birth, the father may compete with the mother or try to control the pregnancy and birth. Somatic symptoms may serve the purpose of providing an emotional outlet for the man's ambivalent feelings, as well as stemming from an unconscious identification with both the woman and fetus. A more constructive approach may be for him to use his own
creativity and productivity in a more constructive way, such as the development of hobbies or interests (Raphael-Leff 1993).

Numerous studies have yielded both a consensus and disparity regarding factors associated with the 'couvade syndrome', and this reflects the fact that 'couvade' is still poorly understood despite its apparent prevalence (Clinton 1986).

In her review of the nursing literature on the 'couvade syndrome', Lemmer found a lack of clarity in the definition of 'couvade', symptoms although the actual physical and physiological alterations in the health of expectant fathers were emphasised (Lemmer 1987).

Teichman & Lahav reported that first-time expectant fathers experience more frequent somatic symptoms than experienced fathers, confirming the hypothesis that the period preceding the birth of the first child is particularly stressful for men. However they found that all expectant fathers reported more symptoms than a control group of non expectant men. Active involvement with the pregnancy was found to reduce depression, hostility and anxiety in expectant fathers, and amongst those subjects who reported more physical symptoms there was a denial of anxiety (Teichman & Lahav 1987).

Several socioeconomic variables have been associated with the occurrence of 'couvade'. Strickland found that planning of pregnancy, social class and racial background were associated with symptom manifestation in expectant fathers (Strickland 1986). Clinton concurs, listing those more 'at risk' as ethnic minorities, those with previous children, low incomes, high affective involvement in the pregnancy and prior poor health status (Clinton 1986). Those men who experienced more 'couvade' symptoms reported more active involvement with preparation for the baby, had a higher
degree of role preparation, and were more involved in the pregnancies than men who did not experience symptoms (Longobucco & Freston 1989).

However Quill et al reported that when the health care seeking behaviour of married expectant fathers was compared to non expectant married men, the expectant fathers had a lower number of medical visits for 'couvade' as well as other symptoms during the months of pregnancy (Quill et al 1984). One explanation for this could be that men have a poorer perception of their own health status after birth than during pregnancy, probably due to their preoccupation with their partner's recovery from childbirth (Ferketich & Mercer 1989). These authors state that as men tend to focus on their wives as their central support person, a positive relationship was found between partner satisfaction and health status. This finding agrees with an earlier finding that satisfaction with partner support was the most important variable studied in understanding the health of expectant fathers (Brown 1985).

3.2 Psychological Health.

The majority of studies of mental health of fathers have focused on postpartum psychiatric health (Lovestone & Kumar 1993, Areias et al 1996, Harvey & McGrath 1988). One of the only studies of expectant father's mental health compared mothers and fathers in a longitudinal study from Portugal. The cumulative incidence of depression in men and women during the nine months of pregnancy was not found to differ significantly. However, the second half of the pregnancy and of the postnatal year were found to be peak periods for the onset of depression in men. Father's depression frequently followed that of their partner's and was more persistent (Areias et al 1996). There is a dearth in the literature on the critical area of psychological health of expectant fathers.
The emotional experience of first-time fathers is another neglected area of research. Gerzi & Berman reported that high levels of anxiety, both overt and covert (including tension and apprehension) were characteristic of expectant fathers, particularly in the last month of their wives' pregnancy. Many defences were mobilised to deal with these unsettling experiences (eg. negation, denial, isolation, depression). Some form of individual or group counselling was recommended to provide a venue for venting some of these emotions (Gerzi & Berman 1981).

When Brown looked at social support as a mediator of stress for both expectant mothers and fathers she found that partner support was the most important variable in understanding expectant father's health. Satisfaction with partner support, stress and a history of chronic illness contributed significantly to the health outcomes of expectant fathers (Brown 1985). Coffman et al. concur, stating that it is the level of support received rather than the expected support that is important to men (Coffman et al 1994).

Parenthood is the only major role for which little preparation is given and difficulties in role transition may adversely affect the quality of the marital and the parent-infant relationship. Some of these difficulties include the father's lack of competence, confidence and preparation in parenting, feelings of neglect and jealousy of the baby, disruption and diminishment of social and sexual life, tiredness due to caring for infant, and little time for other children.
Chapter Four

The Attachment Behavioural System
4.1 Attachment Theory.

According to John Bowlby attachment behaviour is conceived of as any form of behaviour that results in a person attaining or retaining proximity to some other differentiated or preferred individual (Bowlby 1980). Attachment behaviour is a class of behaviour that has its own dynamic, which while different from feeding behaviour and sexual behaviour is equally significant to human life. Attachment is a form of instinctive behaviour which is goal orientated and is mediated by the other behavioural systems.

Attachment theory grew out of the observations of the behaviour of infants and young children who were separated from their primary caregiver (usually their mother) for various lengths of time. A predictable series of reactions was noted in these infants namely: protest, despair and then detachment. The quality of early attachment relationships is rooted in the degree to which the infant has come to rely on the attachment figure as a source of security. When the parent is responsive to the infant's attachment signals and available in stressful situations this provides a 'secure base' from which the child can organise expectations about the world and handle distress (Mikulincer & Erev 1991). Therefore early attachments form the prototype for later attachments via internal working models of "self" and "other".

Mary Ainsworth took up the study of individual differences in the quality of mother-infant interaction and her observations of mothers and infants revealed that maternal sensitivity was significantly correlated with secure attachment. Also mothers enjoyment of breast feeding also correlated positively with secure attachment (Bretherton 1992).

Ainsworth identified three distinct patterns of infant attachment: secure, anxious- resistant and avoidant on the basis of infants' responses to separation from and
reunion with caretakers in a structured laboratory procedure known as the Strange Situation.

Securely attached children welcomed their caretakers return after separation, sought proximity if distressed and were readily comforted. Infants classified as anxious-resistant showed ambivalent behaviour toward caregivers and an inability to be comforted on reunion, and infants classified as avoidant avoided proximity or interaction with the caretaker on reunion (Ainsworth 1979). The evolutionary perspective of attachment theory attributes focal importance to bodily contact, and a striking finding of the mothers of the avoidant group of babies was that the mothers of these babies all evinced a deep aversion to close bodily contact. Avoidance in these babies being seen by the researcher as a defence manoeuvre which lessened the anxiety and anger they experienced and enabled them to remain within a tolerable proximity to the mother.

Ainsworth found that mothers of the secure cohort of babies had been more sensitively responsive to infant signals than the mothers of the two anxiously attached groups. Subsequently these babies were able to form expectations or an inner working model that the mother was generally accessible and responsive to them. In contrast, babies whose mothers had disregarded their signals or who had responded to them belatedly or in an inappropriate fashion had no basis for believing that the mother would be accessible and responsive to them, in fact they did not know what to expect of her.

In interpreting the results of her studies Ainsworth conceded that the question did arise as to what extent the baby's attachment pattern is attributable to the mother's behaviour throughout the first year and to what extent it is attributable to built in differences in potential and temperament within the baby. She concluded that a strong
case could be made for differences in attachment quality being attributable to maternal behaviour and that if the mother's personality or life situation made it hard for her to sensitively respond to her infant's cues, then such a baby would be likely to form an attachment relationship of an anxious quality. Subsequently it was found that in the samples of normal, healthy infants that differences in infant behaviour seemed to be influenced more by maternal responsiveness than does maternal behaviour seem to be influenced by infant characteristics (Ainsworth, Bell & Stayton 1974). Three components of a mother's accurate ability to interpret her baby's communication were identified by the authors namely: her awareness, her freedom from distortion and her empathy.

A basic principle of attachment theory is that attachment relationships continue to be important throughout the lifespan as working models which are believed to represent an established cognitive system that predisposes the individual toward interpreting experiences in ways which are consistent with these working models. These models operate at an unconscious level and become increasingly complex and resistant to change, particularly if the caregiver environment remains stable.

4.2 Internal Working Models.

According to Bowlby's theory internal working models are formed over time with early attachment relations forming the prototype for later relationships outside the family (Bartholomew & Horowitz 1991). The way in which an individual's attachment behaviour becomes organised within his personality establishes the pattern of affectional bonds he makes during his life (Bowlby 1980). The basic character and affective tone of the emerging working models revolves around the answer to two fundamental questions: am I a worthy and lovable person? and are others (the attachment figures)
trustworthy and caring? When caregivers consistently recognise and respond appropriately to the child's needs for comfort, security and independent exploration, the child will likely develop a model of self as valued and self sufficient (ie. positive), and a model of other as trustworthy and caring (ie. positive). However where the caregiver routinely rejects the child's overtures for protection and comfort and also interferes with the infant's desire for independent exploration, the infant will be likely to internalise a model of self as worthless and incompetent (ie. negative) and a model of other as unreliable and rejecting (ie. negative ). The two components of working models of attachment are called models of self and models of others and are thought to vary in valance from emotionally negative to positive (Klohen & John 1998).

These working models may be seen as maps and plans which simulate and predict the behaviour of others in social interaction as well as a means of planning one's own behaviour to achieve relational goals. These internal working models which operate largely outside of conscious awareness, centre around the regulation and fulfilment of attachment needs and will most likely be activated in attachment relevant events (eg. those that create stress) (Feeney & Noller 1996).

Individual differences in attachment styles can be interpreted as a reflection of differences in underlying models of self and other which are formed in early childhood and modified throughout subsequent experiences. The function of working models is to shape cognitive, emotional and behavioural responses to others.

4.3 Adult Attachment

Adult attachment is a stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few specific individuals who provide the subjective potential for physical and or psychological safety and
security. This stable tendency is regulated by internal working models of attachment, which are cognitive-affective motivational schemata built from the individual's experience in his or her interpersonal world. Attachment, therefore defines a behavioural system that may or may not be active in a person's life or in a particular relationship at a given time. Although adult attachment provides the potential for relationship security, it may not actually provide this security. In fact many people maintain attachment relationships that provide significant anxiety and anger because of the belief that the attachment figure has the potential to provide them with a feeling of security. The caregiving system is an integral component and direct outgrowth of the attachment system, and one of the primary adult manifestations of disturbed attachments is compulsive caregiving (Sperling & Berman 1994).

Attachment can be defined operationally in terms of the criteria that differentiate adult attachment from other social behaviours and the provisions which are supplied by attachment relationship. Weiss (1982) concluded that adult attachment bonds largely fulfil the following criteria for attachment: i) in the face of stress individuals will attempt to seek contact with their attachment figure, ii) increased comfort and diminished anxiety are felt in the presence of the attachment figure, and iii) separation or threatened separation from the attachment figure causes discomfort and anxiety if the person is found to be inexplicably inaccessible (West et al 1987). The authors conclude that adult attachment can be distinguished from general social relationships using five criteria: proximity seeking, secure base effect, separation protest, anticipated permanence of the relationship and reciprocity. In general attachment provides a unique relationship with another individual who is perceived as available and responsive and who is turned to for emotional and instrumental support. The use an individual makes of
an attachment relationship may be a function of personality characteristics. Anger is an integral part of the attachment system and may serve two functions: one that is facilitative and one that is coercive. It is possible that anger may serve to block feelings of attachment and some research has suggested that people with avoidant styles experience the most intense anger and loss, which may be expressed under periods of increased stress or decreased ego control (Sperling & Berman 1994). The inability of individuals to recognise and mourn the failures of their caregivers to respond effectively and quickly is the central dynamic in patients with personality disorders. Therefore the principal goal of psychotherapy from an attachment perspective is to identify this 'feared loss dynamic' and to facilitate mourning, sadness and anger in order to provide closure to the unresolved relationship longings with parental attachment figures.

Bowlby (1980) suggested that the childhood experiences of persons who are prone to make anxious and ambivalent attachments has been likely to be of parents who because of their own childhood and/or difficult marital relationships found their children's desire for love and care as a burden and responded to them with irritability and inconsistency. Although these people experienced inconsistent parenting the rejection was more likely to be intermittent and incomplete. Therefore these people still hope for love and care but are deeply anxious about abandonment (Bowlby 1980). Husbands with a secure attachment style have been found to have fewer conflicts and more positive interactions than men with insecure attachment styles.

4.4 Love as Attachment.

Research on romantic love has been primarily descriptive and theoretical and questionnaires were developed which assessed degrees of liking and loving but said little about why these states exist. Hazan & Shaver (1987) have suggested that romantic
love is an attachment process which is experienced somewhat differently by different people according to variations in their attachment histories. However, it may be difficult to consider romantic love as an attachment process which has emotional dynamics and biological functions akin to those of infant caregiver attachment.

The authors have used attachment theory to provide a single conceptual framework which fits the various forms of love together and explains their origins as reasonable adaptations to social circumstances (Hazan & Shaver 1987). This led to the development of a psychometrically based 'love quiz' which incorporated key components of attachment theory, developed by Bowlby and Ainsworth and translated these into terms appropriate to adult romantic love. When this questionnaire was tested on a sample of 620 newspaper readers the results indicated that the relative prevalence of the three attachment styles is roughly the same in adulthood as in infancy with 56% of respondents classifying as secure, 25% as avoidant and 19% as anxious/ambivalent (Hazan & Shaver 1987). The three attachment styles were found to differ predictably in the way they experienced romantic love. Adult love usually involves reciprocal caregiving with both partners serving as attachment figures for each other and therefore romantic love when viewed from an attachment perspective involves the integration of three behavioural systems: attachment, caregiving and sexual mating. Different love relationships involve different mixtures of the three, and in some cases one or more of the components may be absent however, prototypical adult romantic love does contain all three. As the attachment system is the first of the socially relevant behavioural systems to appear in the course of development it lays the foundation for the others (Shaver & Hazan 1988).
When Feeney & Noller (1990) surveyed an Australian sample of 374 undergraduate students to see if attachment style was a predictor of adult romantic relationships, they found that securely attached subjects reported positive perceptions of their early family relationships. However, avoidant subjects were most likely to report a childhood separation from their mothers and to have experienced mistrust of others. Anxious ambivalent subjects were less likely to see their fathers as supportive and reported a lack of independence and a desire for deep commitment in relationships. Attachment styles were found to be strongly related to self-esteem and to the various forms of love described in other theoretical frameworks (Feeney & Noller 1990).

A longitudinal study of 144 dating couples was carried out to test several hypotheses regarding the influence of attachment styles on romantic relationships. Those people who scored higher on the secure attachment index indicated that they were involved in relationships characterised by greater interdependence which was reflected in greater love for, dependency on and self-disclosure with the partner as well as greater levels of commitment, trust and satisfaction (Simpson 1990). Analysis of the data which was generated by this study revealed that secure, anxious and avoidant attachment styles tend to be associated with romantic relationships that differ in their qualitative nature. When a follow up was done of couples who had disbanded it was revealed that avoidant men experienced significantly less post-dissolution emotional distress than other people.

The author proposes that over time highly avoidant people ought to elicit anxious propensities from their romantic partner and vice versa. Highly anxious people on the other hand may have partners who report less interdependence and commitment for several different reasons. By eschewing closeness and commitment, highly avoidant
people may produce heightened distrust in their romantic partner. Conversely, by
displaying a general lack of trust, highly anxious people may generate decreased
closeness and commitment from their partner. Recommendation is made that future
research must examine how positive and negative emotions may affect the quality of
ongoing relationships. Changes in attachment style may be experienced over time and
across generations within families, however it appears that individuals do adopt the
same style in different relationships. This paper recommends that future studies track
people longitudinally to unequivocally establish whether attachment styles remain stable
across several relationships.

Collins & Read (1990) chose a sample of 406 undergraduate students, 206
women and 184 men to explore the role of attachment style dimensions in three aspects
of ongoing dating relationships. Firstly, partner matching on attachment dimensions,
secondly the similarity between the attachment style of one's partner and the caregiving
style of one's parents, and finally the quality of the relationship including
communication, trust and satisfaction. Results indicated that individuals tended to be in
relationships with partners who shared similar beliefs about closeness and intimacy and
about the dependability of others. However, participants did not simply chose partners
who were similar on every dimension of attachment but rather chose partners who
confirmed their expectations of relationship. The authors recommend that future
research examines the influence of attachment history on the process of mate selection
and relationship development (Collins & Read 1990).

Levy & Davis (1988) used several instruments to predict concurrent relationship
characteristics among unmarried dating couples. They found that all three of Hazan &
Shavers' attachment styles were significantly related to relationship characteristics in a
manner which supported their original theory (Levy & Davis 1988). Part of this study was to examine how each of the relationship styles handled relationship conflict using Rahim's five approaches to conflict, namely compromising, integrating, obliging, avoiding and dominating. The secure style was positively and significantly correlated with compromising and integrating, but not with obliging. The anxious/ambivalent was negatively associated with compromising and integrating and positively with dominating. The avoidant style was found to be less likely to correlate with compromising and integrating. The secure attachment style was found to predict positive relationship characteristics and constructive approaches to conflict and both the avoidant and anxious/ambivalent styles predicted negative relationship characteristics (Levy & Davis 1988).

An Israeli study of 337 students explored the adult attachment processes. The differences between secure, avoidant and ambivalent people in their concept of romantic love was examined, and relationships explored from the point of view of both partners. The differences among attachment groups in both actual and ideal relationships was also examined. All subjects were single and committed at the time of the study to a heterosexual romantic relationship that had at least one years duration (Mukilincer & Erev 1991).

The authors found that secure people rated all three components of love, namely intimacy, passion and commitment as high, or higher in importance than insecure people. Avoidant subjects predicably rated low on intimacy but were high on commitment. Although ambivalent people have a high desire for intimacy, they rate low on intimacy and commitment in existing relationships. Failure to realise their desire for a warm and secure relationship can be said to characterise the love style of ambivalent people.
Recommendation is made that future research examine both the avoidant and ambivalent groups.

