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DEVELOPMENTAL FOCUSED CLINICAL CHILD AND ADOLESCENT PSYCHOLOGY

# DEVELOPMENT OF AN INSTRUMENT TO MEASURE PATERNAL POSTPARTUM DEPRESSION

ELİF USTA

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# DEVELOPMENT OF AN INSTRUMENT TO MEASURE PATERNAL POSTPARTUM DEPRESSION

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**I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.**

Name, Last name : Elif Usta

Signature :

# ABSTRACT

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Usta Elif

Master of Science, Developmental Focused Clinical Child and Adolescent Psychology

Supervisor: Assist. Prof. Dr. Yağmur Ar-Karcı

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The main aim of the current thesis was to develop a reliable and valid paternal postpartum depression (PPD) scale and to investigate psychosocial factors associated with PPD. To pursue this aim, a multi-method design was performed in that a qualitative and quantitative study were conducted, sequentially. In the qualitative strand, 12 fathers with moderate to high depression were interviewed, and obtained data was analyzed through Interpretative Phenomenological Analysis (IPA). Four super-ordinate themes were conceptualized: (1) Motherhood as an Idealized yet Overburdening Phenomenon, (2) Masculinity Related Pressures on Fathers, (3)

Masculine Expression of Fatherhood Related Stress, and (4) Compromisation of Couple Relationship due to Parenthood. This strand aimed to gain an in-depth understanding of paternal postpartum depression experiences to delineate items of the newly developed scale. The second quantitative strand had two aims in itself: (1) development and psychometric validation of the paternal postpartum depression scale and (2) testing a moderated mediation model. Sample of the quantitative strand for psychometric validation included 190 fathers with new babies aged between 2 and 8 months old. New fathers completed the newly developed Paternal Postpartum Depression Scale (PPDS), Beck Depression Inventory (BDI), Edinburgh Postnatal Depression Scale (EPDS), and The Satisfaction with Life Scale (SWLS). Based on the results obtained from Exploratory Factor Analysis (EFA), final version of PPDS consisted of 27 items with a 2-factor structure. Cronbach's alpha values were satisfactory. Correlation analysis revealed that PPDS was positively correlated with BDI and EPDS scores and negatively correlated with SWLS. Secondly, a moderated mediation model was tested by using PROCESS software to investigate mediating roles of parenting stress and marital adjustment on the relation between father's attachment styles and paternal depressive symptoms; and to inspect whether maternal depression moderated the proposed relationships. Accordingly, data obtained from 145 father-mother dyads were included for the subsequent analyses. The results showed that perceived parenting stress significantly mediated the relationship between paternal attachment styles and depression scores, and maternal depression significantly moderated this relationship. However, no significant impact was found for marital satisfaction in the model alone or with the involvement of maternal postpartum

depression as the moderator. Findings were discussed in line with the relevant literature.

*Keywords:* Paternal Postpartum Depression, Maternal Depression, Parenting Stress, Child Mental Health, Family Functioning, Interpretative Phenomenological Analysis

# ÖZET

YENİ EBEVEYN OLMUŞ BABALARDA DEPRESİF BELİRTİLERİ DEĞERLENDİREN BİR ÖLÇÜM ARACININ GELİŞTİRİLMESİ

Elif Usta

Master of Science, Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi

Tez Yöneticisi: Dr. Öğr. Üyesi Yağmur Ar-Karcı

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Bu tezin amacı geçerli ve güvenilir bir doğum sonrası baba depresyonu (DBD) ölçeği geliştirmek ve DBD ile ilişkili olabilecek psikososyal faktörleri incelemektir. Bu doğrultuda, tez niteliksel ve niceliksel çalışmaların sırasıyla yürütüldüğü karma desen ile gerçekleştirilmiştir. Çalışmanın niteliksel kısmında, orta ve yüksek depresyona sahip 12 baba ile görüşülmüş, elde edilen veri Yorumlayıcı Fenomenolojik Analiz (YFA) ile analiz edilmiştir. 4 üst tema oluşturulmuştur: (1) İdealleştirilen ancak ezici yüküyle gelen annelik, (2) Babalar üzerinde erkeklik ile ilişkili baskılar, (3) Babalık ile ilişkili stresin erkeksi dışa vurumu, (4) Ebeveynlik adına ödün verilen çift ilişkisi. Bu aşama doğum sonrası baba depresyonu deneyimlerini derinlemesine anlayarak yeni geliştirilen ölçek için madde oluşturulmasını amaçlamaktadır. Çalışmanın ikinci

aşaması ise kendi içerisinde iki amaç içermektedir: (1) doğum sonrası baba depresyonu ölçeğinin geliştirilmesi ve psikometrik geçerliliğinin sağlanması ve (2) bir arabuluculu aracı değişken modelinin test edilmesidir. Niteliksel kısımdaki katılımcılar 2 ile 8 ay arasında yenidoğan sahibi 190 babayı içermektedir. Yeni babalar, yeni geliştirilen Doğum Sonrası Baba Depresyonu Ölçeği (DBD), Beck Depresyon Envanteri (BDE), Edingburgh Doğum Sonrası Depresyon Ölçeği (EDDÖ) ve Yaşam Doyum Ölçeğini (YDÖ) yanıtlamıştır. Açımlayıcı Faktör Analizinden (AFA) edinilen sonuçlara göre, DBD'nin son biçimi 27 madde içermektedir ve 2-faktörlü yapıdadır. Cronbach's alpha değerleri tatmin edicidir. Korelasyon analizleri göstermektedir ki DBD, BDE ve EDDÖ ile pozitif; YDÖ ile negatif ilişkilenmektedir. Ayrıca, arabuluculu aracı değişken modeli PROCESS yazılımı ile test edilmiş; ebeveynlik stresi ve evlilik tatminin aracı rolünün babanın bağlanma stili ve babanın depresif belirtileri arasındaki ilişkiye etkisi ile anne depresyonunun bu model üzerindeki ara bulucu rolü incelenmiştir. Bu doğrultuda, 145 anne-baba çiftinden alınan veriler müteakip analizler için kullanılmıştır. Sonuçlar göstermektedir ki algılanan ebeveynlik stresi anlamlı bir şekilde babanın bağlanma şekli ve depresyon skorları arasındaki ilişkide aracılık etmiş ve bu ilişkide anne depresyonu anlamlı bir şekilde ara buluculuk yapmıştır. Ancak, evlilik tatmininin model üzerinde tek başına veya anne depresyonunun ara bulucu olarak dahiliyetinde anlamlı bir aracı etkisi görülmemiştir. Bulgular ilgili alanyazın ışığında tartışılmıştır.