4.5 A Four Group Model of Adult Attachment.

Working within an attachment framework Bartholomew proposed a new 4-group model of adult attachment which differentiated two forms of avoidance of intimacy namely, a fearful style and a dismissing style. The fearful style is characterised by a desire for intimacy which is coupled with a lack of trust and a fear of rejection. People in this category may undermine the possibility of establishing satisfying social relationships which could serve to modify early attachment representations by avoiding close relationships in which they may be vulnerable to loss and rejection. Dismissing avoidants are characterised by a defensive denial of the need for social contact. Their emphasis being on achievement and self-reliance which maintains a sense of self worth at the expense of intimacy (Feeney & Noller 1996).

Bartholomew developed a theory that adult avoidance of intimacy can be understood as a disturbance in the capacity to form interpersonal attachments which stems from the internalization of early adverse experiences within the family of origin (Bartholomew 1990). The model distinguishes three different insecure attachment styles: namely preoccupied, fearful and dismissing. Each of these is assumed to have arisen out of negative or at least, not consistently positive experiences with attachment figures (Klohn & John 1998). A negative model of others is closely associated with avoidant behaviour and a negative model of self is said to be closely associated with anxiety about abandonment (Brennan et al 1998). Avoidance is seen as a distortion in the balance between independence and dependence, or individuation and connectedness.
and an interpersonal style which is characterised by a lack of desire or capacity to become deeply involved with others is potentially maladaptive.

4.6 The Adult Attachment Interview.

The Adult Attachment Interview (AAI) has been developed as a semi-structured interview which is designed to probe for descriptions and evaluations of childhood attachment relationships and the effects of these experiences on the participant's development and personality (Main 1996). In this hour long interview the speakers are given opportunity to probe specific supportive and contradictory memories and assessments of childhood and current relationships. Interview analysis rests on the study of the verbatim transcript. The assessment of organised thoughts and feelings is considered to be a major means by which variability in the nature of adults' working models of attachment is identified. Security of an individual's model of attachment is inferred on the basis of an overall detailed analysis of interview transcripts. Individuals are assigned to one of four major categories namely: secure, insecure/ dismissing, insecure/ preoccupied and insecure/ unresolved.

Attachment theory does not assume that an adult possesses only one working model of attachment and recognises that in some cases, features of other working models may be concurrently reflected in the individual's mental state with respect to attachment (Radojevic 1994).

One disadvantage of the AAI is that administration and scoring require in depth training and subsequently researchers have sought a simpler and more economical way to assess adult attachment (Feeney & Noller 1996).
Chapter Five

Paternal Fetal Attachment
5.1 Background.

In over two decades of research on parent-infant attachment, the majority of studies have focused on maternal-fetal attachment and as yet little is known about the development of paternal-fetal attachment (Feretich & Mercer 1995).

Condon has proposed five salient features of antenatal attachment behaviour. They are: i) seeking information about the fetus to clarify the mental picture of it, ii) contact and interaction such as in palpating the abdomen and talking to the baby, iii) pain associated with threatened or fantasised loss, such as threatened miscarriage, iv) behaviours, aimed at increasing fetal well being, such as attention to diet and exercise and v) any altruistic, sacrificial activity which is associated with these.

Fatherhood was traditionally believed to commence with the visual and tactile contact with the child, however recent studies have supported the notion that paternal-fetal emotional attachment not only exists but that fathers demonstrate attachment behaviours towards their infants similar to those demonstrated by mothers (Condon 1985). A positive relationship between paternal-fetal attachment and the marital relationship has been reported in a number of studies presumably because the mother controls the father's access to the unborn infant. First-time fathers show higher prenatal attachment than experienced fathers which is reflected in their higher level of involvement in the pregnancy (Feretich & Mercer 1995).

5.2 Comparison of Maternal and Paternal Fetal Attachment

In one of the only studies to compare maternal and paternal-fetal attachment, Condon found that there are more similarities than differences in the way men and women relate to their unborn child. The 'inner world' experience of men and women which consists of the internalised representation of the fetus and the emotional
responses are remarkably similar, although the 'outer world' behavioural expression of these thoughts and feelings were found to be markedly different. Men exhibited a higher level of ambivalence towards the fetus initially than women, and this resolved more slowly.

Although men have less opportunity to palpate the fetus than their wives, both sexes spend about the same amount of time preoccupied with thoughts about the baby and future child. In fact cultural stereotypes may operate to conceal the true similarities between men's and women's inner experiences during pregnancy (Condon 1985). A father does not experience the abundant stimuli and the physical level of involvement in the pregnancy that a mother does, however his fantasies about the fetus may serve to direct his energies towards long term goals with his child (Ferketich & Mercer 1995).

5.3 Influences on Paternal Fetal Attachment

Three factors which are said to influence the development of a father's attachment to his infant are: i) the father's past attachment experiences, ii) how the father perceives the infant, perhaps from the time of birth and iii) the pleasure or pain value the father places on the birth experience (Fortier 1987).

Men's attachment to their unborn child has been found to be independent of many environmental factors, such as social support and stress (Ferketich & Mercer 1995). One descriptive study from the U.S.A. was undertaken to determine if there was a relationship between father-infant attachment and the type of birth. The results of this study showed no significant difference in attachment behaviours between fathers whose babies had been delivered vaginally and those who had their babies delivered by caesarean section. However, the variables of infant gender, previous children, father's presence at the delivery and early contact with the infant did influence the father's self-
reported attachment behaviours. As the sample size in this study was small a caution is given against-applying these findings to the general population. Recommendations for further studies on father-infant attachment and its correlates with representative samples are made by the author of this study (Fortier 1988).

Failure in paternal infant attachment may result in a potential for maladaptive parenting, or even a risk of fetal and child abuse. A longitudinal study of expectant fathers was carried out to assess parenting and child rearing attitudes using the Adult-Adolescent Parenting Inventory (AAPI), the only tool available which has been validated for use with males. The recommendation of this study is that this tool be used more widely to assess couples and identify where the potential for maladaptive parenting exists in order that interventions can be appropriately set in place (Tiller 1990).

5.4 Father's Presence at Delivery.

In view of the evolving literature in the area of father-infant attachment midwives will be challenged to stay up to date on findings in this area.

Chapman (1991) used a grounded theory in obtaining qualitative retrospective data from fathers who had attended the delivery of their babies. Her study concluded that expectant fathers adopted one of three roles at labour and delivery, namely: coach, teammate and witness. These roles were related to the degree of mutuality and understanding within the couple's relationship. The majority of men adopted the role of witness which allowed togetherness without the pressures of being in control of the labour and birth experience. The author recommends that the expectation that fathers adopt the role of coach be reevaluated in view of these findings (Chapman 1991). Berry concurs stating that labour and delivery are progressively stressful for father's and she
counsels midwives against having the attitude that a father's presence primarily serves the purpose of having them 'coach' their wives (Berry 1988). Feelings which have been reported by fathers in the labour ward include: helplessness in the fact of their wife's experience of labour, and of being an encumbrance.

A father's presence at the delivery of his child and early contact may predict his future caretaking activities. It has been suggested that fathers who do fail to attend the birth may not fully integrate their childbirth experience (Draper, 1997). A father's involvement at the birth of his child can be seen as a celebration of a significant event in the lives of everyone concerned and may confirm him as the father. Apart from encouraging a father's presence and participation at delivery, midwives will need to handle each situation individually and not just routinely. Midwives in clinical practice need to adopt an informed and realistic view of the father during labour and delivery when emotional demands on these men are very high.

CHAPTER SUMMARY

The preceding chapter has presented an overview of the literature on expectant fatherhood and has covered the following areas:

* Paternal attachment theory which included the psychodynamic and developmental aspects of expectant and new fatherhood and the Raphael-Leff theory of paternal orientation (the participator, renouncer and reciprocator model).

* Sex-role identity: masculinity femininity and androgyny.

* The physical and psychological health of expectant fathers.

* The attachment behavioural theory which included internal working models of attachment, adult attachment and love as attachment.

* Paternal fetal attachment and the father's presence at delivery.
According to the Raphael-Leff model of paternal orientation three distinct fathering styles (participators, renouncers and reciprocators) can be identified during each pregnancy and will remain consistent with each child. However, no instrument exists which can distinguish these groups of fathers using this model of paternal orientation. This present study aimed to develop an instrument to measure and test the model and to assess the extent to which attachment theory, sex-role identity and early bonding contribute to paternal orientation. Such information can enhance the understanding of midwives and others caring for expectant fathers and enable them to tailor interventions and policies that cater to the needs of individual fathers. Differences have been found to exist between facilitator and regulator mothers in the chronology, nature and psychosocial precipitating factors of postnatal disturbance (Raphael-Leff 1985). Therefore, if such differences exist between the fathering groups, the development of a tool whereby fathering styles can be distinguished may open the way for future research using this model and contribute to the important and infrequently researched area of mental and emotional health of expectant and new fathers.

Despite numerous studies on the physical health of expectant fathers and the 'couvade' phenomenon both a consensus and a disparity exist in the literature regarding the factors associated with this syndrome, and this may indicate that it is still poorly understood (Clinton 1986). At present there is a dearth in the literature in the critical area of psychological health of expectant fathers and the majority of studies that have been done in this area have focused on the postpartum psychiatric health of fathers (Lovestone & Kumar 1993, Areias et al 1996, Harvey & McGrath 1988). Further studies in this area are warranted as family functioning may be compromised by the presence of mental illness. Another neglected area of research has been the emotional
experience of first-time expectant fathers. Results of existing studies indicate that the second half of pregnancy and the first postnatal year are stressful times both emotionally and psychologically for fathers and future research in this area may provide valuable information that can assist carers identify fathers 'at risk' for psychological distress.

There is a dearth of studies on paternal-fetal attachment which is an emerging area of interest in the literature and one which has been recommended for further exploration (Ferketich & Mercer 1995). As yet no studies have explored some of the other possible influences on paternal-fetal attachment by examining attachment styles, early bonding and sex-role identity. First-time fathers have shown a higher prenatal attachment than experienced fathers which is reflected in their higher levels of involvement in the pregnancy. Future studies could examine whether a higher percentage of first-time fathers are participators according to the Raphael-Leff model than experienced fathers. Failures in attachment and bonding have the potential to result in maladaptive parenting, poor family functioning or even a risk of fetal or child abuse.

Attachment theory has become a fertile area of research with studies examining the influence of attachment styles on work, health and romantic relationships. Collins & Read (1990) have recommended that future research examine the influence of attachment history on the process of mate selection and relationship development. Recommendation has also been made that continued and ongoing examination be made of the insecure attachment groups (dismissing, fearful and preoccupied) as these groups show most difficulty in forming and maintaining healthy relationships (Mukilincer & Erev 1991). Bartholomew 1990 claims that adult avoidance of intimacy, as seen in the styles of the fearful and dismissing groups, is a disturbance in the capacity
to form interpersonal relationships stemming from the internalization of early adverse experiences within the family of origin. Avoidant attachment is potentially maladaptive as it results in an interpersonal style which is characterised by a lack of desire or capacity to become deeply involved with others. Therefore the attachment styles of first-time fathers is of interest to researchers as this will affect the formation of paternal attachment. The presence of an avoidant attachment style in these fathers may predispose to the formation of poor paternal-fetal attachment.

In conclusion there is a dearth of studies investigating paternal attachment. There is no research operationalization of Raphael-Leff's paternal orientation categories, so research in this area is in its infancy. How attachment and paternal orientation relate to traditional sex-role identity styles is unknown. There is a critical need for further research into the emotional approach of fathers to pregnancy and childbirth as this has potentially a crucial influence on the future mental health of both themselves and their infants. This study was designed to investigate the relationship between paternal attachment, sex-role identity and Raphael-Leff's paternal orientation model to address these gaps in the literature.
Chapter Six

Research Design and Methodology
6.1 Aims and Significance of the Study.

The aim of this study was to assess the Raphael-Leff model of paternal orientation by examining its relationship to attachment style, sex-role identity and early bonding experiences. The Raphael-Leff model proposes three distinct paternal orientations, namely participators, reciprocators and renouncers. Each style is associated with different clusters of attributes and patterns of behaviours which are said to be evident even in early pregnancy and to foreshadow later interaction between the father and child (Sharpe & Cooper 1992). Raphael-Leff points out that there are very few 'pure' types, but rather indicates that paternal styles or orientations could be placed on a continuum from extreme participator to extreme renouncer with varying combinations and dominance between those two positions.

The model could help carers understand the psychological needs of individual fathers, during pregnancy, childbirth and the postnatal period. This understanding has the potential of assisting the planning and implementation of antenatal programmes and policies for delivery suite and postnatal care that will be more sensitive to the different beliefs and expectations of fathers.

6.2 Research Questions and Hypotheses

The overall intention was to explore the various influences on fathering styles. With this in mind the study aimed at exploring the areas of attachment, early bonding experiences and sex-role identity to ascertain the extent of their influence on paternal orientation.

Research Question: Does attachment style influence paternal orientation as proposed by the Raphael-Leff model?
**Hypothesis 1**: The prediction is that the different groups of fathers (participators, reciprocators and renouncers) will endorse different attachment styles and that a high percentage of participators would be secure in attachment style.

The description of the participator shows elements of secure attachment. The participator shows a willingness and enthusiasm to become involved both emotionally and physically in the pregnancy, labour and childcare. This indicates a valuing of personal relationships as well as a positive view of himself and of others (particularly his baby). The secure person is comfortable having others depend on him which is evident in the participator's comfort with sharing the nurturing role with his partner.

**Research Question**: Do internal working models influence paternal orientation?

**Hypothesis 2**: That the internal working models of the groups of fathers (participators, renouncers and reciprocators) will be different.

The two components of internal working models are called models of self and models of others and are thought to vary in valance from emotionally negative to positive. The prediction is made that the participator will most likely have a positive view of himself and a positive view of others which is reflected by his involvement with the pregnancy, labour and birth and his identification with his baby. Although the participator might be overly identified with his own mother, which might interfere with his relationship with his wife, overall the outcomes should be relatively positive. This study will investigate the internal working models of the reciprocator group which is said to be marked by ambivalence, the pursuit of juggling everyone's needs and a desire to be involved with the pregnancy, labour and childbirth. The reciprocator is probably identified with both maternal and paternal attributes, and this fluidity in identification
may or may not be a positive one. The prediction is that the renouncer because of his overidentification with paternal attributes and his desire to avoid connection with the pregnancy, labour and birth may in some cases have a negative internal working model of others.

**Research Question**: Is there an association between father's paternal orientation and sex-role identity?

**Hypothesis 3**: That different groups of paternal orientation (participators, renouncers and reciprocators) would differ in terms of sex-role identity.

The participator is said to be primarily identified with the feminine, maternal aspects of himself. A renouncer however, has renounced femininity and identification with his mother and strongly engaged a concept of masculinity. The reciprocator is engaged with both masculine and feminine identifications (Raphael-Leff 1991). The prediction is that more of the participator group will be feminine, more of the reciprocator group will be androgynous and the renouncer group would be more likely to endorse a masculine sex-role identity.

**Research Question**: Do early bonding experiences with the parent of the same sex influence paternal orientation?

**Hypothesis 4**: Participators, renouncers and reciprocators will differ in terms of early bonding experiences as measured by the Parental Bonding Instrument (PBI).

The participator shows his attachment to the baby by his active involvement and participation in pregnancy, labour and childcare. The prediction is that this father received high care and low overprotection (optimal bonding) in his early bonding relationships. The reciprocator has mixed feelings and goes to extremes to juggle everyone's needs. The prediction is that his early bonding experiences may have been
high on care, as he shows eagerness to care for his baby, however he may have experienced high overprotection and be less able to maintain his autonomy in close interpersonal relationships. The prediction is that the reciprocator could have an early bonding experience of high care, high overprotection (affectionate constraint).

The behaviour of the renouncer is marked by avoidance of intimacy and a fear of close involvement in the antenatal care, birth and early parenting. Raphael -Leff cites loss of control as a salient feature of this father, therefore it is predicted that they would have experienced low care, high overprotection (affectionless control) in their early bonding experiences.

**Subsidiary hypotheses.**

**Research Question:** Is there a relationship between paternal attachment and early bonding as measured by the Parental Bonding Instrument (PBI)?

**Hypothesis 5:** There will be a difference between the paternal attachment groups in terms of early bonding experiences with their father measured on the PBI.

**Research Question:** Is attachment associated with sex-role identity?

**Hypothesis 6:** That fathers who are secure in attachment will have a positive sex-role identity.

The secure subjects have positive internal working models of self and others and feel comfortable with emotional intimacy while maintaining their autonomy. They do not fear either rejection or being alone. The prediction is that secure attachment is associated with positive sex-role identity.

Positive or well clarified sex-role identity means that the subject will endorse the masculine, feminine or androgynous category on the Australian Sex-Role Scale (1981). The masculine group will score above the median in terms of characteristics of agency
which are considered desirable in males by both males and females. The feminine group will score above the median on characteristics of communion which are considered desirable in females by both females and males. The androgynous group will score above the median on both masculine and feminine positive characteristics of agency and communion.

A negative sex-role identity is defined as endorsing the undifferentiated group where subjects score below both medians: masculine and feminine. These subjects do not score highly on the positive characteristics of either the masculine or feminine group. The undifferentiated group is marked by less self disclosure and responsiveness than the androgynous group and lower self esteem than the masculine and androgynous groups (Bem 1977).

6.3 METHOD.

6.3.1 Pilot Study.

A pilot study was conducted by distributing the expectant father survey to three first-time expectant fathers along with demographic data, the Parental Bonding Instrument (PBI) and the Australian Sex-Role Scale (Personal Description Questionnaire).

After completing the instruments subjects were asked for feedback on the questions and on the format of the questionnaire. The aim of the pilot study was to test the questions and to see if they could be improved before giving the questionnaire to the main sample. Several alterations were made after the pilot study. Instead of a six-point Likert scale it was decided to use a one hundred (0-100) point scale on the questions in the body of the survey which allowed for middle points (eg. 65). A question relating to the father's intention to take time off work when the baby was born was deleted as it was
apparent that this was largely out of the control of the subjects and therefore not indicative of their paternal orientation.