*Anahtar kelimeler:* Doğum Sonrası Baba Depresyonu, Anne Depresyonu, Ebeveynlik Stresi, Çocuk Ruh Sağlığı, Aile İşlevselliği, Yorumlayıcı Fenomenolojik Analiz

To my lovely family and friends …

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## 1. INTRODUCTION

### 1.1. Overview of Postpartum Depression

Several attempts have been made to understand the critical role new mothers play in the psychosocial development of their offspring (Halligan et al., 2007). Accordingly, a robust relation has been established between postpartum maternal depression and various psychological problems among affected offspring (e.g. depression, anxiety, conduct problems, social deficits, attachment insecurity, attention problems, learning difficulties, lower IQ scores, and compromised motor ability) (Canadian Paediatric Society, 2014; Park et al., 2018; Santona et al., 2015; Stein et al., 2014; Tuovinen et al., 2018; Villodas et al., 2018). Recently, researchers have shown an increased interest in understanding and assessing paternal postpartum depression since it is partially triggered and also maintained by early maternal depression. Coupled with the awareness of dynamic relations among different subsystems of the family unit (e.g., child-mother, child-father, mother-father-child), postpartum depression is not a "motherly emotional state" anymore (Glasser & Lerner-Geva, 2018; Gutierrez-Galve et al., 2018). Instead, the symptom manifestation of perinatal depression has been started to be pronounced for fathers with new-borns, as well. Preliminary studies indicated that prevalence rates of paternal postpartum depression ranged between 2 and 20 % (Glasser & Lerner-Geva, 2018; Paulson & Bazemore, 2010). This substantial variability in prevalence rates was attributed to the lack of psychological

assessment tools that are sensitive enough to capture new fathers' depressive experiences as a whole. In fact, existing measurement tools were criticized for failing to cover differential expression of depressive symptoms aroused from psychosocial and cultural expectations centred around manhood and fatherhood (Cameron et al., 2016; Carlberg et al., 2018).

Accordingly, this thesis aimed to investigate depressed new father's psychosocial experiences during the postnatal period and to develop a psychometrically sound instrument to particularly measure paternal postpartum depressive symptoms. In the first chapter, the different nature and manifestation of masculine depression and paternal postpartum depression were explained. Later, major risk factors that were associated with paternal postpartum depression were conceptualized in detail. Thirdly, current measurement tools used to assess paternal postpartum depression were explained with regard to their stated limitations. Finally, the theoretical frame, main research questions, and hypothesis of the two research that were conducted within the scope of the current thesis were provided.

### 1.1.1. Differential Prognosis of Depression across Gender

Differential prognosis of depression for men and women has been a hotly debated topic in clinical psychology literature starting from 2000s. The differences between men and women in terms of experiencing and expressing symptoms of depression have aroused several intriguing questions (Addis, 2008). These questions are mainly categorised into two categories: (1) "Are these differences resulted from the differences in the underlying mechanisms generating depressive symptoms?" and (2)" What if only manifestation of the symptoms are different across genders while

the experience is still the same? To answer these questions, Addis (2008) delineates four conceptual frameworks. These frameworks are titled (1) sex differences, (2) masked depression, (3) masculine depression, and (4) gendered responding. According to sex difference framework, men and women have the same depressive experience except from minor phenotypic variations. This means that, although the depressive experience is same across genders, men are more likely to have somatic symptoms and less likely to have emotional sadness. This framework was partially supported by the existing findings suggesting that men are more likely to distract themselves and ruminate less (Nolen-Hoeksema, 2002) while their help seeking behaviour is also compromised (Addis & Mahalik, 2003). Yet, this view has been criticized as it includes several limitations such as putting individuals in strict gender categories, omitting the same symptomatology shared by different genders and disregarding the symptom variance within the same sex. Second framework, known as masked depression, suggests that gender socialization practices are the main reasons for the differential expression of depression across genders (Addis, 2008). Western masculine norms give importance to emotional stoicism, self-reliance, physical toughness and strength that usually directs men more to culturally acceptable manifestations of depressive symptoms (e.g., alcohol abuse and physical aggression) (Addis & Cohene, 2005). This framework has received support by several indirect evidence. For example, when men have depression, they might have difficulty in identifying and communicating their affective state, which, in turn, might lead their depression to remain invisible (Addis, 2008). That is, men tend to manifest their depression in accordance with the gender stereotypical expectations imposed by society. Still, this framework is not without limitations since it does not

offer an explanation for the internalizing symptomology of depression. The third framework, masculine depression, is closely related with masked depression framework particularly with regard to gender socialization process (Addis, 2008). It posited that men experience a form of "masculine depression" instead of "a masked depression". Accordingly, unattainable, and contradictory standards of masculinity create emotional strains for men which encourage action while devaluing introspection. That is, masculine gender norms affect how men experience, express and respond to depression. Thus, masculine depression is evaluated as a phenotypic variant of the prototypic depression. Still, this view has also been criticised since it undermines the variance of the social construction of masculinity across different cultures, ethnicities and social classes. Last but not least, gendered responding framework focuses on how masculinity impacts on the experience and expression of different emotions (Addis, 2008). According to this framework, the way individuals respond to depressed mood has a strong influence on the probability of developing major depressive disorder. Men have different styles of interpreting and responding to negative stimuli such as engaging in less rumination and distracting themselves more as a result of the social learning practises (Broderick, 1998; Sethi & Nolen-Hoeksema, 1997; Johnson & Whisman, 2013). Due to absence of typical depression related coping strategies, prevalence rate of depression among men is somehow lower than women. Yet, whether this difference is due to absence of depression or differential responses given to depressive emotions is still a question that needs to be addressed (Addis, 2008).

Understanding the possible differences in the experience and expression of depressive symptoms across gender requires a unifying perspective. Despite nuances

in their theoretical assumptions, all proposed frameworks and existing findings have pointed out to a common ground which is gender socialization process (Addis & Cohane, 2005; Addis & Mahalik, 2003; Martin et al., 2013; Cochran & Rabinowitz, 1999). Masculine norms favouring emotional stoicism, invulnerability, self-reliance and emotional toughness usually direct men to experience depressive symptoms through culturally accepted ways such as risk-taking behaviours, anger attacks, isolation, ambivalence, hyperactivity, alcohol abuse and physical aggression (Addis & Cohane, 2005; Martin et al., 2013; Cochran &Rabinowitz, 1999). In fact, such an emotional state is usually referred as a "masked depression" since gender roles might discourage men from expressing sadness and despair through more direct ways (Addis, 2008). Accordingly, masculine norms seem to lead expression of sadness through more externalizing actions (Addis & Mahalik, 2003; Seidler et al., 2016). Coupled with negative assumptions about asking help from professionals, men themselves might not be even aware of the fact that their symptoms indicate a serious mental health problem (Call & Shafer, 2018; Lynch, 2013). However, a note to caution is due here. Such findings do not exclude the fact that men suffer from common internalizing symptoms of depression (e.g., sadness, exhaustion, crying, somatic symptoms and guilt), as well (Cochran & Rabinowitz, 1999; Martin et al., 2013). Rather, assessment tools measuring both internalizing and masked symptoms of depression might be much more effective to understand prevalence and nature of depressive symptoms among men.

### 1.1.2. Specific Issues Regarding Paternal Postpartum Depression

Like general depressive symptoms, experience and manifestation of postpartum depression also differ across gender. Emerging literature pointed out that depressed fathers are more likely to exhibit symptoms that are not typical of depression (e.g., anger, frustration, impulsiveness, irritability, and anxiety) while new moms with postpartum depression display more central symptoms of a depressive episode (Davis et al., 2011; Karam et al., 2016). Men usually manifest "male-typical symptoms" such as irritability, violence, substance abuse, risk-taking behaviour, hyperactivity, stress, loss of vitality, tiredness, and emotional ambivalence during their depressive episodes (Cochran & Rabinovitz, 2003; Martin, Neighbors, & Griffith, 2013). Still, depressed fathers also reported to experience conventional symptoms of depression including but not limited to lack of interest, anhedonia, sleep disturbances, worthlessness and suicidal ideation (Kim & Swain 2007; Misri, 2018).

Both biological and sociocultural factors have been investigated to understand different manifestations of postpartum depression among new mothers and fathers. Studies examining hormonal changes have suggested that lower levels of testosterone, oestrogen, cortisol and vasopressin are associated with greater levels of paternal postpartum depression (Berg & Wynne-Edwards, 2002; Ehret et al., 1993; Storey et al., 2000; Welberg 2006; Wynne-Edwards, 2001). Yet, these studies have also been criticized as the majority of them sampled animals compromising the generalizability of the findings. In the last 20 years, sociocultural explanations have gained scientific popularity as the psychosocial risk factors for paternal postpartum depression are more amenable to change through intervention strategies (Gutierrez-

Galve et al., 2018; Misri, 2018; Ramchandani; 2011). Accordingly, fathers usually perceive themselves as the sole supporter of the mother-inborn dyad. They reported to feel pressurized due to increased responsibility both as a parent and as a husband (Darwin, 2017; Edhborgh et al., 2016). Coupled with the societal expectations centred around manhood, new fathers might have the need to be emotionally though as expressing more fragile emotions is not something appreciated by the mainstream culture. Yet, this does not mean that fathers do not suffer from postnatal and/or postpartum depression. Instead, new fathers might either suppress or convert their sadness into externalizing symptoms such as anger and hostility since these symptoms are more compatible with the traditional gender roles imposed on men (Addis & Cohane, 2005; Martin et al., 2013; Cochran & Rabinowitz, 1999). As a result, such atypical manifestations of depression might cause paternal postpartum depression to remain as a "hidden diagnosis" (Addis, 2008; Paulson, 2010). A growing body of evidence has suggested that paternal depression is a real diagnosis increasing the risk of marital conflict, partner violence, and dysfunctional parenting among couples with new-borns (Gutierrez-Galve et al., 2018; Misri, 2018). Nevertheless, far too little attention has been paid to account for the underlying processes, and integrative models remained underdeveloped. Additionally, except a few, the majority of studies (Azad et al., 2019; Wang et al., 2016; Serhan, 2010) were conducted in Western cultures employing more egalitarian values while defining tasks and duties of new parents. Hence, future studies are better to be conducted in non-Western societies with collectivistic norms to understand the impacts of sociocultural factors in the development and maintenance of paternal postpartum depression.

## 1.2. Factors Associated with Postpartum Depression Among Fathers

### 1.2.1. Maternal Postpartum Depression

Existing literature has pointed out some risk factors for PPD. Amongst others, maternal postpartum depression seems to be one of the most significant ones (Glasser & Lerner-Geva, 2019; Paulson et al., 2016; Zhang et al., 2016). Maternal postpartum depression has been described as a depressive episode during the postpartum period persisting more than two weeks (American Psychiatric Association, 2013). Symptoms include compromisation of well-being and psychosocial health, hopelessness, anhedonia, sleep disorders, fear of injury, serious concern about the baby and suicidal ideation (Ashwathi et al., 2015; Norhayati et al., 2015; Slomian et al.; 2019). Several psychosocial factors might predispose women to experience postpartum depression such as negative life events, relationship dysfunctionality, intimate partner violence, job loss, miscarriage and lower partner support (Azad et al., 2019; Nagy et al.; 2011; Ongeri et al., 2018; Yim et al.; 2015). There has been a vast majority of research that focusing on the association between maternal and paternal postpartum depression (Duan et al., 2020; Kamalifard et al., 2018; Paulson et al., 2016; Zhang et al., 2016). Partners of depressed mothers are more likely to develop depressive symptoms over time and their marital relationship starts to suffer due to this bidirectional relation (Darwin et al., 2017; Goodman, 2004; Goodman, 2008; Zhang et al., 2016; Matthey et al., 2000). In fact, the relationship between maternal and paternal postpartum depression was partially accounted by the marital conflict and father's parenting distress (Bruno et al., 2020; Holopainen, & Hakulinen, 2019). Preliminary evidence also suggested that partners of depressive mothers more likely to experience parenting stress and attachment

difficulties with their infants in addition to the increased risk for paternal depression (Johansson et al., 2020). Also, the depressive history of one parent predicts the parenting behaviours of the other parent above and beyond each parents' own mental health history (Kopala-Sibley et al., 2017). Hence, these findings once again highlight the importance of evaluating father postpartum depression in the family context both as an affected and affecting actor among new parents.