A revised version of the expectant father survey was produced and it was decided to include the Relationship Questionnaire (RQ) which was developed by Bartholomew & Horowitz as an adaptation of Hazan & Shavers' measure. This instrument asks subjects to classify themselves according to four different attachment styles.

6.3.2 Main Study.

Surveys were distributed to the early parenting classes and the antenatal clinic of two public hospitals which are part of the Illawarra Area Health Service. The researcher attended several early parenting classes at the Shellharbour Hospital to outline the research to fathers. Surveys were collected by the staff at both hospitals. The support and cooperation of the midwives in both hospitals was sought as this would facilitate the gathering of data. The only criteria for inclusion in the sample was that the men were expecting their first child and that they were fluent in English.

An attitudinal survey entitled "Being an Expectant Father: attitudes, beliefs and expectations." (Appendix B) was developed by the researcher drawing extensively from the theory in the literature of expectant fatherhood. Other instruments that were given to the subjects to complete were the Parental Bonding Instrument PBI (Parker et al 1979), the Personal Description Questionnaire (Antill et al, 1981), the Relationship Questionnaire (RQ) (Bartholomew & Horowitz 1991) and a forced-choice self-classification which was devised for this study based on the Raphael-Leff participator, reciprocator, renouncer model of father's orientation.
6.3.3 Sample.

The population was first-time expectant fathers who were attending early parenting classes from January, 1999 to September, 1999. A sample of first-time fathers who participated in early parenting classes at the Wollongong Hospital and at Shellharbour Hospital within the Illawarra Area Health Service was targeted. The cooperation was sought from community midwives at both of these venues. A small number of surveys were also distributed at the antenatal clinic at Shellharbour Hospital. The researcher aimed at attending as many early parenting classes at the venues as possible, to recruit first-time fathers and to briefly outline the aims and significance of the survey. The willingness of the participants to fill in and return the questionnaire after the research had been explained to them was taken as indication that they consented to participate in this research. This research was approved by the University of Wollongong and the Illawarra Area Health Service Human Research Ethics Committee. The confidentiality and anonymity of respondents was ensured as no names were required.

6.4 Instruments.

6.4.1 Paternal Orientation Questionnaire (POQ) based on the Raphael-Leff Model.

A questionnaire was administered which asked the subjects to self classify, according to a forced choice format with only one of three classifications to fathering recorded. This was directly modelled on the Bartholomew & Horowitz Relationship Questionnaire (RQ) which is also used in this study. The methodology of using short paragraph descriptions and obtaining forced-choice classifications, follows that
successfully used by Bartholomew & Horowitz for classifying attachment patterns. The POQ was developed along the same lines as the RQ due to the fact that the research involved an anonymous survey of volunteer fathers attending pregnancy classes and due to the simplicity and validity of the RQ. A short paragraph described each of the three orientations to fathering identified by Raphael-Leff, namely participator, renouncer and reciprocator. The order of these three descriptions was changed and randomly allocated. An overview of the different classifications of fathers according to Raphael-Leff is as follows.

**Participator:**

Shows his active and eager participation throughout pregnancy, birth and the neonatal period by his involvement in antenatal care, labour and care of the newborn. He has a flexible gender identity that includes masculine and feminine aspects. The participator will see himself as spokesman for the helpless, vulnerable baby with whom he may overidentify. The following self-description was developed to identify participators.

*I am excited about the pregnancy, labour, birth and childcare and want to become actively involved. I see nurturing infants as being an important role for men. In understanding babies needs I believe that the infant knows best and will tell me what it needs.*

**Reciprocator:**

His position is marked by ambivalence and he is aware of having mixed feelings about pregnancy, labour and care of a newborn. In order to cope with the pressure of juggling everyone's needs he adopts a policy of negotiation. The reciprocator is able to
accept good and bad aspects of himself and his new baby. The following self-description was developed to identify reciprocators.

I have mixed feelings about the pregnancy, labour, birth and childcare but want to become involved. I see nurturing infants as a shared role with my partner. In understanding babies needs I believe that together the infant and I can work out what is best.

Renouncer:

The renouncer avoids or shuns involvement in the antenatal preparation, labour and the care of the newborn. He has a rigid gender identity that has strongly engaged masculinity. The renouncer fears the lack of control and heightened emotions that may be aroused by the labour and birth experience and the care of a newborn. The following self-description was developed to identify renouncers.

I am uneasy about the pregnancy, labour, birth and childcare and do not want to become too involved. I see nurturing infants as primarily the female role. In understanding babies needs I believe that the mother and medical staff know best and will tell what to do.

6.4.2 The Relationship Questionnaire RQ (Bartholomew & Horowitz 1991).

The Relationship Questionnaire (RQ) was developed by Bartholomew & Horowitz (1991) to identify adult attachment style and is an adaptation of the measure developed by Hazan & Shaver (1987). Respondents are asked to classify themselves using a forced-choice classification scheme. Four short paragraphs describe the four attachment styles (secure, preoccupied, fearful and dismissing). (see Appendix A)
The secure prototype is characterised by a valuing of intimate friendships, the capacity to maintain close relationships without the loss of personal autonomy, and a coherence and thoughtfulness in discussing relationships and related issues.

*It is easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others accept me.*

The dismissing prototype characteristically play down the importance of close relationships, have restricted emotionality and emphasise self-reliance and independence. This prototype will lack both thoughtfulness and coherence in discussing relationships and related issues.

*I am comfortable without close emotional relationships. It is very important for me to feel independent and self-sufficient, and I prefer not to depend on others, or have others depend on me.*

The characteristic of the preoccupied prototype is that they are overly involved in close relationships, depending on the acceptance of others for their sense of personal well being. The idealisation of others is present and this is combined with incoherence and exaggerated emotionality when discussing relationships.

*I want to be completely emotionally intimate with others but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.*

The fearful prototype is characterised by an avoidance of close relationships because of fear of rejection, a sense of personal insecurity and a distrust of others (Bartholomew & Horowitz 1991).
I am uncomfortable getting close to others. I want emotionally close relationships but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

The childhood experiences of individuals who are anxiously attached or preoccupied have been such that the confidence in the attachment figure being available when needed has been so shaken that there is a feared loss of security. Secure and anxious attachment can be differentiated by the different thresholds for the expression of attachment behaviour. The anxiously attached individual will react intensely to all anticipated or actual separations from the attachment figure, whereas the secure individual is able to maintain a sense of security by reference to an internal representation of the attachment figure rather than through seeking physical proximity (West et al 1993).

Bartholomew's four group model of adult attachment recognises that there are two styles of adult avoidance of intimacy namely, fearful and dismissing. The fearful style is characterised by a conscious desire for social contact which is counteracted by fears of the consequences of attachment. The dismissing style moreover is characterised by a defensive denial of the need or desire for attachment bonds. Bartholomew explains this difference as reflecting differing models of the self. A fearful person will view themselves as undeserving of the love and support of others, whereas a dismissing person will have a positive model of themselves which minimises the subjective awareness of distress or social needs that might activate the desire for close attachments. Adult avoidance of intimacy therefore can be understood as a disturbance in the capacity to form interpersonal attachments which stems from early adverse experiences with attachment figures (Bartholomew 1990).
Characteristics which Raphael-Leff claims are found in fathers of the three styles, namely participators, reciprocators and renouncers indicate that the different groups have a different attachment style in interpersonal relationships and different internal working models of attachment. The behaviour of the participator indicates that he is comfortable with closeness to others and to having others dependent on him, he also has a positive view of others (particularly evident with his new baby) and a positive view of himself as he enters into the new role of father. However the reciprocator shows by his ambivalence more concern about the reliability and availability of others, however despite the hesitancy he does value relationships. It is hypothesised that the renouncer is most likely to be avoidant (fearful or dismissing) in his attachment style. This style is marked by self sufficiency and discomfort in having others too close or dependent. This indicates a negative inner working model of others namely a view of others as unreliable and rejecting.

The Relationship Questionnaire (RQ) was tested for validity and reliability by using self report measures of self-concept and interpersonal functioning to validate attachment ratings. Attachment styles within the family and with peers was also independently assessed. A strong convergence was found between the RQ and the Peer Attachment Interview and the Family Attachment Interview (Bartholomew & Horowitz 1991). When an 8 month retest of attachment styles was carried out the authors found that 75% of females and 80% of males retained their initial attachment style (Scharfe & Bartholomew 1994). The four group model has been used in subsequent research which validates its utility (Brennan, Clarke & Shaver 1996, Jones 1998).
6.4.3 The Parental Bonding Instrument (PBI; Parker, Tupling & Brown 1979)

The work of Parker, Tupling & Brown (1979) aimed at examining the parental contribution to a parent-child bond through the development of a parental bonding instrument (PBI) which consists of two scales: one for care and one for overprotection.

The PBI asks adults to rate each parent on the basis of their earliest memories they have of their parents up until the age of 16 years on a 25 item scale (see Appendix D). Parker et al identified the two principal dimensions which contribute to parental bonding as care and overprotection. The care dimension, contrasts emotional responsiveness and frequent expressions of warmth and positive regard with a cold, emotionally aloof, and unresponsive parenting style. The second dimension which is labelled overprotection contrasts intrusive parental control and active resistance to the child's attempts to gain autonomy with encouragement of independence in the child and the development of a separate sense of identity.

The scale consists of 25 items, 12 care items and 13 overprotection items. Likert scaling is used, the maximum score for care is 36 and the maximum score for overprotection is 39. Both of these scales can be used either separately or together. When used together they allow for five types of parental bonding: average (defined statistically), high care-low overprotection (optimal bonding), low care- low overprotection (absent or weak bonding), high care- high overprotection (affectionate constraint) and low care- high overprotection (affectionless control).

To test for reliability and validity of the PBI seventeen members of the sample completed the inventory on two occasions three weeks apart to assess test-retest
reliability. Factor analysis supported the PBI, with test-retest reliability of .76 for the care scale however, only .63 for the overprotection scale. Split half reliability of .88 and .79 for the care and overprotection scales respectively, were also obtained.

Research suggests that early bonds with parents affect healthy adult personality adjustments and parental bonds may also form a relatively enduring template that strongly influences subsequent adult relationships, especially those which involve emotional intimacy and social support (Strahan 1995, Richman & Flaherty 1987, Mallinkrodt 1991). Neurotically depressed adults have been found to be significantly more likely than non depressed controls to report a low care representation of one or both of their parents and high parental overprotection may also be associated with external locus of control and interpersonal dependency (Parker 1983, Mallinckrodt 1991).

Both the care and overprotection scales were used together in this study. Subjects were asked to fill in the PBI in regard to their memory of their father only in their first 16 years of life as it was considered that the same sex parent would be most influential for fathers during the transition to parenthood and the process of paternal role attainment.

In using the Raphael-Leff model it is predicted that the different orientations of fathers (participators, reciprocators and renouncers) would have resulted from different early bonding experiences. The participator shows by his desire and intention to nurture his new baby that he has probably received high levels of care himself. However the avoidant position of the renouncer suggests an early bonding experience that has been at least partially rejecting and therefore low on care. The renouncer's marked fear of the loss of control is suggestive of overprotection. The reciprocator's early bonding
experience will differ from the other two orientations. A desire to be involved suggests a satisfactory level of care however the marked ambivalence of the reciprocator and his attempt to juggle everyone's needs indicates an experience of overprotection that has interfered with his own autonomy. Therefore it is predicted that the different groups of fathers will differ in their overall PBI classification as well as in scores on the care and overprotection scales when looked at separately. The participator group should most strongly endorse the optimal bonding (high care, low overprotection) classification on the PBI.

6.4.4 The Personal Description Questionnaire (Antill, Cunningham, Russell & Thompson, 1981)

This instrument was developed to parallel the Bem Sex Role Inventory (BSRI) using an Australian sample. The Personal Description Scales A and B each comprise 10 masculine positive, 10 masculine negative, 10 feminine positive, 10 feminine negative and 10 social desirability items. The participants are asked to rate each item between 1 and 7 according to how they feel they would be best described. Each number corresponds to a description ranging from 1) Never or almost never true and 7) Always or almost always true. Participants are classified according to empirically defined sex traits as masculine, androgynous, undifferentiated or feminine. (see Appendix C)

Each adjective is classified according to the following criteria.

(i) Masculine positive (M+): comprising those items that are seen as significantly (p< .05) more typical of males than females by both males and females. In addition these items were seen as desirable in males by both males and females. List A produced 11 such items and List B 20.
(ii) **Masculine negative (M-):** comprising those items which are seen as significantly (p < .05) more typical of males than females by both males and females. These items were seen as undesirable by both males and females. List A had 22 such items and List B 17 items.

(iii) **Feminine positive (F+):** comprising those items that are seen as significantly (p < .05) more typical of females than males by both males and females. These items were seen as desirable in females by both males and females. List A has 49 such items and List B 37 items.

(iv) **Feminine negative (F-):** comprising those items that are seen as significantly (p < .05) more typical of females than males and that are considered undesirable by both. List A has 21 such items and List B 13 items.

As high internal consistency (coefficient alpha) of the scales was considered important; the only items that were retained were those that highly correlated to the scale to which they had initially been allocated. As independence of the resultant scales was considered important items that correlated highly to a scale to which they had not been allocated were removed (Antill et al 1981).

According to the Raphael- Leff model the three groups of fathers would differ significantly in their sex-role identity. As participators have a gender identity that is identified with the feminine aspects, it is aimed to investigate the sex-role identity of this group. As the renouncer group is reported to have a rigid gender identity that strongly engages masculinity, it is predicted that this group will strongly endorse the masculine sex-role identity group. This study will explore the sex-role identity of the reciprocator group which is thought to be more androgynous.
It was decided to use List B which contains the highest number of masculine positive characteristics as it was considered to be a more sensitive instrument when surveying expectant fathers.

6.4.5 The Expectant Father Survey.

The survey consists of 19 questions which were aimed at eliciting information about key areas which were identified in the literature on expectant fatherhood namely: health, sexuality, the expectant father's relationship with his own father, paternal-fetal attachment, nurturing, participation in pregnancy and childbirth, the role of the father and social support. A space was provided for respondents to make further comments at the end of the survey in order to elicit some qualitative data. The content of the questions aims at eliciting information that would point to the father's orientation according to the Raphael-Leff theory.

6.4.6 Rationale for the Survey Questions.

Likert scaling was used on all questions except questions 5 and 13.

The Physical and Psychological Health of Expectant Fathers.

**Question 1:** How would you describe your own health during pregnancy?

**Question 2:** During this pregnancy how often have you sought medical consultation for your own health?

These two questions aimed at finding out about the health of the expectant father. It has been reported that first-time expectant fathers experience more frequent somatic symptoms than experienced fathers as the period preceding the birth of the first child is particularly stressful. All expectant fathers have been shown to report more
symptoms than a control group of non expectant men (Teichman & Lahav 1987). The 'couvade phenomenon' which describes the existence of physical symptoms in expectant fathers which mimic those which would be expected in the pregnant mother has been widely documented and is the subject of several studies (Strickland 1986, Clinton 1986, Lemmer 1987, Lonbobucco & Freston 1989, Ferketich & Mercer 1989, Quill, Lipkin & Lamb 1984, Teichman & Lahav 1987, Brown 1985). Although the issue of psychological health of expectant and new fathers has received less attention in the literature it is an emerging area of interest to researchers (Areias et al 1996, Harvey & McGrath 1988, Gerzi & Berman 1981, Lovestone & Kumar 1993, Teichman & Lahav 1987).

**Paternal-fetal Attachment.**

The first three questions were adapted from the Maternal Fetal Attachment Scale (MFAS, Cranley, 1981).

**Question 3:** How often do you "talk" to your unborn baby?

**Question 4:** How often do you feel your baby?

**Question 11:** I picture myself holding the newborn baby.

It is expected that the participant group would score significantly higher on these three questions than the other groups as thinking about and talking to their unborn baby is reported by Raphael-Leff as being a major part of their inner world. Alternatively the renouncer group would be expected to score significantly lower on these questions because of their avoidant stance.

The following questions were developed for this survey.

**Question 5:** During this pregnancy have you attended the following? (circle your answer)
Question 15: Which statement best describes your intentions for the labour and delivery?

1. I plan to be present helping where I can.
2. I have not yet decided whether to be present or not.
3. I plan not to be present.

Question 16: How comfortable do you feel with the idea of being present at the labour and birth?

The development of paternal-fetal attachment has been an emerging theme in the literature in recent years. Originally it was thought that fatherhood commenced with the visual and tactile contact with the child, however the results of recent research supports the idea that paternal-fetal attachment exists and fathers demonstrate similar attachment behaviours towards their infants to mothers. The 'inner world' experience of men and women which consists of the internalised representation of the fetus and the emotional responses are considered to be similar. Men may have less opportunity to palpate the fetus than their wives however they spend the same amount of time thinking about the baby (Condon 1985). First-time expectant fathers have been reported to show higher prenatal attachment than experienced fathers which is reflected in their higher level of involvement in the pregnancy (Ferketich & Mercer 1995).
Paternal-fetal attachment will be influenced by the father's past attachment history, his perception of the infant and the impact of the birth experience. Other influential variables include the gender of the baby, previous children, presence at delivery and early contact with the baby.

According to Hypothesis 1 the participator group is predicted to show higher levels of paternal-fetal attachment. Alternatively the renouncer group is predicted to show the lowest levels of paternal-fetal attachment.