### 1.2.2. Attachment

Father-baby bonding after birth is a relatively new researched topic in PPD literature (Johansson et al., 2020; Psouni & Eichbichler, 2020). Studies have indicated that attachment difficulties of the father predispose new fathers for postpartum depression. Attachment is generally explained as an emotional bond between two people affecting the behaviour, emotions and cognitions of the offspring from infancy to an old age (Bowlby, 1969). Interactions with the caregiver during infancy is of utmost importance since it creates an inner working model for the subsequent interpersonal relations (Allen et al., 2013). The relationship between infant and caregiver is both effecting and effected by the transactions of individual, social and ecological factors (Goodman, 2007). The quality of the relationship and the attachment security between infant and the caregiver construct the basis of infant mentalization and predicts socio-emotional-cognitive development of the infant (Osofsky & Fitzgerald, 1999; Feldman, 2007). Attachment styles have an impact on the child's representation of the self (Toth et al., 2009), relationship with friends, romantic partners and even parenting behaviours displayed towards their own children (Simpson and Rholes, 2012).

Preliminary evidence pointed out that fathers with avoidant attachment style are more likely to develop depression during the postnatal period (Psouni & Eichbichler, 2020). Attachment difficulties make it harder for these fathers to emotionally connect with the baby, which, in turn, creates a sense of estrangement compromising father's wellbeing (Edhborgh et al., 2016). It has been noted that the emotional bond between father and infant develops more slowly than mother-infant attachment (Edhborg, Matthiesen, Lund, & Widström, 2005). Thus, some fathers feel more excluded from the mother-infant relationship especially within the first months after birth (Bruno et al., 2020; Edhborgh, 2016). Sociocultural expectations centred around fatherhood might also influence the quality of relationship that the fathers establish with their new-borns. Accordingly, assuming the mother as the primary caregiver while defining the father as the supporter might lead some fathers to feel isolated from mother-child dyad (Bruno et al., 2020; Edhborgh et al., 2016; Misri, 2018). All in all, attachment difficulties could make fathers more vulnerable to postpartum depression. However, more research is required to understand the relational paths between attachment and PPD by considering other individual, relational and family level factors.

### 1.2.3. Marital Satisfaction

Marital relationship difficulties and adjustment problems are the other risk factors for PPD (Massoidi, 2016; Zhang, 2016). First of all, marital dissatisfaction was found as a significant predictor of PPD (Morse et al., 2000, Zhang, 2016). Marital satisfaction refers to the attitude of an individual toward the partner in a romantic relationship (Fincham et al.; 2010). The level of marital satisfaction fluctuates in different periods (Lawrence et al., 2008) with a particular decrement after having the first child

(Barnes, 2006; Lawrence et al., 2008). The change in the relationship after birth affects the marital satisfaction of couple's negatively (Lawrence et al., 2008). Fathers who are dissatisfied with their relationship is more likely to develop depression and avoid supporting their partners (Kim & Swain, 2007).

Besides marital dissatisfaction, fathers who reported to be in a conflicting relationship with their partners tend to have increased levels of postpartum depression (Carlberg et al., 2016; deMontigny et al., 2013; Sockol & Allred, 2018) and the relational difficulties might even create a risk for marital separation (Kerstis et al., 2014). New responsibilities that come with the new-born usually overburden couples and creates additional problems particularly for couples with intensify couples' already unsettled conflicts. Furthermore, assuming the new roles of parenthood might also impair marital satisfaction due to the role incongruences after childbirth (Cast, 2004). Changes in the nature of couple relationship brought by birth might lead some couples to feel that they had lost the previous closeness (Darwin et al., 2017). Unfortunately, depressed fathers are also more prone to use both verbal and physical aggression compromising the quality of marital relationship further (Addis, 2008). Consequently, depression of men does not only affect the individual himself but also has detrimental impacts on partners and children. Thus, it is required to evaluate the impacts of marital satisfaction on paternal postpartum depression with respect to dynamic family context. Also, the father's understanding of and expectations from their marital relationship after birth can differ across cultures (Fakher, 2018; Wendorf et al., 2011). On that account, observing the relationship between marital satisfaction and paternal postpartum depression in different cultures, especially in less studied non-western societies, once again gains importance.

### 1.2.4. Parenting Stress

Emerging evidence pointed out that parenting stress is an important risk factor for PPD (deMontigny et al., 2013; deMontigny et al., 2012; Johansson et al., 2020). Parenting stress is usually defined as an aversive reaction resulting from actions or attempts failing to meet the demands of parenthood (Deater-Deckard, 2004). Stress resulted from parenting role is qualitatively different from other sources of stress in parents' daily life such as parental unemployment and marital decomposition, although each domain is interrelated to some extend (Deater-Deckard et al., 2005). Transition to parenthood is a distressing situation that requires adjustment in terms of several aspects such as lifestyle, couple relations, and identity (Condon et al., 2004). Parenting stress particularly emerges when the parent-child system is under tension (Abidin, 1995; Deater-Deckard et al., 1998). Incongruency among the parent's perception of available psychological family resources and the demands of parenthood creates parenting stress.

Emerging literature suggested that fathers with higher levels of parenting stress are more vulnerable to PPD (Chhabra et al., 2020). The impacts of parenting stress on the father's depression level were mainly explained by some psychosocial mechanisms. For instance, in their study, Psouni and Eichbichler (2020) found that fathers' attachment insecurity mediated the relation PPD had with parenting stress. This finding is also consistent with Johansson et al. (2020) study which showed that depression level was predicted both by parental stress and preoccupied attachment style. Additionally, depressed fathers tend to display less warmth, sensitivity, and they are also more prone to detachment and withdrawn during child care (Wilson &

Durbin, 2010; Sroufe et al., 2010; Jones et al., 2015). Hence, parenting stress is obviously another important factor affecting well-being of all family units. However, there is little published data on the relationship between perceived parenting stress and PPD within the context of family system.

### 1.3. Measurement Tools Assessing Paternal Postpartum Depression

Paternal postpartum depression is a relatively topic in the literature compared to the maternal postpartum depression (Garthus-Niegel et al., 2020). Herewith, existing scales of postpartum depression were initially developed for mothers by mainly focusing on maternal aspects or traditional symptomology of depression. For example, Edinburgh Postnatal Depression Scale (EPDS) was amongst the first developed to measure particularly maternal postpartum depression. Yet, it has been also widely used to identify paternal perinatal depression among new fathers as well (Cox et al., 1987), although psychometric studies proved that EPDS is insufficient to grasp externalizing symptoms of depression commonly observed among new fathers (Carlberg et l., 2018). Hence, the substantial variety between the prevalence of maternal and paternal postpartum depression is attributed to lack of a psychometrically valid tool targeting both common and unique symptoms of PPD. In an attempt to fill this gap, another instrument, Gotland Male Depression Scale (GMDS), was developed to identify both internal and external manifestations of depressive symptoms (Zierau et al., 2002). However, studies comparing EPDS and GMDS show that perinatal depression of some fathers still remains undetected due to lack of specific items measuring emotional states in relation to fatherhood experience (Carlberg et al., 2018; Madsen & Juhl, 2007). Thus, a new comprehensive scale

assessing both unique and common symptoms of postpartum depression in relation to parenthood and family dynamics are suggested to be developed (Zierau et al., 2002).

### 1.4. The Scope and the Purpose of the Thesis

There are many studies focusing on the impacts of maternal postpartum depression on parenting, marital satisfaction and child psychosocial well-being, whilst much less is known about possible impacts of PPD on family related variables such as parenting, child-father bond and marital functioning (Slomian et al., 2019; Hahn-Holbrook et al., 2018). Existing studies usually investigate aforementioned variables separately without offering a general framework to understand mechanisms triggering and maintaining PPD in the family system. Besides, existing studies are criticized for using scales for not being sensitive enough to capture symptoms pertaining to PPD (Carlberg et al., 2018; Cameron et al., 2016). Hence, the validity of the existing findings has been questioned by many theorists and researchers as the current assessment tools fail to assess nature and intensity of PPD (Carlberg et al., 2018). Thus, the main aim of the study was to develop a psychometrically sound instrument to measure paternal postpartum depression in its entirety and to investigate psychosocial variables associated with PPD.

### 1.5. Research Questions and Hypothesis of The Thesis

In order to pursue this general aim, two consecutive studies were conducted within the scope the current thesis. The first study employed a qualitative methodology to develop an item pool particularly assessing symptoms pertaining to PPD. As a result, semi-structured interviews were conducted to better grasp depressed fathers'

experiences during the postnatal period. This methodology was purposefully chosen to investigate the meaning beyond each statement and appraisal in a detailed manner. Accordingly, the research question of the first qualitative strand was formed as follows:

1. How do new fathers experience depressive symptoms during the postnatal period?

The second research was employed with a quantitative methodology to achieve two interrelated aims. The first aim was to evaluate psychometric properties of the newly developed PPD scale based on data obtained from semi-structured interviews and literature findings. The second aim was to test a moderated mediation model to understand psychosocial variables associated with paternal postpartum depression using the new scale that we had developed. Accordingly, we tested a moderated mediation model investigating the individual and familial mechanisms perpetuating paternal depression (Figure 1). In this respect, we expected that parenting stress (Mediator 1-M1) and marital satisfaction (Mediator 2-M2) would mediate the relation between fathers' attachment style (Independent Variable-IV) and paternal postpartum depression (Dependent Variable-DV). Besides, we hypothesized that maternal depression (Moderator-W) would moderate the relation between (1) M1 and DV; and (2) M2 and DV. More specifically:

1. Fathers with insecure attachment styles would have higher parental stress and lower marital satisfaction scores which would be associated with increased paternal postpartum depression.

2. The mediating impacts of parental stress and marital satisfaction on father attachment and paternal depression relation would differ depending on the different levels of maternal depression scores.