**Relationship of Expectant Father to His Own Father.**

**Question 6:** During this pregnancy how often do you think about your own father?

**Question 7:** During this pregnancy how often do you dream about your own father?

**Question 8:** Right now, how close do you feel to your own father?

As the first-time expectant father moves into the place of father and displaces his own father there will be a revisiting and reappraisal of that relationship. This may evoke either tender or painful memories. In most men the process of transition to fatherhood takes place in dreams, but may also be played out in reality with his father or with other important male mentors (Raphael-Leff 1993).

Zayas (1987) reported that the dreams of first-time expectant fathers were filled with images of their own fathers, which indicated the presence of an unconscious process whereby perceptions of the father son relationship were being reworked and revived. The initiation and consolidation of the father's paternal identity will involve both taking on and discarding aspects of their own father's style of parenting.

It is predicted that participators will be more comfortable and less conflicted in their relationship to their own father than the other groups of fathers.
Social Support

**Question 9:** How often do you discuss the details of your partner's pregnancy with other people?

**Question 10:** Right now, how much time do you spend with your male mates?

The amount of social support available to expectant parents has been associated with physical and psychological health, stress, relationship functioning and attachment (Brown 1985, Cronenwett 1985, Coffman, Levitt & Brown 1994, Brown 1986, Taucher, 1991). By including these questions it was intended to gain further insight into the relational and attachment styles of the subjects.

Raphael-Leff claims that the renouncer father seeks out male companionship during pregnancy as one attempt to opt out of the family circle and it is therefore predicted that this type of father will spend more time with his male mates during the pregnancy than the other groups of fathers.

The area of social support is intricately connected to attachment theory. The secure group should feel comfortable with disclosure and with maintaining relationships. The fearful and dismissing groups will avoid close relationship and may therefore not have the skills to maintain social support during the transition to pregnancy. Hypothesis 2 predicts that the internal working models of the different groups of fathers will vary.
Sexuality.

Question 12: When you compare your partner's body to the way it was before pregnancy you think that it is:

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<th>80</th>
<th>90</th>
<th>100</th>
</tr>
</thead>
</table>

Less beautiful than it was before ................. More beautiful than it was before.

Question 13: When I think about having sexual intercourse with my partner during the pregnancy I feel (please circle the answer):

1. it is a way for me to get closer to, and nurture my baby.
2. a bit nervous that I could harm the baby.
3. sometimes that the baby could harm me.

Question 14: How do you feel about sex with your partner now, compared to before the pregnancy?

The area of sexuality is one that has the potential to bring out differences in the groups of fathers. The participator father it is said to feel closer to his baby during sexual intercourse and may 'fantasise' that he is nurturing his baby with his sperm. The renouncer father however may find the sexual relationship more threatening now that his partner is a 'mother to be.'

The Role of the Father

Question 17: How much do you agree with the following statements?

a) I think my role as a father will be mainly as a provider.

b) I will be happy to help out where necessary, but see my partner as doing most of the nurturing.
c) I intend to be involved in the practical care of the newborn baby. (ie. I see myself changing nappies.)

d) I feel I will be more competent with an older child than a newborn.

Participators are reported to feel that their role is as co-nurturer of their child, whereas the renouncer father will feel that he is mainly the provider, he will endorse a more stereotypical gender behaviour. It is predicted that the groups of fathers (participators, reciprocators and renouncers) will be significantly different in their interpretation of the father's role.

**Relationship with Significant Others**

**Question 18: How much do you agree with the following statements?**

a) the baby infant may take over my wife's affection.

b) I feel that my wife or other family members may not allow me to spend the time I want to spend with my newborn baby.

These questions were designed to tap into the internal working models of the father's in respect to fear of rejection and/or abandonment. A negative model of self is closely associated with anxiety about abandonment and a negative model of others with avoidant behaviour (Brennan, Clarke & Shaver 1996). According to the Raphael-Leff model the avoidant behaviour of the renouncer suggests a negative internal working model of others.
Timing of the Pregnancy

**Question 19:** Please mark on the scale where you think you are right now.

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<tbody>
<tr>
<td></td>
<td>I'm 100% happy to have</td>
<td>I'm not sure that this is the right time to have a child.</td>
<td></td>
</tr>
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<td></td>
<td>a child at this time</td>
<td></td>
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This question aimed at tapping into the ambivalence of the reciprocator and/or the exuberance of the participator.

### 6.4.7 General Demographic Questionnaire.

This was specifically developed for this study in order to elicit information about the expectant father.

The questionnaire asked questions related to the gestation of the pregnancy, the age of the father, if the pregnancy was planned or not, marital status, length of relationship, hours of work per week, Hollingshead classification, level of education, country of birth of subject and each of his parents and if he has a nickname for his baby. (see Appendix B)

### 6.4.8 Data Analysis.

Relationships between variables were assessed using a combination of chi square, t tests and Pearson correlations depending on the nature of the data. Criteria for statistical significance was $p < .05$. 
Chapter Seven

Results
The following chapter will report the statistical findings of the study of first-time expectant fathers.

Of the 230 surveys which were distributed to first-time expectant fathers attending early parenting classes, 109 were returned. The final sample size was 101 as surveys were excluded that did not contain a completed PBI.

The age range of the sample was 16 to 41 years, mean 28.93 years and the mode 30 years. The gestation of the pregnancies ranged from 5 to 40 weeks, mean 31.04 weeks and the mode was 34 weeks. The distribution of marital status of the sample was as follows: married 69.52% (n= 73), defacto 20% (n= 21), divorced 0.95% (n=1) and single 9.52% (n= 10). The mean level of education of the sample was 14.76 years with the range being 9 to 24 years. The Hollingshead classification ranged from 1 to 9 (excluding 8) with the mode classification 5 (skilled manual). The mode of the Hollingshead classification for each of the four attachment groups (secure, preoccupied, fearful and dismissing) was 5 (skilled manual). 71.57% (n= 73) of the pregnancies were planned and 28.43% (n=29) were unplanned. 61.29% (n= 57) of the sample had a nickname for the baby and 38.71 % (n= 36) did not. The length of the relationship with their partner ranged from 10 months to 11 years 7 months, mean 6.6 years and the mode was 10 years. 81% of the sample were born in Australia and the next largest group were born in England.

Fifty five fathers self-classified as participators (55.55%), 43 as reciprocators (43.43%) and 1 father self-classified as a renouncer. It was decided to exclude the one renouncer from the statistical analysis.
7.1 THE RELATIONSHIP BETWEEN ATTACHMENT AND PATERNAL ORIENTATION

Ninety one fathers filled in their attachment classification. The distribution of attachment groups within this sample of first-time expectant fathers was, secure n= 56 (61.54%), preoccupied n= 12 (13.9%), fearful n= 8 (8.79%) and dismissing n= 15 (16.48%).

7.1.1 The Relationship Between Secure and Insecure Attachment and Paternal Orientation

Research Question: Does attachment style influence paternal orientation as proposed by the Raphael-Leff model?

Hypothesis 1: That different groups of fathers will endorse different attachment styles. That a significantly high percentage of the participator group will be secure in attachment style compared with the reciprocator group.

Table 7.1 shows a comparison between the participator and reciprocator groups in terms of the four-group model of attachment (Bartholomew & Horowitz 1991).

A Chi square test revealed that there was no significant difference between the two groups of fathers. $x^2=5.17$, df=3, n=90, p=0.16. Therefore in this sample of first-time expectant fathers no significant difference was found between the participator and reciprocator groups when using the four group attachment classification.
<table>
<thead>
<tr>
<th></th>
<th>Participators</th>
<th>Reciprocators</th>
<th>Total</th>
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<tbody>
<tr>
<td>Secure</td>
<td>33 (71.7%)</td>
<td>20 (51.28%)</td>
<td>53</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>5 (13%)</td>
<td>6 (15.38%)</td>
<td>11</td>
</tr>
<tr>
<td>Fearful</td>
<td>3 (4%)</td>
<td>5 (12.82%)</td>
<td>8</td>
</tr>
<tr>
<td>Dismissing</td>
<td>5 (10%)</td>
<td>8 (20.51%)</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>46</strong></td>
<td><strong>39</strong></td>
<td><strong>85</strong></td>
</tr>
</tbody>
</table>

Table 7.1 Differences between the participator and reciprocator groups in terms of attachment classification using the four-group model of Bartholomew and Horowitz.

The following Table 7.2 shows a comparison between the participator and reciprocator groups using Hazan and Shavers' three-group model of attachment. The two insecure avoidant groups (fearful and dismissing) have been collapsed down to make one avoidant group. The two avoidant attachment groups are characterised by a negative model of others which results in an avoidance of intimacy. This behaviour is associated with the renouncer father.

<table>
<thead>
<tr>
<th></th>
<th>Participators</th>
<th>Reciprocators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>n= 36 (72%)</td>
<td>n= 20 (50%)</td>
<td>56</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>n= 6 (12%)</td>
<td>n= 6 (15%)</td>
<td>12</td>
</tr>
<tr>
<td>Avoidant</td>
<td>n=8 (16%)</td>
<td>n=14 (35%)</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>40</strong></td>
<td><strong>90</strong></td>
</tr>
</tbody>
</table>

Table 7.2. Differences between the participator and reciprocator groups in terms of attachment classification using Hazan and Shavers' three group category.
A Chi square test revealed that there was no significant difference between the two groups of fathers. $x^2 = 5.16$, df=2, n= 90, p=0.08. Therefore in this sample of first-time expectant fathers no significant difference was found between the participator and reciprocator groups when using the three group attachment classification.

In order to further test hypothesis 1, the three insecure attachment groups (preoccupied, fearful and dismissing) were collapsed into one group. Each three of the insecure attachment groups has a negative internal working model of self (preoccupied), others (dismissing) or both (fearful). A relationship was found to exist between the Raphael-Leff fathering styles of participators and reciprocators and secure versus insecure attachment.

The following Table 7.3 shows a comparison between the participator and reciprocator groups in terms of secure and insecure attachment when the three insecure groups (preoccupied, fearful and dismissing have been collapsed down to make one insecure category).

<table>
<thead>
<tr>
<th></th>
<th>Participators</th>
<th>Reciprocators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>n=36 (72%)</td>
<td>n= 20 (50%)</td>
<td>56</td>
</tr>
<tr>
<td>Insecure</td>
<td>n=14 (28%)</td>
<td>n=20 (50%)</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>40</td>
<td>90</td>
</tr>
</tbody>
</table>

Table 7.3 Differences between the participator and reciprocator groups in terms of secure and insecure attachment.
A Chi square test revealed that the differences were statistically significant. $x^2 = 4.58$, df = 1, n = 90, p = 0.03 (participators 50, reciprocators 40). 72% of participators classified as secure and 28% classified as insecure, whereas 50% of reciprocators classified as secure and 50% classified as insecure.

Therefore in this sample of first-time expectant fathers more participators than reciprocators were secure in attachment style, and more reciprocators than participators were insecure in attachment style. This result supports hypothesis 1.

Table 7.4 shows a comparison of the results of the secure and insecure attachment groups in their answers to the father's survey.
Table 7.4 Differences between the secure and insecure attachment groups in their answers to the father's survey.

The results of questions 5 and 13 are not recorded on this table as these two questions did not use likert scaling. Chi square tests revealed that there was no significant difference between the two groups in their answers to these questions.

According to table 7.4 men with a secure attachment style were more likely to seek medical consultation for their own health than men with an insecure attachment style.
7.1.2 The Relationship Between Internal Working Models (+ ve / -ve view of others) and Paternal Orientation

**Research Question**: Do internal working models influence paternal orientation?

**Hypothesis 2**: That the internal working models of the groups of fathers will be different and that participators will have a positive view of others.

The following Table 7.5 shows a comparison between the two groups of fathers in terms of internal working models of others, as measured when the secure and preoccupied groups were collapsed into a 'positive' view of others group, based on the supposition that they both have a positive view of others, and the fearful and dismissing groups were collapsed down into one 'negative' group based on the supposition that they both have a negative view of others.
Table 7.5 Differences between the participator and reciprocator groups in terms of internal working models (positive or negative) of others.

<table>
<thead>
<tr>
<th></th>
<th>Participators</th>
<th>Reciprocators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive view of others</td>
<td>42 (84%)</td>
<td>26 (65%)</td>
<td>68</td>
</tr>
<tr>
<td>Negative view of others</td>
<td>8 (16%)</td>
<td>14 (35%)</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>40</td>
<td>90</td>
</tr>
</tbody>
</table>

The results show that 84% of participators had a positive view of others in their internal working model and 16% had a negative view of others, whereas 65% of reciprocators had a positive view of others and 35% had a negative view of others.

A Chi square test revealed that the differences between the two groups were statistically significant. \( x^2 = 4.34, \text{df} = 1, n = 90, p = 0.04 \).

Therefore in this sample of first-time expectant fathers more participators than reciprocators have a positive view of others, which confirms hypothesis 2.

Table 7.6 shows a comparison between the two groups positive/negative view of others in their answers to the father's survey.
<table>
<thead>
<tr>
<th>Question No</th>
<th>Positive View of Others Mean (SD)</th>
<th>Negative View of Others Mean (SD)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>79.09 (18.58)</td>
<td>86.22 (16.32)</td>
<td>1.63</td>
<td>0.1</td>
</tr>
<tr>
<td>2</td>
<td>11.32 (22.98)</td>
<td>8.91 (11.28)</td>
<td>0.48</td>
<td>0.63</td>
</tr>
<tr>
<td>3</td>
<td>61.99 (36.74)</td>
<td>50.22 (37.16)</td>
<td>1.32</td>
<td>0.18</td>
</tr>
<tr>
<td>4</td>
<td>84.37 (24.67)</td>
<td>67.64 (33.65)</td>
<td>2.51</td>
<td>0.01*</td>
</tr>
<tr>
<td>6</td>
<td>50.96 (24.41)</td>
<td>55.45 (12.24)</td>
<td>0.82</td>
<td>0.4</td>
</tr>
<tr>
<td>7</td>
<td>33.58 (27.27)</td>
<td>30.23 (23.22)</td>
<td>0.51</td>
<td>0.6</td>
</tr>
<tr>
<td>8</td>
<td>52.03 (26.24)</td>
<td>56.43 (17.76)</td>
<td>0.71</td>
<td>0.47</td>
</tr>
<tr>
<td>9</td>
<td>77.94 (22.68)</td>
<td>57.61 (27.01)</td>
<td>3.53</td>
<td>0.0006*</td>
</tr>
<tr>
<td>10</td>
<td>39.49 (22.25)</td>
<td>33.91 (16.99)</td>
<td>1.09</td>
<td>0.27</td>
</tr>
<tr>
<td>11</td>
<td>87.79 (20.08)</td>
<td>76.09 (26.84)</td>
<td>2.21</td>
<td>0.02*</td>
</tr>
<tr>
<td>12</td>
<td>70.96 (24.41)</td>
<td>56.30 (22.77)</td>
<td>2.52</td>
<td>0.01*</td>
</tr>
<tr>
<td>14</td>
<td>51.62 (20.05)</td>
<td>38.26 (19.69)</td>
<td>2.77</td>
<td>0.006*</td>
</tr>
<tr>
<td>15A</td>
<td>94.19 (12.60)</td>
<td>83.48 (20.31)</td>
<td>2.98</td>
<td>0.003*</td>
</tr>
<tr>
<td>15B</td>
<td>9.91 (26.70)</td>
<td>27.95 (38.87)</td>
<td>2.35</td>
<td>0.02*</td>
</tr>
<tr>
<td>15C</td>
<td>3.40 (15.04)</td>
<td>7.27 (17.51)</td>
<td>0.98</td>
<td>0.32</td>
</tr>
<tr>
<td>16</td>
<td>85.93 (20.17)</td>
<td>72.39 (20.61)</td>
<td>2.76</td>
<td>0.01*</td>
</tr>
<tr>
<td>17A</td>
<td>42.17 (32.44)</td>
<td>31.52 (27.28)</td>
<td>1.4</td>
<td>0.16</td>
</tr>
<tr>
<td>17B</td>
<td>32.12 (26.66)</td>
<td>41.74 (31.54)</td>
<td>1.41</td>
<td>0.16</td>
</tr>
<tr>
<td>17C</td>
<td>88.97 (17.46)</td>
<td>76.52 (21.87)</td>
<td>2.76</td>
<td>0.01*</td>
</tr>
<tr>
<td>17D</td>
<td>37.01 (30.06)</td>
<td>41.74 (31.65)</td>
<td>0.64</td>
<td>0.52</td>
</tr>
<tr>
<td>18A</td>
<td>33.69 (26.84)</td>
<td>43.48 (24)</td>
<td>1.54</td>
<td>0.12</td>
</tr>
<tr>
<td>18B</td>
<td>16.51 (23.76)</td>
<td>21.30 (32.22)</td>
<td>0.83</td>
<td>0.4</td>
</tr>
<tr>
<td>19</td>
<td>7.83 (20.10)</td>
<td>10.22 (18)</td>
<td>0.5</td>
<td>0.61</td>
</tr>
</tbody>
</table>

* Significant statistical difference.

Table 7.6 Differences between the positive and negative view of others groups in their answers to the father's survey.

The results of questions 5 and 13 are not recorded on this table as these two questions did not use likert scaling. Chi square tests revealed that there was no significant difference between the two groups in their answers to these questions.
Analysis of Table 7.6 reveals that men with a positive view of others were more likely to feel their baby (Q. 4) and to picture themselves holding the new baby (Q.11) than men with a negative view of others. The positive view of others group were also more likely to talk about the pregnancy to others (Q.9) than the negative view of others group. In the area of sexuality men with a negative view of others were more likely to perceive their partner's pregnant body as less beautiful than it was before (Q.12) and to be less satisfied with the sexual relationship during pregnancy (Q.14) than men with a positive view of others. The three questions on the birth all showed significant differences between the two groups. Men with a positive view of others were more likely to plan to be present at the birth (Q.15a), to be more decided about (Q.15b) and more comfortable with (Q.16) the idea of being present at the birth than men with a negative view of others. Finally the positive group of men were more likely to agree that they would be involved in the practical care of the newborn (Q. 17c) than men with a negative view of others.