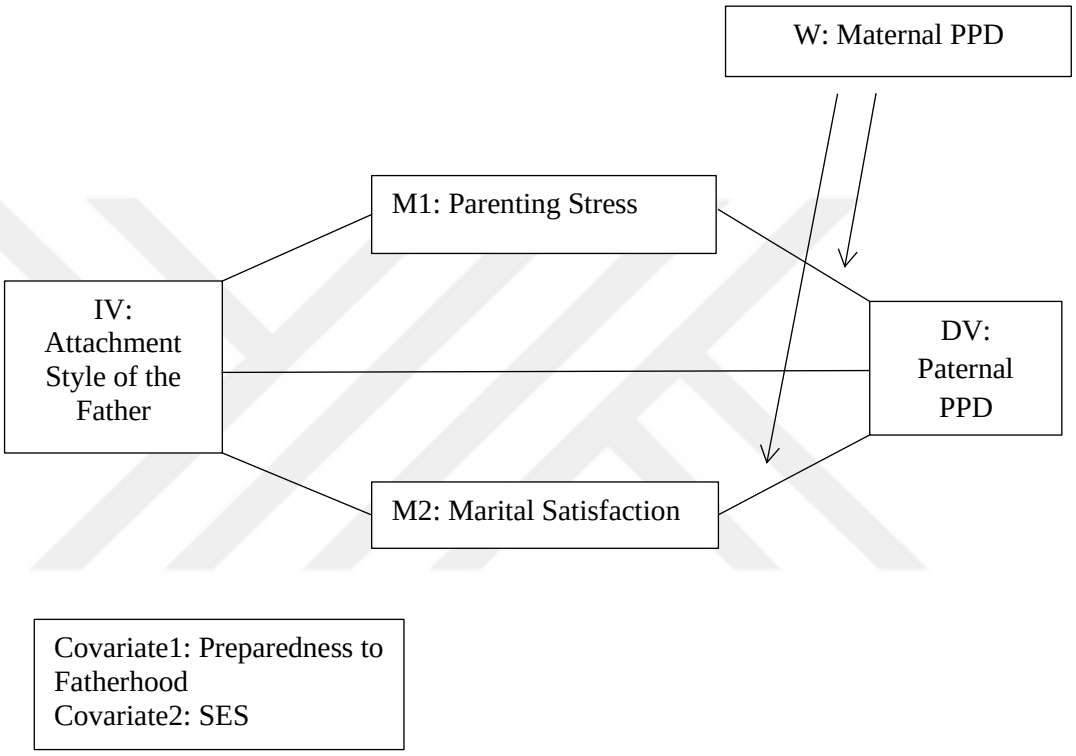


*Figure 1*. Moderated mediation model. Independent variable: Attachment Style of the Father, dependent variable: Paternal PPD, mediators: Parenting Stress, Marital Satisfaction, Moderator: Maternal PPD.

# CHAPTER 2

## 2. GENERAL METHODOLOGY

The present thesis aimed to understand new fathers' depressive experiences during postpartum period and to develop a psychometrically valid instrument to assess postpartum depression among fathers. In this chapter, general methodology and general procedures performed within the scope of the current thesis was mentioned.

### 2.1. General Research Design

A multimethod research design was conducted in this thesis in order to understand new father's experiences in the postpartum period. Accordingly, a qualitative and quantitative study were employed sequentially. In multimethod research design, two or more related studies with different methodologies are performed to answer a general research question in an attempt to provide a comprehensive framework for the investigated topic (Whitehead & Schneider, 2007). Although each study is interrelated and serves for a better understanding of the targeted phenomenon, each research is self-contained and autonomous in terms of methodological requirements (Schoonenboom, & Johnson, 2017; Tassakkori & Teddle, 2003). In that respect, two studies were conducted with their own separate methodologies and the results were later combined to obtain in-depth knowledge about symptoms and correlates of paternal postpartum depression.

Among multimethod designs, QUAL - QUAN (equal-status sequential design) was conducted. In this design, qualitative study is conducted initially, and later it is

followed by a separate autonomous quantitative study (Johnson & Christensen 2017; Schoonenboom, & Johnson, 2017). Qualitative and quantitative methodology equally weighted in this design and they both contributes equally to the main findings (Davis et al., 2011; Johnson and Christensen 2017; Tassakkori & Teddle, 2003). In the current study, firstly a qualitative methodology was employed to capture fathers' depressive postpartum experiences in detail. This methodology was purposefully chosen since it was believed that standardized measurements of paternal postpartum depression might lack necessary items adequately measuring unique depressive experiences of new fathers. Besides, it was well-established in the literature that manifestation and experience of depression differ depending on the cultural values and living practises (Chang et al., 2017; Kirmayer et al., 2017). Hence, qualitative methodology was purposefully employed to delineate possible cultural influences on father's experiences. Accordingly, 12 fathers with moderate to severe depression were interview and obtained data was analysed with guidelines of Interpretative Phenomenogical Analysis (IPA). Later, a question pool was developed with the aim of developing a paternal postpartum depression scale capturing common and unique experiences of paternal postpartum depression based on the themes obtained in the qualitative strand. In the second study which employed a quantitative methodology, the newly developed scale was inspected with regard to its content and psychometric properties. Also, a moderated mediation model was tested in the same quantitative strand grounded on the themes emerged in the qualitative strand. Lastly, findings of both qualitative and quantitative studies were evaluated comprehensively to explain depressive experiences of Turkish new father in the postpartum period.

## 2.2. General Procedure

The study was started after ethical permissions were obtained from TED University Human Subjects Ethics Committee. For the first study, which employed a qualitative methodology, fathers of new-borns whose ages ranged between 2-8 months with no serious birth complications were targeted. In order to reach participants meeting the eligibility criteria two routes were followed: (1) getting into the contact with the new fathers in their routine controls, and (2) getting into the contact with participants via social media platforms. First of all, in order to reach participants in an hospital settings Local Health Authority of Trabzon and Karadeniz Technical University Faculty of Medicine Farabi Hospital were contacted. Having received formal approvals, the researcher informed health personnel about the scope of the study via an information form. Either the researcher or the health personnel informed new fathers about the study in their routine controls in the gynaecology and paediatric clinics. Fathers who accepted to participate to the study were given the informed consent form. When they signed it, they were also given demographic information form and Beck Depression Inventory (BDI). Additionally, fathers of new-born were also reached through online social media platforms. Moderators of these platforms which are actively used by new parents were contacted via a standardized e-mail. Once the moderators accepted to support the research, announcement materials including a link for informed consent and questionnaires were sent out. Fathers of new-borns who signed and confirmed the informed consent were sent the survey battery including demographic Information form and BDI. Fathers who had scores of 15 and above form BDI were further contacted for the interviews in the qualitative part of the study. Interviews were performed either face to face or online depending

on the fathers' personal preferences. In both face-to-face and online format of the interviews, meeting time was arranged with the fathers through email and interviews were conducted in an environment assuring privacy and confidentiality. Among 26 fathers who had scores of 15 and above from BDI, only 12 fathers were interviewed and analysed as the remaining participants were excluded as their babies had medical complications during and after birth. Before starting each interview, the process and the scope of the study were explained both verbally and in a written letter. Also, willingness for both participation and audio recording of the interviews was documented.