7.2 The Relationship Between Early Bonding on the PBI and Paternal Orientation

Research Question: Do early bonding experiences with the parent of the same sex influence paternal orientation?

Hypothesis 4: That participators, renouncers and reciprocators will be different in their early bonding experiences.

The four categories on the PBI were high care low overprotection (optimal bonding), high care, high overprotection (affectionate constraint), low care, high overprotection (affectionless control) and low care, low overprotection (poor bonding).
The overall distribution of PBI categories within this sample of first-time expectant fathers was optimal bonding (high care, low overprotection) n = 28 (29.47%), affectionate constraint (high care, high overprotection) n = 9 (9.47%), affectionless control (low care, high overprotection) n = 32 (33.68%) and poor bonding (low care, low overprotection) n = 26 (27.37%).

The following Table 7.7 shows the results of the two groups of fathers participators and reciprocators in terms of total PBI classification.

<table>
<thead>
<tr>
<th></th>
<th>Participators</th>
<th>Reciprocators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Optimal bonding</strong> (high care / low overprotection)</td>
<td>17 (31.48%)</td>
<td>11 (28.21%)</td>
<td>28</td>
</tr>
<tr>
<td><strong>Affectionnate constraint</strong> (high care / high overprotection)</td>
<td>5 (9.26%)</td>
<td>4 (10.26%)</td>
<td>9</td>
</tr>
<tr>
<td><strong>Affectionless control</strong> (low care / high overprotection)</td>
<td>17 (31.48%)</td>
<td>12 (30.77%)</td>
<td>29</td>
</tr>
<tr>
<td><strong>Poor bonding</strong> (low care / low overprotection)</td>
<td>15 (27.78%)</td>
<td>12 (30.77%)</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>54</td>
<td>39</td>
<td>93</td>
</tr>
</tbody>
</table>

Table 7.7 Differences between the participator and reciprocator groups in terms of total classification on the PBI.

A Chi square test was performed which revealed that there was no statistically significant association between early bonding on the PBI (using both care and overprotection scores) and paternal orientation. \( x^2 = 0.18, df = 3, n = 93, p = 0.98. \)
Therefore in this sample of first-time expectant fathers there was no difference between participators and reciprocators in terms of early bonding with their father on the PBI.

The following Table 7.8 shows a comparison between the mean scores of the two groups of fathers participators and reciprocators in terms of the care dimension on the PBI.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>Pr &gt; t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participators</td>
<td>54</td>
<td>19.67</td>
<td>10.19</td>
<td>0.35</td>
<td>0.72</td>
</tr>
<tr>
<td>Reciprocators</td>
<td>40</td>
<td>20.38</td>
<td>8.45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7.8 Differences between the participator and reciprocator groups in terms of the care dimension on the PBI.

Therefore in this sample of first-time expectant fathers there was no significant difference between the two groups of fathers participators and reciprocators in terms of care scores on the PBI.

The following Table 7.9 shows a comparison of the mean scores of the two groups of fathers participators and reciprocators in terms of overprotection on the PBI.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>Pr &gt; t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participators</td>
<td>50</td>
<td>0.42</td>
<td>0.5</td>
<td>0.35</td>
<td>0.21</td>
</tr>
<tr>
<td>Reciprocators</td>
<td>38</td>
<td>0.29</td>
<td>0.46</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7.9 Differences between the participator and reciprocator groups in terms of overprotection on the PBI.

Therefore in this sample of first-time expectant fathers there was no statistical difference between the two groups of fathers participators and reciprocators in terms of the overprotection score on the PBI.
7.3 THE RELATIONSHIP BETWEEN SEX-ROLE IDENTITY AND PATERNAL ORIENTATION

Research Question: Is there an association between paternal orientation as proposed by the Raphael-Leff model and sex-role identity?

Hypothesis 3: That the different groups of fathers namely participators, reciprocators and renouncers would differ significantly in terms of sex-role identity.

The following Table 7.10 shows a comparison between the two groups of fathers, participators and reciprocators in terms of sex-role orientation as measured by the Australian Sex-Role Scale

<table>
<thead>
<tr>
<th>Sex-Role Orientation</th>
<th>Participators</th>
<th>Reciprocators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Androgynous</td>
<td>13 (25.49%)</td>
<td>8 (19.51%)</td>
<td>21</td>
</tr>
<tr>
<td>Masculine</td>
<td>8 (15.69%)</td>
<td>10 (24.39%)</td>
<td>18</td>
</tr>
<tr>
<td>Feminine</td>
<td>14 (27.45%)</td>
<td>8 (19.51%)</td>
<td>22</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>16 (31.37%)</td>
<td>15 (36.59%)</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>41</strong></td>
<td><strong>92</strong></td>
</tr>
</tbody>
</table>

Table 7.10 Differences between the participator and reciprocator groups in terms of sex-role orientation.

A Chi Square test revealed that the difference between the participator and reciprocator groups of fathers in terms of sex-role orientation was not significant. $\chi^2 = 2.02$, df = 3, $n = 92$ p = 0.57.

Therefore in this sample of first-time expectant fathers there was no significant difference between the two groups of fathers participators and reciprocators in terms of sex-role identity.
7.3.1 Secondary Analyses.

The answers of the different sex-role identity groups were compared in their answers to questions on the survey that were expected to bring out different intentions and patterns of behaviour within the sex-role groups. The masculine group scores above the median on masculine positive attributes of agency whereas the androgynous group scores above the median in both masculine positive attributes of agency and feminine positive attributes of communion. The androgynous group scores above the median on both masculine positive (agency) and feminine positive (communion) attributes whereas the undifferentiated group scores below the median on both and the feminine group scores above the median on positive feminine attributes of communion. Therefore it is expected that between the four sex-role groups will have different intentions re nurturing the newborn.

a) The means of the masculine and androgynous groups were compared in their answer to Question 17b) I will be happy to help out where necessary, but see my partner as doing most of the nurturing. A two sample t test revealed the differences between the two groups were statistically significant. \( t(2, 43) = 2.79, \; n=73 \), \( p = 0.01 \).

Therefore in this sample of first-time expectant fathers the masculine group was more likely to see the mother as doing most of the nurturing of the newborn than the androgynous group.

b) The means of the androgynous and the undifferentiated groups were compared in their answers to Question 17b) I will be happy to help out where necessary, but see my partner as doing most of the nurturing. A two sample t test
revealed that the differences between the two groups were statistically significant. \( t(2, 58) = 2.20, n = 88, p = 0.03. \)

Therefore in this sample of first-time expectant fathers the androgynous group was significantly more likely to have the intention to be involved with the practical care of the newborn than the undifferentiated group.

c) The means of the masculine and androgynous groups were compared in their answers to **Question 17 c) I intend to be involved in the practical care of my newborn baby (ie. I see myself changing nappies).**

A two sample t test revealed that the differences between the two groups were statistically significant. \( t(2, 43) = 2.19, n = 45, p = 0.03. \)

Therefore in this sample of first-time expectant fathers the androgynous group was significantly more likely to have the intention to be involved with the newborn in a practical way than the masculine group.

The means of the androgynous and undifferentiated groups were compared in their answers to **Question 17 c) I intend to be involved in the practical care of my newborn baby (ie. I see myself changing nappies).**

A two sample t test revealed that the difference between the two groups was statistically significant. \( t(2, 58) = 2.20, n = 60, p = 0.03. \)

Therefore the in this sample of expectant fathers the androgynous group were significantly more likely to intend to be involved in practical care of the newborn.

Comparisons were made between the different sex-role identity groups in their answers to Question 17 d).
a) The means of the feminine and the masculine sex role orientation groups were compared in their answers to Question 17 d). I feel I will be more competent with an older child than with a newborn.

A two sample t test revealed that the difference between the two groups was statistically significant. $t(2, 41) = 2.80$, $n=43$, $p = 0.01$.

Therefore in this sample of first-time expectant fathers when a comparison was made between the androgynous group and the masculine group, it was found that the masculine group were significantly more likely than the androgynous group to agree with the statement that they will feel more competent with an older child.

b) The means of the masculine and the androgynous groups were compared in their answers to Question 17 d) I feel I will be more competent with an older child than with a newborn.

A two sample t test revealed that the difference between the two groups was statistically significant. $t(2, 43) = 3.21$, $n=45$, $p = 0.003$.

Therefore in this sample of first-time expectant fathers the masculine group were significantly more likely than the androgynous group to feel that they will be more competent with an older child than with a newborn. The androgynous group will feel significantly more competent with a newborn than the masculine group.

7.4 The Relationship Between Attachment and Sex-Role Identity

**Research Question:** Is attachment associated with sex-role identity?

**Hypothesis 6:** That secure subjects will be positive in sex-role identity.

The three sex-role orientation categories masculine, feminine and androgynous were collapsed down into one positive sex role orientation group. These three groups are
considered positive because the subjects score above the median in masculine positive characteristics (masculine), feminine positive characteristics (feminine) and above the median on both (androgy nous) or that their sex-role identity is well clarified. The undifferentiated or negative sex-role identity group scored below the median on both masculine positive and feminine positive characteristics. The three insecure attachment groups preoccupied, fearful and dismissing were collapsed down into one insecure group. A relationship was found to exist between +ve/-ve sex role identity and secure/insecure attachment. 73.08% of secure subjects had a positive sex role identity and 26.92% had a negative sex-role identity. By comparison 51.52% of the insecure group had a positive sex-role identity and 48.48% had a negative sex-role identity.

A Chi square test revealed that the differences between the two groups were statistically significant. $x^2 = 4.11$, df = 3, n = 86, p = 0.04.

Therefore in this sample of first-time expectant fathers more secure subjects had a positive sex role orientation than insecure subjects.

7.5 The Relationship Between Early Bonding and Paternal Orientation

Research Question: Is there a relationship between early bonding measured on the PBI and attachment?

Hypothesis 5: There will be a difference between the attachment groups in terms of early bonding experiences with their father measured on the PBI.

7.5.1 The Relationship Between Overprotection on the PBI and Attachment

A relationship was found to exist between overprotection on the PBI and attachment. High overprotection on the PBI is defined as a score greater that 12.5 on the
overprotection dimension. Low overprotection is defined as a score below 12.5 out of a maximum score of 39 (Parker 1983). The four groups of attachment (secure, preoccupied, fearful and dismissing) were compared in terms of their overprotection score on the PBI.

A Chi square test revealed that there were statistically significant differences between the four groups. $X^2 = 8.64$, $df = 3$, $n = 91$, $p = 0.03$.

75% of subjects who classified as fearful had a father who was high on overprotection on the PBI whereas 86% of dismissing subjects had a father who was low on overprotection. Therefore in this sample of first-time expectant fathers more fearful participants had an experience of high overprotection and more dismissing subjects had an experience of low overprotection.

7.5.2 The Relationship Between Overprotection on the PBI and Current Relationship with Father

The means of the two overprotection groups, low and high were compared in their answers to Question 7: During this pregnancy, how often do you dream about your own father. A two sample t test was performed $t(2, 96) = 2.20$, $n=98$ $p = 0.03$.

Therefore in this sample of expectant fathers, those fathers who rated their own fathers as low on overprotection during the first 16 years of their lives dreamt about them more often than the fathers who rated their own fathers as high on overprotection.

7.5.3 The Relationship Between Early Bonding on the PBI and Time Spent with Male Friends

A relationship was found to exist between early bonding and time currently spent with male mates.
The mean scores of the groups 1 optimal bonding (high care, low overprotection) and 3 affectionless control (low care, high overprotection) were compared in their answers to **Question 10: Right now, how much time do you spend with your male mates?** A two sample t test was performed which revealed statistically significant differences in the answers of the two groups. $t(2, 60) = 2.25, n = 100, p = 0.03$.

The expectant fathers in the optimal bonding group (high care, low overprotection) spend significantly more time with their male mates during the pregnancy than the affectionless control group (low care, high overprotection).

A relationship was found to exist between overprotection on the PBI and time spent with male mates during the pregnancy. The fathers in the high overprotection group scored greater than 12.5 on the overprotection scale of the PBI and the fathers in the low overprotection group scored below 12.5 (out of a possible score of 39). The mean answers of the two overprotection groups (low and high) were compared on their answers to **Question 10: Right now, how much time do you spend with your male mates?** A two sample t test was performed $t(2, 97) = 2.09, n=98, p = 0.04$.

Therefore in this sample of first-time expectant fathers the participants who rated their own fathers as low on overprotection on the PBI spend significantly more time with their male mates during the pregnancy than those participants who rated their father as high on overprotection.
7.5.4 The Relationship Between Care on the PBI and Current Relationship with Father

a) The two care groups on the PBI, low care and high care were compared in their answers to Question 6: *During this pregnancy how often do you think about your own father?*

A two sample t test revealed statistically significant differences between the two groups. \( t(2, 98) = 2.52, n = 100, p = 0.01. \)

The expectant fathers who perceived that their own fathers were high on care during the first 16 years of their lives were significantly more likely to think about them during the pregnancy than those expectant fathers who classified their fathers as low on care.

Therefore in this sample of first-time expectant fathers there is an association between care in early bonding and the current relationship with the father.

b) The two care groups on the PBI, low care and high care were compared in their answers to Question 7: *During this pregnancy how often do you dream about your own father?*

A two sample t test revealed differences between the two groups that were statistically significant. \( t(2, 97) = 2.02, n = 100, p = 0.05. \)

The expectant fathers who perceived that their own fathers were high on care during the first 16 years were significantly more likely to dream about them during the pregnancy than the fathers who classified their own fathers as low on care.

The means of the two care groups on the PBI were compared in their answers to Question 8: *Right now, how close do you feel to your own father?*
A two sample t test revealed differences in the two groups that were statistically significant. \( t(2, 92) = 2.50, n = 100, p = 0.01 \).

The expectant fathers who had perceived their own fathers as high on care during the first 16 years of their lives were significantly more likely to feel close to them than those fathers who rated their own fathers as low on care.

A summary of the statistical analysis performed for this section on the care dimension of the PBI is given in Table 7.11

<table>
<thead>
<tr>
<th>Question No</th>
<th>High Care Mean (SD)</th>
<th>Low Care Mean (SD)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>83.02 (16.63)</td>
<td>80.21 (18.69)</td>
<td>0.76</td>
<td>0.44</td>
</tr>
<tr>
<td>2</td>
<td>8.71 (18.55)</td>
<td>9.58 (19.12)</td>
<td>0.22</td>
<td>0.82</td>
</tr>
<tr>
<td>3</td>
<td>54.23 (36.80)</td>
<td>59.80 (36.80)</td>
<td>0.74</td>
<td>0.45</td>
</tr>
<tr>
<td>4</td>
<td>80 (28.58)</td>
<td>81.58 (26.28)</td>
<td>0.28</td>
<td>0.77</td>
</tr>
<tr>
<td>6</td>
<td>56.15 (25.70)</td>
<td>44.42 (25.70)</td>
<td>2.52</td>
<td>0.01 *</td>
</tr>
<tr>
<td>7</td>
<td>36.92 (22.95)</td>
<td>25.83 (28.88)</td>
<td>2.02</td>
<td>0.05 *</td>
</tr>
<tr>
<td>8</td>
<td>60.56 (19.67)</td>
<td>49.05 (22.91)</td>
<td>2.5</td>
<td>0.01 *</td>
</tr>
<tr>
<td>9</td>
<td>71.28 (27.90)</td>
<td>72.95 (24.21)</td>
<td>0.32</td>
<td>0.75</td>
</tr>
<tr>
<td>10</td>
<td>42.56 (17.24)</td>
<td>36.39 (21.84)</td>
<td>1.5</td>
<td>0.14</td>
</tr>
<tr>
<td>11</td>
<td>85.27 (23.03)</td>
<td>84.13 (21.19)</td>
<td>0.24</td>
<td>0.8</td>
</tr>
<tr>
<td>12</td>
<td>64.74 (21.24)</td>
<td>65.24 (22.55)</td>
<td>0.11</td>
<td>0.91</td>
</tr>
<tr>
<td>14</td>
<td>48.97 (16.39)</td>
<td>49.26 (21.98)</td>
<td>0.07</td>
<td>0.94</td>
</tr>
<tr>
<td>15A</td>
<td>92.82 (14.64)</td>
<td>89.92 (19.3)</td>
<td>0.8</td>
<td>0.42</td>
</tr>
<tr>
<td>15B</td>
<td>15.69 (32.30)</td>
<td>15.29 (31.90)</td>
<td>0.05</td>
<td>0.95</td>
</tr>
<tr>
<td>15C</td>
<td>6.39 (20.86)</td>
<td>4.17 (16.07)</td>
<td>0.57</td>
<td>0.57</td>
</tr>
<tr>
<td>16</td>
<td>83.33 (20.66)</td>
<td>79.93 (24.86)</td>
<td>0.71</td>
<td>0.48</td>
</tr>
<tr>
<td>17A</td>
<td>41.89 (30.31)</td>
<td>35.42 (32.99)</td>
<td>0.96</td>
<td>0.33</td>
</tr>
<tr>
<td>17B</td>
<td>33.63 (26.68)</td>
<td>34.91 (28.74)</td>
<td>0.22</td>
<td>0.82</td>
</tr>
<tr>
<td>17C</td>
<td>88.72 (17.04)</td>
<td>82.54 (21.81)</td>
<td>1.5</td>
<td>0.14</td>
</tr>
<tr>
<td>17D</td>
<td>43.85 (34.82)</td>
<td>36.25 (29.78)</td>
<td>1.16</td>
<td>0.25</td>
</tr>
<tr>
<td>18A</td>
<td>37.31 (22.68)</td>
<td>34.75 (29.48)</td>
<td>0.46</td>
<td>0.65</td>
</tr>
<tr>
<td>18B</td>
<td>14.95 (22.03)</td>
<td>19.34 (24.38)</td>
<td>0.91</td>
<td>0.36</td>
</tr>
<tr>
<td>19</td>
<td>7.63 (19.37)</td>
<td>11.61 (22.24)</td>
<td>0.93</td>
<td>0.35</td>
</tr>
</tbody>
</table>

* Significant statistical difference
Table 7. Summary of the statistical analysis on the care dimension for questions on the father's survey.