For the second study, which employed a quantitative methodology, both mothers and fathers of new-borns whose ages ranged between 3 months to 1 year were targeted. Two routes for recruitment were followed once again (1) getting into the contact with participants in their routine controls, and (2) getting into the contact with participant via social media platforms. In addition to Local Health Authority of Trabzon and Karadeniz Technical University Faculty of Medicine Farabi Hospital, an official permission was also received from Public Health Authority to collect data at the family practice centres in Trabzon and Ankara. For this aim, the researcher visited family practice centres and informed the health personnel about the study. After receiving a formal acceptance letter, the process was continued with 17 family practice centres who accepted to support the research process. Parents of new-borns were informed about the study in their routine control calls or in the health centres. Participants who were accepted to participate to the study was sent the survey link via email. Additionally, parents of new-borns were also reached through social media platforms. Moderators of these platforms were contacted. Announcement poster and

survey link were shared with the moderators who agreed to support the study. Fathers who wished to take part in the were given informed consent and once they confirm the questionnaires presented.

# CHAPTER 3

## 3. STUDY 1: DEPRESSIVE EXPERIENCES OF NEW FATHERS DURING THE POSTNATAL PERIOD

In the first study, in-depth interviews were held with 12 new fathers with moderate to severe depression to delineate their unique and common experiences during post-natal period. In the second strand, obtained themes were used to develop an item pool for measuring postpartum depression of new fathers. Accordingly, the research question of the first qualitative study was formed as follows:

1. How do new fathers experience depressive symptoms during postnatal period?

In this chapter, methodology, analyses and discussion of the results of the first study were presented in detail.

### 3.1. Method

#### 3.1.1. Methodological Background

Interpretative Phenomenological Analysis (IPA) aims to explore a phenomenon in its natural context (Howitt, 2010). This methodology is called as phenomenological because it is concerned with personal experiences and individual's personal perceptions about an interest topic (Smith, & Osborn, 2003). Additionally, IPA accentuates the active role of the researcher in the dynamic process of the research in consistent with its interpretative approach. Since the meaning making process has great importance, the researcher tries to make sense of the situation regarding their

presuppositions (Willig, 2008). The presumptions are evolved through the participant's accounts and used as additional sources for the analysis. All in all, the conveyed meaning consists of the participant's account, researcher's contextualization, and the interaction between the participants and the researcher (Smith et al., 1999).

IPA was chosen as the most appropriate methodology for this study because it is particularly useful in exploring issues that are relatively new and sensitive to the socio-cultural context (Chapman & Smith, 2002). Accordingly, IPA's inductive approach provides better and deeper understanding of experiences of new fathers. It also takes into consideration cultural context as a sphere that includes the experimentation and expression of the participants (Larkin et al., 2006). Person-in-context approach of IPA was particularly useful for the current study since the depressive experiences of men likely to be culture bonded (Kleinman, 1987).

### 3.1.2. Participants

In the first phase, biological fathers of new-born babies between 3-8 months were targeted. In order to reach out new fathers with moderate to high depression scores, a pre-screening assessment tool (i.e., Beck Depression Inventory) was distributed to Paediatric Units of state hospitals in Trabzon. Also, the research was announced in online platforms such as websites, forums and social media platforms that are commonly used by parents with new-borns.

In the first qualitative part, a pre-screening test was initially delivered to 279 new fathers. After the elimination of incomplete responses, the total number of

participants was 232. Mean age for the fathers was 34, with ages ranging from 20 to 53 (*M* = 33.59, *SD* = 5.58). Mean age for new-borns was 5 months and age range were in between 1 month and 13 months (*M* = 4.77, *SD* = 1.83). Also, the mean of father's depressive scores according to Beck Depression Inventory was 7 and BDI scores of fathers were ranging between 0 to 40 (*M*=6,77, *SD*=6,65). Of the 232 fathers, the ones who met the following eligibility criteria was invited to the semi-structured interviews: (1) Expressing an interest to participate to study, (2) Being a father to a baby between 3-8 months, (3) Having depression scores above 15, (4) Having no other diagnosed psychiatric history except depression and (5) Having an inborn without life-threatening birth complications and/or chronic health problems.

The interviews were conducted with fathers with moderate to high depression scores who received 15 and above from BDI. The cut off scores for moderate and clinical depression were determined on the basis of relevant literature findings. Accordingly, fathers who receive a score between 10 and 18 are regarded as mild-to-moderately depressed; 19 and 29 are regarded as moderately depressed, while fathers who receive a score above 29 are considered to have high intensity depression (Beck et al., 1988). For Turkish samples, individuals scored above 17 have been accepted as clinically depressed and defined at risk consistent with the international literature (Hisli, 1989; Nielsen, & Williams, 1980; Schwab et al., 1967). Yet, some unique characteristics of the sample (e.g., comorbid mental health problems, gender, age etc.) might affect the threshold of the depression scores, as well (Moullec et al., 2015; Wang, & Gorenstein, 2013). For example, women tend to score higher in BDI compared with men (Salokangas, 2002). Accordingly, cut-off scores for the categorization of depression intensity are suggested to be determined on the basis of

aim and implications of the proposed studies (Beck, & Beamesderfer, 1974). In the current study, we expected that BDI did not cover the whole depressive symptomology of new fathers as it does not include gender specific expressions of depression (Carlberg et al., 2018). Hence, it is probable that new fathers who took lower scores from BDI could have experience depressive symptoms necessitating clinical intervention. Thus, to increase true positives in the data, we decided to conduct semi-structured interviews with fathers who received a BDI score 15 and above.

Among 232 fathers, 26 of them had 15 and above from BDI, with a minimum score of 15 and maximum score of 40 (*M*=21,38, *SD*=6.57). Two participants were excluded since they did not meet the eligibility criteria (e.g., having a new-born with health complications, having a mental diagnosis), while nine participants rejected to participate in semi-structured interviews. Further, 3 fathers were excluded because of the age of the infant (11 month), and the age of the fathers (42 and 44). As a result, 12 fathers were eligible for the semi-structured interviews. Since the data saturation was achieved and the data started to repeat itself during the analysis, recruitment phase had been terminated. The mean age of the participants was 31, ranging between 27 to 36 (*M* = 31,58, *SD* = 3,26). All fathers were married, and their babies were their biological children from those marriages. Half of the fathers have 1 child and the rest have 2 children. 8% of the participants described their SES as extremely low (*N*= 1), 8 % as low (*N* = 1), 25 % as medium (*N* = 3), and 58 % as high (*N* = 7). 75 % participants had educated beyond high school (*N* = 9). All of the participants were employed. One father was officially diagnosed with depression by a mental health professional. None of the participants had any mental health diagnosis except

for depression. None of the infants have a concurrent physiological health problem. Socio-demographic characteristics of the participants can be seen in the Table 1.