The results of questions 5 and 13 are not recorded on this table. These two questions did not use likert scaling. Chi square tests revealed that there was no significant difference between the two groups in their answers to these questions.

The maximum score for the care scale is 36, high care was defined as a score greater than or equal to 24 and low care below 24 as this was the dichotomising care score proposed for fathers by Parker (1982).
### Subsidiary Findings

The following Table 7.12 summarises the comparison of the two groups of fathers in their answers to the father's survey.

<table>
<thead>
<tr>
<th>Question No</th>
<th>Participators Mean (SD)</th>
<th>Reciprocators Mean (SD)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>82.24 (17.29)</td>
<td>80.65 (19.15)</td>
<td>0.43</td>
<td>0.66</td>
</tr>
<tr>
<td>2</td>
<td>10.91 (21.30)</td>
<td>8.72 (18.26)</td>
<td>0.53</td>
<td>0.59</td>
</tr>
<tr>
<td>3</td>
<td>62.18 (38.85)</td>
<td>53.72 (35.61)</td>
<td>1.11</td>
<td>0.27</td>
</tr>
<tr>
<td>4</td>
<td>84.09 (25.28)</td>
<td>75 (30.38)</td>
<td>1.6</td>
<td>0.11</td>
</tr>
<tr>
<td>5</td>
<td>51.36 (27.07)</td>
<td>49.76 (14.73)</td>
<td>0.34</td>
<td>0.73</td>
</tr>
<tr>
<td>6</td>
<td>32.69 (30.07)</td>
<td>30.95 (23.54)</td>
<td>0.3</td>
<td>0.75</td>
</tr>
<tr>
<td>7</td>
<td>50.66 (22.61)</td>
<td>57.5 (25.27)</td>
<td>1.35</td>
<td>0.17</td>
</tr>
<tr>
<td>8</td>
<td>70.09 (28.42)</td>
<td>76.51 (21.14)</td>
<td>1.23</td>
<td>0.21</td>
</tr>
<tr>
<td>9</td>
<td>37.45 (22.02)</td>
<td>38.26 (20.76)</td>
<td>0.18</td>
<td>0.85</td>
</tr>
<tr>
<td>10</td>
<td>86 (21.70)</td>
<td>84.77 (22.33)</td>
<td>0.27</td>
<td>0.78</td>
</tr>
<tr>
<td>11</td>
<td>70.82 (22.02)</td>
<td>63.26 (24.44)</td>
<td>1.6</td>
<td>0.11</td>
</tr>
<tr>
<td>12</td>
<td>49.73 (20.01)</td>
<td>49.77 (21.32)</td>
<td>0.01</td>
<td>0.99</td>
</tr>
<tr>
<td>13</td>
<td>93.27 (14.66)</td>
<td>90.47 (15.69)</td>
<td>0.91</td>
<td>0.36</td>
</tr>
<tr>
<td>14</td>
<td>9.79 (27.70)</td>
<td>18.95 (33.29)</td>
<td>1.38</td>
<td>0.16</td>
</tr>
<tr>
<td>15A</td>
<td>3.83 (16.62)</td>
<td>4.39 (13.43)</td>
<td>0.17</td>
<td>0.86</td>
</tr>
<tr>
<td>15B</td>
<td>82.87 (22.41)</td>
<td>82.91 (18.52)</td>
<td>0.01</td>
<td>0.99</td>
</tr>
<tr>
<td>15C</td>
<td>40.24 (35.02)</td>
<td>42.44 (26.93)</td>
<td>0.33</td>
<td>0.73</td>
</tr>
<tr>
<td>16</td>
<td>32.46 (25.84)</td>
<td>43.66 (32.04)</td>
<td>1.88</td>
<td>0.06</td>
</tr>
<tr>
<td>17A</td>
<td>89.27 (16.26)</td>
<td>80.70 (22.61)</td>
<td>2.18</td>
<td>0.03*</td>
</tr>
<tr>
<td>17B</td>
<td>32.87 (29.92)</td>
<td>48.93 (31.44)</td>
<td>2.55</td>
<td>0.01*</td>
</tr>
<tr>
<td>17C</td>
<td>30.32 (24.76)</td>
<td>43.96 (28.60)</td>
<td>2.38</td>
<td>0.01*</td>
</tr>
<tr>
<td>17D</td>
<td>16.27 (22.41)</td>
<td>19.72 (25.02)</td>
<td>0.71</td>
<td>0.47</td>
</tr>
<tr>
<td>19</td>
<td>5.65 (14.83 )</td>
<td>14.42 (24.69)</td>
<td>2.16</td>
<td>0.03*</td>
</tr>
</tbody>
</table>

* Significant statistical difference.

Table 7.12 Differences between the participate and reciprocator groups in their answers to the father's survey.

The results of questions 5 and 13 are not recorded on this table. These two questions did not use likert scaling. Chi square tests revealed that there was no significant difference between the two groups in their answers to these questions.
Analysis of Table 7.12 reveals significant differences between the two groups of fathers in some of their answers. Participator fathers were more likely to intend to be involved with the practical, nappy changing care of the baby than the reciprocator fathers (Q.17c). Reciprocator fathers were more likely than participators to say they would feel more competent with an older child than a newborn (Q.17d). The reciprocator men were also more likely to feel that the baby may take over their wife’s affection than the participator men (Q.18a). Finally, the reciprocator group showed less certainty (more ambivalence) about it being the right time to have a baby than the participator group (Q.19).

7.5.5 The Relationship Between Attachment and Positive or Negative Sex-Role Identity

The following Table 7.13 shows a comparison between the four attachment groups in terms of sex-role identity.

<table>
<thead>
<tr>
<th></th>
<th>Secure</th>
<th>Preoccupied</th>
<th>Fearful</th>
<th>Dismissing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Androgynous</td>
<td>12 (23.08%)</td>
<td>3 (27.27%)</td>
<td>3 (37.50%)</td>
<td>1 (6.67%)</td>
<td>19</td>
</tr>
<tr>
<td>Masculine</td>
<td>10 (19.23%)</td>
<td>0</td>
<td>5 (33.33%)</td>
<td>5 (33.33%)</td>
<td>20</td>
</tr>
<tr>
<td>Feminine</td>
<td>16 (30.77%)</td>
<td>2 (18.18%)</td>
<td>1 (6.67%)</td>
<td>1 (6.67%)</td>
<td>20</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>14 (26.92%)</td>
<td>6 (54.55%)</td>
<td>8 (53.33%)</td>
<td>8 (53.33%)</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52</td>
<td>11</td>
<td>17</td>
<td>15</td>
<td>95</td>
</tr>
</tbody>
</table>

Table 7.13 Differences between the four groups of attachment in terms of sex-role identity.
Table 7.13 Differences between the four groups of attachment in terms of sex-role identity.

The following Table 7.14 shows a comparison between the three attachment groups in terms of sex-role identity. The two insecure avoidant groups (fearful and dismissing have been collapsed down into one avoidant group).

<table>
<thead>
<tr>
<th></th>
<th>Secure</th>
<th>Preoccupied</th>
<th>Avoidant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Androgynous</td>
<td>12 (23.08%)</td>
<td>3 (27.27%)</td>
<td>4 (17.39%)</td>
<td>19</td>
</tr>
<tr>
<td>Masculine</td>
<td>10 (19.23%)</td>
<td>0</td>
<td>6 (26.09%)</td>
<td>16</td>
</tr>
<tr>
<td>Feminine</td>
<td>16 (30.77%)</td>
<td>2 (18.18%)</td>
<td>2 (8.70%)</td>
<td>20</td>
</tr>
<tr>
<td>Undifferentiated</td>
<td>14 (26.92%)</td>
<td>6 (54.55%)</td>
<td>11 (47.83%)</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>52</td>
<td>11</td>
<td>23</td>
<td>86</td>
</tr>
</tbody>
</table>

Table 7.14 Differences between the three attachment groups in terms of sex-role identity

The fearful and dismissing category was collapsed down to make one insecure, avoidant group of attachment. The reason for this is that both of these groups have a negative working model of other people. The three sex role orientation groups masculine, feminine and androgynous were collapsed down to make one positive group. The reason for this is that the three groups all endorse positive sex-role characteristics which are masculine positive, feminine positive or both in the case of the androgynous group.

A Chi square test revealed that there were no significant differences between the two groups. \( x^2 = 4.38 \), df = 2, n = 85, \( p = 0.11 \).

Therefore in this sample of first-time expectant fathers no association was found between positive vs negative sex-role orientation and insecure avoidant attachment.
7.5.6 The Relationship Between Internal Working Models of Others and Overprotection on the PBI

The secure and preoccupied groups were collapsed into a 'positive' view of others group, based on the supposition that they both have a positive view of others and the fearful and dismissing groups were collapsed into a 'negative' view of others group based on the supposition that they both have a negative view of others. No relationship was found to exist between a positive and negative view of others and low or high overprotection on the PBI. A Chi square test was performed and revealed the following results: $x^2 = 0.096$, df = 1, n = 83, p = 0.76.

Therefore in this sample of first-time expectant fathers there no association between high or low overprotection on the PBI and a positive or negative internal working models of others.
Chapter Eight

Discussion
8.1 Assessing the Raphael-Leff Model of Paternal Orientation.

The aim of this study was to assess the Raphael-Leff model of paternal orientation by examining its relationship to attachment style, sex-role identity and early bonding experiences. This model proposes three distinct paternal orientations, namely participators, reciprocators and renouncers, each style being associated with different clusters of attributes and patterns of behaviours which are said to be evident even in early pregnancy and to foreshadow later interaction between the father and child (Sharpe & Cooper 1992). Raphael-Leff points out that there are very few 'pure' types, but indicates that paternal styles or orientations could be placed on a continuum from extreme participator to extreme renouncer with varying combinations and dominance between those two positions. Since her theory emerged in the early 1980's the Raphael-Leff model has been the basis of many and varied studies. The development of a Facilitator-Regulator Questionnaire (FRQ) as a measure for identifying maternal orientations described by the author has led to studies that show that there are significant differences between facilitator and regulator mothers in their work patterns, shared caretaking, self esteem and in the chronology, nature, and precipitating factors of postnatal disturbance (Raphael-Leff 1985). The model is an invaluable tool that can provide understanding to health care professionals who care for pregnant women and their partners.

The major findings of this study supported the Raphael-Leff model of paternal orientation namely the participator, reciprocator and renouncer model, yet found it difficult to identify the last category in this present sample.

It is necessary to be able to further understand and be aware of differing orientations as proposed by the Raphael-Leff model and to assist all fathers in the
transition to parenthood and to tailor interventions that are appropriate to individual
needs. This study aimed at helping clinicians further understand the groups of fathers,
participators, reciprocators or renouncers through the development of a father's survey.
The participator and reciprocator groups were strongly represented in this sample of
first-time fathers with the strong representation of the reciprocator group supporting
Raphael-Leff's findings of increased numbers of subjects who endorse this category in
recent studies. She attributes this to the result of societal changes over the last three
decades and states that the reciprocator group flourishes in an environment of personal
choice and global responsibility, which advocates individuation but recognises the
accountability of people to each other and to the wider community (Raphael-Leff 1993,
p.153). However, the challenge for individuals who endorse this style of parenting is to
balance the needs and rights of all involved.

One major limitation of the present study is the fact that only one father in the
sample endorsed the renouncer category. Some of the possible explanations for this will
be discussed. All of the first-time fathers with the exception of those in the pilot study,
were recruited from early parenting classes and antenatal clinics. There may be
difficulty in accessing the renouncer group in the population given their avoidance of
involvement in antenatal care. However, it is worth noting that the majority of the
surveys were given out on the first night of the four week early parenting classes.
According to verbal feedback given by the midwives who conduct these classes there is
a high drop out rate (approx. 60% ) from these classes, even for first-time fathers. This
suggests that many men may be coerced into 'reluctant' involvement in antenatal
preparations and the attendance of some fathers at the early parenting classes may mask
their reluctance to become involved with the pregnancy and birth. Therefore some of the
fathers who filled in these surveys on the first night of the early parenting classes may have withdrawn from the classes after that night which suggests that we would have expected more renouncers in the sample.

Another explanation may be that some of the fathers who self-classified in the other two groups were actually renouncers. The words 'mixed feelings' in the self-description of the reciprocator may have acted as a magnet for the renouncers in the sample and attracted them to this classification rather than to one of the other more extreme classifications. Alternatively, the wording of the description of the renouncer may have been threatening and therefore fathers were more likely to self-classify as reciprocators. Another possibility for the low representation of the renouncer group in this sample is that the renouncer orientation is only an extreme on the continuum of paternal orientation according to Raphael-Leff's model. There are limitations in the methodology of asking fathers to self classify according to a forced choice format modelled on the Relationship Questionnaire (Bartholomew & Horowitz 1991). Future research could use a semi structured interview of the fathers could be used to assess the degree to which the subjects approximate each of the three fathering styles. A longer questionnaire with multiple items could also be developed to improve reliability. Alternatively their partners could be asked to classify the fathers as a means of checking validity. Due to time constraints and an attempt to keep the survey simple, these procedures were not carried out in the present study however, future use of the questionnaire could include semi structured interviews and checking of classification with the partners. The challenge remains for future studies to further explore the position of the renouncer father and to discover the representation of this orientation of father within the population.
Three questions on the father's survey showed significant differences between the participator and reciprocator groups in their answers. (Refer Table 7.12, p.)

**Question 17 c)** How much do you agree with the following statement:

I intend to be involved in the practical care of my newborn baby (i.e., I see myself changing nappies). The participator group were significantly more likely to agree with this statement than the reciprocator group and this supports Raphael-Leff's existing model of the participator. It suggests that the area of intentions to be involved in hands on care of the newborn is an important one which will differentiate between the groups of fathers. Another question which bought out significant differences between the participator and reciprocator groups was **Question 17 d)** How much do you agree with the following statement:

I feel I will be more competent with an older child than with a newborn.

The reciprocator group were significantly more likely to agree with this statement than the participator group. This result also adds support to the Raphael-Leff model of both the participator and reciprocator. The fact that the reciprocator fathers are more likely to feel they will be more competent with an older child does not imply that they will be more competent, but rather it does indicate some of their ambivalence and lack of confidence with the newborn. These results also supports the theory that the participator orientation has more confidence about being involved with his newborn.

Question 18 was designed to tap into negative internal working models of the fathers in respect to fear of rejection and/or abandonment during the transition to parenthood.

**Question 18:** How much do you agree with the following statements:

a) the baby infant may take over my wife's affection.
b) I feel that my wife or other family members may not allow me to spend the time I want to spend with my newborn baby.

In answering Question 18 a) the reciprocator group were significantly more likely to feel that the baby may take over their partner's affection than the participator group. However there was no difference between the two groups in their answers to Question 18 b). The reciprocator father because of his increased sensitivity to rejection and abandonment during the transition to parenthood will need support available to prevent pre and postnatal psychological disturbance. The results support the Raphael-Leff model which states that the participator sees himself as a spokesman for his baby but not a rival. However, this study adds to the knowledge of the reciprocator group who show significantly more apprehension that the baby may take over the partner's affection. This indicates that fathers in this group are more likely to see the baby as a rival, a characteristic which Raphael-Leff has reported in the renouncer group. As mentioned previously these results lend support for the idea that the reciprocator group in this sample of first-time expectant fathers may actually contain some Renouncers according to the Raphael-Leff model.

It has been suggested that there may be pressure exerted on men by society to share the nurturing role in the wake of both the women's and men's movement. Therefore it is possible that the renouncer group in this sample endorsed one of the other groups. If this is so then this group may be under a strain to perform in the way they feel is necessary to fulfil their own expectations and those of society.

8.2 The Relationship Between Attachment and Paternal Orientation

The results of this study supported Hypothesis 1 which predicted that the groups of fathers would endorse different styles of attachment and that secure attachment would
be associated with the participator group. In this sample of first-time expectant fathers more Participators were secure in attachment style than Reciprocators and alternatively more Reciprocators than Participators endorsed an insecure attachment style.

The only other Australian sample of first-time expectant fathers that recorded the attachment groups of the participants used the AAI (Adult Attachment Inventory) and reported a lower percentage in the secure group and higher percentages of fathers in the three insecure attachment groups (Radojevic 1994). The fearful group of the current study corresponded with the fearful or unresolved with respect to trauma in Radojevic's study.

Within the sample of first-time expectant fathers in the present study there was a high percentage of fathers in the secure attachment group and low percentages in the preoccupied and fearful groups. It has been reported that a greater proportion of males than females endorse the dismissing category and a greater proportion of females than males endorse the fearful style (Jones 1998). This may offer a partial explanation for the low number of fearful males in this sample. Another explanation is that fearful attachment is associated with distrust and fear of social interaction which stems from a negative internal working models of self and of others. Such individuals will actively avoid social situations and close relationships in which they perceive themselves as vulnerable to rejection (Bartholomew 1990). Therefore males in the fearful attachment group may be unlikely participators in early parenting classes.

Bartholomew & Horowitz state that the preoccupied and fearful groups, because of their negative self image, are expected to exhibit problems with passivity and unassertiveness and the fearful and dismissing groups may have problems with socialising and intimacy (Bartholomew & Horowitz 1991, p.228). Future research with
larger samples of fathers who endorse the preoccupied and fearful groups is needed to further investigate the impact of these attachment styles on paternal orientation.

8.2.1 The Relationship Between Secure and Insecure Attachment and Paternal Orientation

When the attachment styles of the two groups of fathers (Participators and Reciprocators) were compared, more participators endorsed a secure attachment style and more reciprocators an insecure attachment style. The preoccupied attachment category was evenly distributed in the two groups of fathers. Preoccupied attachment is characterised by a negative view of self and a positive view of others (a 'mixed' insecure style) and in overvaluing intimate relationships for fear of abandonment. Bartholomew is quoted in Klohnen & John (1998) as suggesting that the positive model of others in the preoccupied individual masks a less conscious negative model of others with the idealisation of others being a defence against acknowledging that they are at least at times uncaring and unavailable. The results of the present study support hypothesis 1 that the different groups of fathers will endorse different attachment styles.

When the two attachment groups (fearful and dismissing), were collapsed down into one avoidant group, there was a significant difference between the participator and reciprocator groups with the reciprocator group showing a much higher percentage of fathers with an avoidant style than the participator group. The two avoidant groups, fearful and dismissing both have negative models of others but they differ in the valence of their self models. An avoidant style of attachment has been associated with poor relationship functioning (Klohen & John 1998). This result also supports hypothesis 1 that the groups would differ in attachment style. The two groups with a negative self image namely preoccupied and fearful have reported higher levels of interpersonal
problems than the two groups with a positive model of self, namely secure and dismissing (Bartholomew & Horowitz 1991). The reciprocator group had a significantly higher percentage of fathers with a negative model of self than the participator group. It seems sensible for increased focus to be directed to the reciprocator group because of the higher numbers within it of fathers with negative internal working models of self and of others.

Within this present study a significantly higher percentage of the participator group endorsed a secure attachment style than the reciprocator group. Secure attachment has been associated with a more constructive response to stress of various kinds, more satisfying intimate relationship, higher self esteem and low levels of negative affect (Feeney & Noller 1996). In examining the relationship between attachment styles and love and work, Hazan & Shaver (1990) found that secure attachment was associated with higher work performance and satisfaction. The secure group has been found to adopt a healthy approach to work which does not interfere with relationships and health. By contrast the preoccupied and avoidant groups have been found to adopt an attitude to work that was detrimental to the functioning of their personal relationships (Hazan & Shaver 1990).

The reciprocator group has a high level of fathers who endorsed the insecure attachment categories in this study. This finding adds new information to the Raphael-Leff model as it indicates that rather than being able to draw on multiple inner resources this father may struggle with both the fear of others and the avoidance of intimacy that is associated with avoidant, insecure attachment. Given that this father is said to experience ambivalence and is struggling to juggle his own needs with the needs
of his partner and the new baby, it seems probable that he may need support during the transition to fatherhood to revisit and rework existing negative internal working models.

Some significant differences between the secure and insecure attachment groups were found in their answers to several questions on the father's survey (Ref. Table 7.4). In answering **Question 2: During this pregnancy how often have you sought medical consultation for your own health?** the secure group were significantly more likely to have sought medical consultation than the insecure group. Secure attachment was found to be associated with the participator group in this sample and Raphael-Leff (1991) has stated that an extreme participator may experience 'couvade' symptoms.

**Question 9: How often do you discuss the details of your partner's pregnancy with other people?** Here the secure group was significantly more likely than the insecure group to discuss the pregnancy with others, a characteristic of the participator orientation.

**Question 12: When you compare your partner's body to the way it was before pregnancy you think that it is:**

**Question 14: How do you feel about sex with your partner now, compared to before the pregnancy?** In answering both of these questions on sexuality the secure group were more likely to have a positive perception of their partner's body and to feel more positive about sexual activity during pregnancy. Both of these factors have been associated by Raphael-Leff with participators and disassociated with renouncers.

**Question 15 b): Which statement best describes your intentions for the labour and delivery**

- **I have not yet decided whether to be present or not.**
The insecure attachment group were significantly more likely to agree with this statement than the secure group indicating either their ambivalence about the labour and birth and/or their reluctance to be involved. This behaviour has been associated with the renouncer group.

**Question 17**: How much do you agree with the following statements:

b) I will be happy to help out where necessary, but see my partner as doing most of the nurturing.

c) I intend to be involved in the practical care of my newborn baby. (i.e., I see myself changing nappies) Here the secure group was significantly more likely to see themselves involved in nurturing and practical care of the newborn than the insecure group. This confirms the association between secure attachment and the participator orientation and insecure attachment with the other paternal orientations.

### 8.2.2 The Relationship Between Internal Working Models and Paternal Orientation

The research question asked was whether internal working models of attachment influence paternal orientation, and hypothesis 2 predicted that the internal working models of the participator and reciprocator groups would be different. The results of this study showed significant differences between the two groups of fathers, participators and reciprocators in terms of internal working models of others which supported hypothesis 2. A significantly higher percentage of participator fathers were found to have a positive view of others. This finding lends support to Raphael-Leff's model of the participator and it adds to her model of the reciprocator.
These internal working models are thought to be shaped by early interaction with primary attachment figures and to equip the individual with models of their own potentials and skills as well as models of the availability and responsiveness of others. Although these models are formed early they are said to remain influential throughout the life cycle and are activated in times of transition or stress. These life crises have the potential of enabling the individual to revise their inner working models, however both Bowlby and later Bretherton maintain that change will be minor, slow and even difficult (Feeney & Noller 1996). The transition to parenthood is a crisis period during which the attachment system will be activated and an opportunity exists to revisit and rework existing internal models of self and of others.

Results of this present study of first-time expectant fathers showed that the internal working model of others was significant in differentiating the two groups of fathers. These findings support the Raphael-Leff model and add to it. The association found between being a participator and having a positive view of others means that this father will see others as trustworthy and caring. Paternal fetal attachment and early bonding will be facilitated by his positive view of others and will enable him to have confidence in the trustworthiness of his partner to nurture his child (depending on the marital relationship). A positive view of others will also help this father to trust in the availability and responsiveness of health carers looking after his pregnant partner. However the association that was found between the reciprocator and a negative view of others may predispose him to distrust, fear of rejection and failure to value and invest in interpersonal relationships.

Significant differences emerged between the two groups (positive or negative view of others), when the secure and preoccupied attachment groups were collapsed
down into one positive view of others group and the fearful and dismissing groups were collapsed down into one negative view of others group (Refer to Table 7.6 for a summary of these results). There were significant differences between the two groups in their answers to several questions on the father's survey. Two of these questions 4 and 11 examined paternal fetal attachment and were adapted from the Maternal Foetal Attachment Scale (MFAS, Cranley 1981). **Question 4: How often do you feel your baby?** and **Question 11: I picture myself holding the newborn baby.** The group with a positive view of others showed that they were significantly more likely to engage in positive attachment behaviours towards their unborn baby than the group with a negative view of others.

In answering **Question 9: How often do you discuss the details of your partner's pregnancy with other people?** (e.g., friends, co-workers) the positive view of others group discussed the pregnancy with significant others much more than the group with a negative view of others.

Both **Question 12: When you compare your partner's body to the way it was before pregnancy you think it is.** and **Question 14: How do you feel about sex with your partner now compared to before pregnancy?** explored the sexuality dimension of expectant fatherhood. The positive view of others group showed by their answers to these questions a more positive view of their partner's pregnant body and a much higher satisfaction with the sexual relationship during pregnancy. This is indicative of the participator orientation. However the negative view of others group show a more negative perception of the pregnant body and dissatisfaction with sexual intimacy during pregnancy both features of the renouncer orientation as proposed by Raphael-Leff.
Question 16: How comfortable do you feel with the idea of being present at the labour and birth?

The labour experience is consistently noted in the literature as a focal point of concern and anxiety for expectant fathers. Answers to this question indicated that the positive view of others group felt significantly more comfortable with being at the labour and delivery than the group with a negative view of others. It is important for midwives and others who work in the delivery suite to realise that those fathers with negative internal working models of others will feel more ambivalence and stress coming into the labour experience.

Question 17 c): How much do you agree with the following statement?

I intend to be involved in the practical care of my newborn baby (i.e., I see myself changing nappies). This question brought out significant differences between the two groups in that those with a positive view of others were significantly more likely to have the intention to be involved in the hands on care of the newborn than the group with a negative view of others.

Pregnancy is a high stress time and the transition to fatherhood is a critical period in which the attachment system will be reactivated. However an opportunity exists for fathers to revise and rework existing negative models. Health carers need to help facilitate this and not to reaffirm existing negative models by overlooking the father and marginalising him during the antenatal, labour and neonatal periods. The father is not merely one of the support people for the pregnant woman or a 'coach' in the labour ward, but a principal attachment figure for her and the baby. The process of maternal and paternal role attainment are complementary and mutually affirming. The persistence
8.3 THE RELATIONSHIP BETWEEN SEX-ROLE IDENTITY AND PATERNAL ORIENTATION

Hypothesis 3 predicted that the groups of fathers would be different in sex-role identity. However the results of this study did not support this hypothesis and there was no significant difference between the two groups participators and reciprocators in terms of sex-role identity when using the Australian Sex Scale. However a secondary finding of the study was an association between sex-role identity and secure and insecure attachment. When the three sex-role groups (masculine, feminine and androgynous) were collapsed down to form one positive or well clarified group vs. the undifferentiated or negative sex-role group and the three attachment groups (preoccupied, fearful and dismissing) were collapsed down into one insecure group vs. the secure group, a high percentage of the secure attachment group had a positive sex-role identity. In this sample of first-time expectant fathers a positive association was found to exist between secure attachment and positive sex-role identity.

Secondary analysis revealed significant differences between the sex-role orientation groups on their answers to some questions on the father's survey. The differences emerged in the answers of the androgynous group and they are summarised below.

Question 17 b) I will be happy to help out where necessary but see my partner as doing most of the nurturing. The androgynous group was significantly more likely than the masculine group to disagree with this statement. Question 17 c) I
intend to be involved in the practical care of the newborn baby (i.e., I see myself changing nappies). The androgynous group was significantly more likely to agree with this statement than the undifferentiated group. The androgynous group was also more likely than the masculine group to intend to change nappies. Although there was not an association between androgyyny and the participator orientation in this sample of first-time expectant fathers the androgynous group were more likely than the other sex-role groups to show support for those behaviours which have been associated with the participator group. The masculine sex-role group was less likely to endorse those behaviours which Raphael-Leff has associated with the participator father and more likely to avoid involvement with the newborn which is characteristic of the renouncer group.

Question 17 d) I feel I will be more competent with an older child than with a newborn. The masculine group was significantly more likely to feel they would be more competent with an older child than the feminine and androgynous groups.

Further research is indicated to investigate the research hypothesis that more participators would be androgynous in their sex-role identity, however the significant results in the answers to these questions indicate that there is an association between sex-role orientation and the intentions and behaviours that Raphael-Leff describes in her model of fathers.

8.4 The Relationship Between Early Bonding on the PBI and Paternal Orientation

Hypothesis 4 predicted that the groups of fathers would differ in terms of early bonding experiences. However the results of this study did not support this hypothesis.
The two groups of fathers participators and reciprocators were compared in terms of total PBI scores. In this sample of first-time expectant fathers there was no significant difference between the two groups in early bonding with their father as measured on the PBI. However, when the care and overprotection dimensions were analysed separately sensible behavioural differences were differentiated in the two groups of fathers, participators and reciprocators.

8.4.1 The Care Dimension on the PBI.

The expectant father's relationship to his own father is a key theme in the literature and Raphael-Leff observes that men who have experienced paternal deprivation may find the pregnancy difficult as they lack the experience of an internalised paternal figure from whom to draw strength (Raphael-Leff 1991).

The two groups of fathers (low care and high care) on the PBI were compared in their answers to all the questions on the father's survey (with the exception of questions 5 and 13). The maximum score for the care scale is 36, high care was defined as a score greater than or equal to 24 and low care below 24 as this was the dichotomising care score proposed by Parker (1982). The group that reported high care from their fathers reported thinking and dreaming about them significantly more than the group who reported low care. Predictably the high care group felt significantly closer to their fathers during the pregnancy than the low care group. The high care group are potentially more able to identify with and access a positive father figure during the transition to parenthood. The implications of this finding are that while there were no overall differences between the participator and reciprocator groups on their total PBI scores however, the care dimension (low vs. high) seems to differentiate sensible
behavioural differences between the groups of fathers. Future research could further
explore the early bonding experiences of expectant fathers with both parents.

8.4.2 The Overprotection Dimension on the PBI

The results of the present study found that a relationship existed between the
overprotection score on the PBI and attachment. 75% of subjects who classified in the
fearful group had reported their own father as high on overprotection. This group is
classified as negative in their view of self and of others and has been found to be
positively associated with problems of introversion, lack of assertiveness and the
tendency to be exploited (Bartholomew & Horowitz 1991).

An association was found to exist in this sample of first-time fathers between
fearful attachment and overprotection by the father on the PBI. This finding supported
hypothesis 5 that the attachment groups will differ in terms of early bonding
experiences.

The two groups of fathers low and high overprotection showed significant
differences in their answers to several questions. Although there was no difference in
the two groups in regard to the frequency of thinking about their fathers during the
pregnancy, the low overprotection group dreamt more often of their fathers than the high
overprotection group. Both groups were similar in how close they currently felt to their
father. According to Zayas (1987) an expectant father's dreams about his own father are
an integral part of the formation of his paternal identity. Psychiatrically impaired
expectant fathers were seen to lack a rather stable and complete internal representation
of themselves as capable and loving fathers (Zayas 1987).

A statistical association was found between overprotection and attachment
classification in respect to the fearful and dismissing groups. The fearful group showed
a higher percentage of subjects who reported high overprotection and the dismissing group showed a higher percentage of subjects who reported low overprotection. The secure and preoccupied attachment groups showed similar distributions of the two overprotection categories. This finding adds support to hypothesis 5 that the attachment groups will differ in terms of early bonding experiences.

Parker (1979) found that overprotection from the parent of the same sex was significantly associated with neuroticism, trait anxiety, longer duration of depressive episodes and lower self-esteem. Parker concluded that those who are exposed to deficient parental care tend to place a lower estimate on their worth and are therefore likely to experience further devaluation and depression (Parker 1979).

Richman and Flaherty (1987) found in their study of first year medical students that earlier paternal coldness and both maternal and paternal overprotection significantly predicted depressive symptomology. The authors concede that attempting to delineate the potentially complex relationship between early bonding and attachments raises a host of methodological and theoretical issues. However internal representations measured by the PBI have been found in earlier validation studies to significantly correlate with 'objective' attachment experiences as reported by the parent's themselves (Richman & Flaherty 1987).

Mallinckrodt found partial support for his hypothesis that early parental bonds as operationalised as adult's parental representations on the PBI care and overprotection scales would be positively correlated with current ratings of social support (Mallinckrodt 1991). His study found that clients in counselling who reported their fathers as more warm and expressive on the PBI were able to form better therapeutic relationships.
Results of comparing the PBI scores of psychiatric patients with a control group has shown that the depressive group has received qualitatively different parenting than non depressive control group. The parental style of low care and high overprotection termed 'affectionless control' is associated with both depressive and neurotic disorders (Parker 1983). Future studies should seek to explore this 'affectionless control' group during the transition to parenthood as these fathers may be vulnerable to prenatal and postnatal disturbance during the formation of their paternal identity.

8.5 Concluding Remarks

Fathers were asked to make further comments at the end of the survey. Most participants did not fill this section in however, several did and some of these comments follow.

Several fathers made short comments which included:

'Can't wait for it!', 'I can't wait!!', 'Looking forward to the ups and downs of fatherhood. Bring it on!, 'No, I'm too close.'

Other comments included:

'I broke out into a cold sweat and felt nauseous during the first antenatal class. So I'm hoping this doesn't happen during the birth.' (A 36 year old, participator with secure attachment).

These expectant fathers were revisiting and reworking their relationship with their own father during the transition to parenthood:

'My father died last year before the baby was conceived. I feel closer to him now than when he was alive, I've learnt to accept him for who he was and not to dwell on what he did or didn't do for me as a child. I'm confident that I can be a more supportive
and understanding father than my own father.' (A 29 year old participator with secure attachment).

'My father wasn't around after my 7th year. When we (my brother as well) were to see my father on weekends he disappointed us by not turning up. He was very selfish and didn't care about us. I have much pity and hatred for him and when I told him he has a lot to make up for he got aggressive and hung up. He gave us no maintenance or financial support.' (A 27 year old reciprocator with dismissing attachment).

Raphael-Leff (1991) states that men who have been deprived of close relationships with their fathers during childhood may struggle with the emotional demands of the transition to parenthood as they may be unable to draw on a strong internalised paternal figure. During pregnancy he may become aware of his own lack of a loving paternal model (Raphael-Leff 1991).

A 33 year old participator with secure attachment wrote 'My role as a father involves a lot more than just being a provider. Yes I will be changing nappies and anything else I can do to look after the baby. Obviously my wife will have a lot of affection for the baby, but we are already very close.'

A 39 year old reciprocator with secure attachment: 'I am happy about the baby but believe that the medical staff will be helpful if problems occur. I don't think the baby will alter our love for one another. I was sick for the first-time and had my gall bladder removed during the pregnancy.' It is possible that this father had experienced the 'couvade' phenomenon.

Finally these very positive comments:

'I'm very excited about becoming a father. I hope to be a good one as well as being a supportive husband.' (A participator with secure attachment).
'I have dreamed of being married and having kids since I was very young and now I'm 24 it has finally come true, I feel my life has just begun.' (A 24 year old participator with secure attachment)
Chapter Nine

Conclusion
9.1 SUMMARY and CONCLUSION

This study aimed to investigate the Raphael-Leff model of paternal orientation, namely the participator, renouncer, reciprocator model, and to assess whether fathers could be meaningfully distinguished in terms of attachment style, early bonding experiences and sex-role identity. A 19 question attitudinal survey was administered to a sample of 101 first-time expectant fathers (age range 16-41 years) recruited from the early parenting classes and antenatal clinics within two public hospitals in the Illawarra. The questions on the survey were designed to probe the key areas which were identified in the literature on expectant fatherhood as well as to test the definitions Raphael-Leff had proposed for the groups of fathers. The following areas were salient: the expectant father's relationship with his own father; health; intentions to nurture; involvement with the antenatal preparations and delivery; sexuality and paternal-fetal attachment.

In order to find out how participators, renouncers and reciprocators differ, the study explored whether attachment, early bonding and sex-role identity contributed to fathering styles. Therefore the fathers were asked to complete the Parental Bonding Instrument PBI (Parker, Tupling & Brown 1979), the Relationship Questionnaire RQ (Bartholomew & Horowitz 1991) and the Personal Description Questionnaire (Antill, Cunningham, Russell & Thompson 1981).

Findings of this study supported the Raphael-Leff model of paternal orientation and added to it. According to the Raphael-Leff model using a new assessment instrument developed for this study revealed that 55% of the sample classified as participators (n=50), 44% as reciprocators (n=40) and 1% as renouncers (n=1). The participator group were more likely to have a secure attachment style and positive internal working models of others. The reciprocator group were more likely to have an...
insecure and avoidant attachment style and negative internal working models of others. The difficulty in sampling fathers who endorse the renouncer group remains a challenge to future studies which use the Raphael-Leff model.

Fathers with secure attachment were more likely to have a positive or well clarified sex-role identity (masculine, feminine or androgynous). 73% of fathers in this sample who had a secure attachment style had a positive gender identity. Androgynous fathers were significantly more likely to intend to nurture their baby and to feel more competent with a newborn than masculine men and men who did not strongly identify with any sex-role orientation.

No association was found between early bonding or sex-role identity and fathering styles. However, a relationship was found between early bonding and the expectant fathers' current relationship with his own father. Fathers who reported high care from their father in childhood felt closer to their own father during the pregnancy and thought and dreamt about them more than the fathers who reported low care on.

An association was found between attachment and overprotection on the PBI with the fearful group reporting that they were more likely to have had high paternal overprotection during childhood. This group spent significantly less time with their male mates during the pregnancy. The 'affectionless control' group who had histories of high paternal overprotection and low paternal care during childhood also spent significantly less time with male mates during the pregnancy than the 'optimal bonding' (high care, low overprotection) group.

The findings of this study about the reciprocator group added to the existing Raphael-Leff model. The reciprocator group has been described by Raphael-Leff as marked by ambivalence and mixed feelings towards pregnancy, labour and childcare.
However she states that this category of father is able to move between different senses of himself in his inner worlds while at the same time feeling at ease with both masculine and feminine sides of himself (Raphael-Leff 1993). She states that he is able to accept both good and bad aspects of himself and his baby, which seems to be indicative of a secure attachment style. However the results of this study show that there is a relationship between the reciprocator group and insecure, avoidant attachment and negative working models of others. Therefore the result of this study would appear to differ from the some of the claims of Raphael-Leff. One explanation for the finding of an association between insecure avoidant attachment and negative working models of others and the reciprocator group may be that in this sample of fathers some renouncer fathers actually endorsed the descriptor of the reciprocator. However if as the results suggest that for some, being a reciprocator is marked by more negative internal working models then in their ambivalence and struggle to juggle everyone's needs they may need additional support by health professionals to revisit and rework existing negative models during the transition to fatherhood. Counselling during the transition to parenthood could reduce the effect of pre and postnatal distress on family functioning. Recommendation is made that future studies further explore through qualitative data the 'inner reality' of fathers in the reciprocator group to clarify their attachment style.

The following limitations of this study need to be considered. Only 1% (n=1) of the sample endorsed the renouncer group. However there are possible explanations for the low number of the renouncer category in this sample of first-time expectant fathers. The measurement used in this study may not have been sensitive enough to detect the renouncers in the sample, or alternatively the question is raised as to whether there does exist this category as it has been defined until now. As there was a low return rate of the
surveys (less than 50%) it is possible that the renouncer group are represented in the group of fathers who chose not to participate in the study. If the current definition is valid a challenge remains for future studies using this model to access the renouncer group who eschew involvement with antenatal preparations and health care workers.

Another limitation of this study is that fathers were asked to fill in the PBI in respect to their fathers only. Future studies using the PBI for both parents could provide more comprehensive information about the relationship between early bonding with both parents and paternal attachment.

This study has implications for midwives, counsellors and social workers who are working with expectant couples. Women's needs continue to be the focus of the health system, and neglecting the dyadic relationship in which most women give birth limits the antenatal preparation for parents (Barcley, Donovan & Genovese 1996).

Pregnancy is a high stress time and the transition to fatherhood is a critical period in which the attachment system will be reactivated. Results of this study suggest that the reciprocator group because of insecure, avoidant behaviour and negative working models of others may be predisposed to prenatal and postnatal distress and find the transition to parenthood difficult. Recommendation of this study is for further exploration of the reciprocator group who show a willingness to be involved in the pregnancy and the birth of their baby. Future studies could aim at checking on the model of paternal orientation at different stages of pregnancy to identify whether transition in any way alters the father's paternal orientation. Midwives need to be sensitive to the different orientations to fatherhood and the significance this has for their relationship to participating in the perinatal period and to early parenting. The current practice of
midwives which often neglects the dyadic relationship in which most women give birth may not be addressing the psychological needs of the father.


Appendix A

Four-Group Model of Adult Attachment (Bartholomew 1990)
PLEASE INDICATE FROM THE FOLLOWING STATEMENTS WHICH STATEMENT BEST DESCRIBES YOU (by circling the appropriate statement 1, 2, 3 or 4).

1) It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others accept me.

2) I want to be completely emotionally intimate with others but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

3) I am uncomfortable getting close to others. I want emotionally close relationships but I find it difficult to trust others completely, or to depend on them. I worry that I will become hurt if I allow myself to become too close to others.

4) I am comfortable without close emotional relationships. It is very important for me to feel independent and self-sufficient, and I prefer not to depend on others, or have others depend on me.
Appendix B

Survey Being an Expectant Father: Attitudes, beliefs and expectations
PLEASE CIRCLE THE NUMBER OF THE DESCRIPTION THAT YOU FEEL MOST DESCRIBES YOU.

1) I am excited about the pregnancy, labour, birth and childcare and want to become actively involved. I see nurturing infant as an important role for men. In understanding babies needs I believe that the infant knows best and will tell me what it needs.

2) I have mixed feelings about the pregnancy, labour, birth and childcare but want to become involved. I see nurturing infants as being a shared role with my partner. In understanding babies needs I believe that together the infant and I can work out what is best.

3) I am uneasy about the pregnancy, labour, birth and childcare and do not want to become too involved. I see nurturing infants as primarily the female role. In understanding babies needs I believe that the mother and medical staff know best and will tell what to do.
BEING AN EXPECTANT FATHER
Attitudes, beliefs and expectations

This research is being conducted by Lesley Serje as part of a Masters Honours degree supervised by Dr. Brin Grenyer in the Department of Nursing at the University of Wollongong.

This questionnaire is designed to improve our knowledge of the experience of fathers during their partner's pregnancy. The questions concern different feelings and attitudes men may experience during their partner's pregnancy. There are also some more general questions about yourself and your relationships with significant others. Please take a few minutes now to fill out this questionnaire. There are no right or wrong answers, we want to know how you are feeling now.

You can expect no personal benefit from filling out this questionnaire, however, your responses might help us to gain more understanding which would help us to support expectant fathers.

Thank you for your participation
Lesley Serje and Brin Grenyer

Confidentiality

• This research is being conducted within the Department of Nursing at the University of Wollongong
• At no time will it be possible for you to be identified by the researcher, please do not put your name on this survey
• Your willingness to fill in and return these questionnaires indicates your consent to participate in this research.

Note: According to the approval of the Human Research Ethics Committee at the University of Wollongong, any concerns regarding the conduct of this research may be directed to the Secretary of that Committee on (02) 42214457
Today's date ___/___/19

When is the baby due? ___/___/19

How many weeks is your partner pregnant? ___________ weeks

Is this a planned pregnancy? (circle) YES / NO

How old are you? ________ years

What is your current marital status? (circle) MARRIED / SINGLE / DEFACTO / DIVORCED

How long is your relationship with your partner? ________ years ________ months

How many hours a week do you work? (eg. 35 hours) ________ hours

What is your usual job? ____________________________________________

How many years did you stay at school? ________ years (eg. 9, 12 etc.)

How many years have you done other formal education or training? (eg. TAFE/diplomas or degrees/traineeships/apprentice years) ________ years

Your country of birth ____________________________________________

Country of birth of your parents: Mother: ___________ Father: ___________

Do you have a nickname for this baby? (circle) YES / NO

PLEASE CIRCLE THE NUMBER OF THE DESCRIPTION THAT YOU FEEL MOST DESCRIBES YOU.

1) I am excited about the pregnancy, labour, birth and childcare and want to become actively involved. I see nurturing infants as being an important role for men. In understanding babies needs I believe that the infant knows best and will tell me what it needs.

2) I am uneasy about the pregnancy labour, birth and childcare and do not want to become too involved. I see nurturing infants as primarily the female role. In understanding babies needs I believe that the mother and medical staff know best and will tell what to do.

3) I have mixed feelings about the pregnancy, labour, birth and childcare but want to become involved. I see nurturing infants as a shared role with my partner. In understanding babies needs I believe that together the infant and I can work out what is best.

PLEASE INDICATE FROM THE FOLLOWING STATEMENTS WHICH STATEMENT BEST DESCRIBES YOU (by circling the appropriate statement 1, 2, 3 or 4).

1) It is easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don’t worry about being alone or having others accept me.

2) I want to be completely emotionally intimate with others but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don’t value me as much as I value them.

3) I am uncomfortable getting close to others. I want emotionally close relationships but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

4) I am comfortable without close emotional relationships. It is very important for me to feel independent and self sufficient, and I prefer not to depend on others, or have others depend on me.
1. How would you describe your own health during this pregnancy?

VERY POOR

0 10 20 30 40 50 60 70 80 90 100

VERY GOOD

2. During this pregnancy how often have you sought medical consultation for your own health?

0 10 20 30 40 50 60 70 80 90 100

NEVER

A LOT

3. How often do you "talk" to your unborn baby?

0 10 20 30 40 50 60 70 80 90 100

NEVER

SOMETIMES

WEEKLY

DAILY

4. How often do you feel your baby?

0 10 20 30 40 50 60 70 80 90 100

NEVER

SOMETIMES

WEEKLY

DAILY

5. During this pregnancy have you attended the following? (circle your answer)

a) First GP visit to confirm pregnancy?

b) First antenatal assessment? (eg. obstetrician, GP, or clinic)

c) Ultrasound examination?

d) Routine antenatal check visits?

e) Early parenting classes?
Please mark the line with an X

6. During this pregnancy **how often do you think** about your own father?

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<tbody>
<tr>
<td></td>
<td>MUCH LESS</td>
<td>THAN USUAL</td>
<td>MUCH MORE</td>
<td>THAN USUAL</td>
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7. During this pregnancy **how often do you dream** about your own father?

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<td>MUCH LESS</td>
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</table>

8. Right now, how close do you feel to your own father?

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<tbody>
<tr>
<td></td>
<td>LESS CLOSE</td>
<td>THAN USUAL</td>
<td>MUCH CLOSER</td>
<td>THAN USUAL</td>
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9. How often do you discuss the details of your partner's pregnancy with other people? (eg. friends, coworkers)

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<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>SOMETIMES</td>
<td>WEEKLY</td>
<td>DAILY</td>
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</table>

10. Right now, how much time do you spend time with your male mates?

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<td></td>
<td>MUCH LESS</td>
<td>THAN USUAL</td>
<td>MUCH MORE</td>
<td>THAN USUAL</td>
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</tbody>
</table>
11. I picture myself holding the newborn baby:

- 0 10 20 30 40 50 60 70 80 90 100
  - NEVER  SOMETIMES  WEEKLY  DAILY

12. When you compare your partner's body to the way it was before pregnancy you think that it is:

- 0 10 20 30 40 50 60 70 80 90 100
  - Less beautiful than it was before  More beautiful than it was before

13. When I think about having sexual intercourse with my partner during pregnancy I feel (please circle your answer):

1. It is a way for me to get closer to, and nurture my baby.
2. A bit nervous that I could harm the baby.
3. Sometimes that the baby could harm me.

Please mark the line with an X

14. How do your feelings about sex with your partner now, compared to before the pregnancy?

- 0 10 20 30 40 50 60 70 80 90 100
  - LESS SATISFIED  ABOUT THE SAME  MORE SATISFIED

15. Which statement best describes your intentions for the labour and delivery

1. I plan to be present helping where I can.

- 0 10 20 30 40 50 60 70 80 90 100
  - STRONGLY DISAGREE  DISAGREE  AGREE  STRONGLY AGREE
2. I have not yet decided whether to be present or not.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
<td>20</td>
<td>30</td>
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</table>

3. I plan not to be present.

<table>
<thead>
<tr>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
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<tbody>
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</table>

Please mark X to correspond with your answer.

16. How comfortable do you feel with the idea of being present at the labour and birth.

<table>
<thead>
<tr>
<th>VERY uncomfortable</th>
<th>uncomfortable</th>
<th>comfortable</th>
<th>VERY comfortable</th>
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</thead>
<tbody>
<tr>
<td>0</td>
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</table>

17. How much do you agree with the following statements:

a.) I think my role as a father will be *mainly* as a provider.

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<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
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<tbody>
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</table>

b.) I will be happy to help out where necessary, but see my partner as doing most of the nurturing.

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<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
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<tr>
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</table>
c) I intend to be involved in the practical care of my newborn baby. (i.e. I see myself changing nappies.)

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d) I feel I will be more competent with an older child than with a newborn.

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<tr>
<td>STRONGLY DISAGREE</td>
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</table>

18. How much do you agree with the following statements:
   a) the baby infant may take over my wife's affection.

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<tbody>
<tr>
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<td>AGREE</td>
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</tbody>
</table>

b) I feel that my wife or other family members may not allow me to spend the time I want to spend with my newborn baby:

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<th>40</th>
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<tbody>
<tr>
<td>STRONGLY DISAGREE</td>
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<td>AGREE</td>
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</table>

19. Please mark on the scale where you think you are right now.

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<th>100</th>
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</thead>
<tbody>
<tr>
<td>I'm 100% happy to have a child at this time.</td>
<td>I'm not sure that this is the right time to have a child</td>
<td></td>
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Would you like to make any further comments?
Appendix C

Personal Description
Questionnaire
**Personal Description Questionnaire.**

This task asks you to describe *yourself*. Below is a list of personality characteristics to describe yourself. Please circle the number from 1 to 7 which corresponds with how true of you these various characteristics are. Please do not leave any characteristic unmarked.

1. **Never or Almost Never True.**
2. **Usually Not True.**
3. **Sometimes But Infrequently True.**
4. **Occasionally True.**
5. **Often True.**
6. **Usually True.**
7. **Always or Almost Always True.**

<table>
<thead>
<tr>
<th>Characteristic</th>
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<th>2</th>
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<th>4</th>
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<tr>
<td>Helpful</td>
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<tr>
<td>Dreamy</td>
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<td>7</td>
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<tr>
<td>Big-Headed</td>
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<tr>
<td>Swears</td>
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<td>3</td>
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<td>6</td>
<td>7</td>
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<tr>
<td>Fussy</td>
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<td>Complicated</td>
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<td>Crude</td>
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<td>Soft-hearted</td>
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<td>Mechanical ability</td>
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<td>7</td>
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<tr>
<td>Not timid</td>
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<td>7</td>
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<td>Changes mind easily</td>
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<td>7</td>
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<td>Interests wide</td>
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<td>Selfish</td>
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<td>Gullible</td>
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Appendix D

Parental Bonding Instrument
Male Parent Form.

This questionnaire lists various attitudes and behaviours of parents. As you remember your Father in your first 16 years would you place a tick in the most appropriate bracket next to each question.

<table>
<thead>
<tr>
<th></th>
<th>Very like</th>
<th>Moderately like</th>
<th>Moderately unlike</th>
<th>Very unlike</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spoke to me with a warm and friendly voice.</td>
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<tr>
<td>2. Did not help me as much as I needed.</td>
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<tr>
<td>3. Let me do those things I liked doing.</td>
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<tr>
<td>4. Seemed emotionally cold to me.</td>
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<tr>
<td>5. Appeared to understand my problems and worries.</td>
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<tr>
<td>6. Was affectionate to me.</td>
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<tr>
<td>7. Liked me to make my own decisions.</td>
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<tr>
<td>8. Did not want me to grow up.</td>
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<tr>
<td>9. Tried to control everything I did.</td>
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<tr>
<td>10. Invaded my privacy.</td>
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<tr>
<td>11. Enjoyed talking things over with me.</td>
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<tr>
<td>12. Frequently smiled with me.</td>
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<tr>
<td>13. Tended to baby me.</td>
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<tr>
<td>14. Did not seem to understand what I needed or wanted.</td>
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<tr>
<td>15. Let me decide things for myself.</td>
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<tr>
<td>16. Made me feel I wasn't wanted.</td>
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<tr>
<td>17. Could make me feel better when I was upset.</td>
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<tr>
<td>18. Did not talk with me very much.</td>
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<tr>
<td>19. Tried to make me dependent on him.</td>
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<tr>
<td>20. Felt I could not look after myself.</td>
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<tr>
<td>21. Gave me as much freedom as I wanted.</td>
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<tr>
<td>22. Let me go out as often as I wanted.</td>
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<tr>
<td>23. Was overprotective of me.</td>
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<tr>
<td>24. Did not praise me.</td>
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<tr>
<td>25. Let me dress in any way I pleased.</td>
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</table>