*Table 1.* Socio-demographic characteristics of the participants in the qualitative study

| **Variable** | **f** | **%** | **M** | **SD** | **Range** |
|---|---|---|---|---|---|
| **Gender** | | | | | |
| Female | | | | | |
| Male | 12 | 100 | | | |
| **Age** | | | 31,58 | 3,26 | 27-36 |
| **Marital Status** | | | | | |
| Married | 12 | 100 | | | |
| Divorced | | | | | |
| Single | | | | | |
| **Educational Level** | | | | | |
| High School | 3 | 25 | | | |
| University | 4 | 33,3 | | | |
| Master's Degree | 4 | 33,3 | | | |
| Doctoral Degree | 1 | 8,3 | | | |
| **Employment Status** | | | | | |
| Employed | 12 | 100 | | | |
| Unemployed | | | | | |
| **Monthly Income Level** | | | | | |
| 1500-2500TL | 1 | 8,3 | | | |
| 2500-3500TL | 1 | 8,3 | | | |
| 3500-5000TL | 3 | 25 | | | |
| 5000TL and above | 7 | 58,3 | | | |
| **Having a psychiatric history** | | | | | |
| Yes | 1 | 8,3 | | | |
| No | 11 | 91,7 | | | |
| **Infant's having a current health condition** | | | | | |
| Yes | 0 | 0 | | | |
| No | 1 | 100 | | | |
| **Infant's Age (Month)** | | | 5 | 1,3 | 3-7 |
| **Planned pregnancy of wife** | 12 | 100 | | | |
| **BDI score** | | | 22,4 | 7,78 | 15-40 |

### 3.1.3. Ethical Permission

Initial ethical approval was obtained from TED University Human Subjects Ethics Committee. Afterwards, researchers sent an official letter to Local Health Authority of Trabzon to receive legal and ethical permission for data collection. The same protocol was followed, and formal permission was obtained from Karadeniz Technical University Faculty of Medicine Farabi Hospital head physician's offices, as well. All of the aforementioned institutions gave permission for data collection.

The purpose of the study and the confidentiality issues were explained to the participants both verbally and in a written document. Participants were informed that they had right to withdraw from the study without an explanation. An additional approval was also obtained for the audio-recording of the interviews both verbally and in written format. In addition, participants' names and identity were kept confidential while giving quotations to illustrate results.

### 3.1.4. Procedure

Purposive sampling was applied to select appropriate candidates in consistent with the recruitment methods employed in IPA research (Smith, & Osborn, 2008). Criteria are determined in the light of the research interests. Having reached sufficient number of participants, data recruitment process was ended. Sample size depends on the aims and the resources of the researcher in IPA research (Howitt, and Cramer, 2008). Also, the idiographic nature of IPA research emphasizes importance of in-depth examination of small number of participants (Reid et al., 2005; Smith, & Osborn, 2008). Homogenous group refers to the people of similar experiences of a particular phenomenon which is being investigated (Willig 2008). Accordingly, pre-

assessment phase (BDI) was performed in the current study to choose participants with moderate to severe depression who are supposed to have similar experiences. Semi-structured interview is the most preferred form of the data collection in IPA studies since it perpetuates rapport, flexibility, and coverage (Smith, & Osborn, 2008). Also, conducting interviews with nondirective questions provides richer data without being restricted to preliminary hypothesis (Willig, 2008). Accordingly, 17 number of non-directive research questions were created based upon the basic principles of IPA.

The first study was performed through two stages in itself (i.e., pre-screening and semi-structured interviews, respectively). Firstly, an appointment was arranged with the health care practitioners in Paediatric and Gynaecology Clinics in Trabzon either via e-mail or phone. In the arranged appointments, the researcher informed physicians about the study protocol via an information form. Upon permission of the doctors, the researcher was present available in the hospitals for data collection during arranged time periods. Fathers of the new-borns were informed either by physicians or the researcher in the hospitals during their routine controls. Volunteered fathers were assisted by the researchers and were given informed consent form, demographic information form and Beck Depression Inventory (BDI) for the pre-screening stage. Before completion of the scales, written consent was obtained for participation. A quiet and confidential room was arranged for the completion of aforementioned scales. In addition to the face-to-face recruitment in Paediatric and Gynaecology Clinics, participants were also reached through social media platforms. Social media platforms (e.g., parenting groups, forums etc.) which were actively used by new parents were searched and moderators of those platforms

were contacted via a standardized e-mail. Online study recruitment announcement was sent to the moderators who decided to support our research by posting the announcement materials.

When participants clicked the link in the announcement, they were first required to sign the informed consent form. The form was prepared to identify participants meeting the eligibility criteria. In this form, participants were informed about the survey questions that they are supposed to fill out. Besides, they were asked whether they would be volunteered to take part in the online semi-structured interviews if they had met the inclusion criteria. Accordingly, volunteered fathers were asked to provide their e-mail addresses for further arrangements. In the pre-screening part, participants only completed Demographic Information Form and Beck Depression Inventory.

Having identified the fathers meeting the eligibility criteria, participants were further contacted via e-mail for their preferences for either face to face or online interviews. Before the interviews, an informed consent was provided, and a written consent was obtained both for participation and audio recording of the interviews. For face-to-face arrangements, interviews were conducted in meeting rooms of the hospitals depending on the availability or in any other place that confidentiality was guaranteed. Interviews were recorded by a voice recording device, but those records were only used for scientific reasons and identity of the participants were distorted. For online arrangements, informed consent form for semi-structured interviews was delivered through emails via “Qualtrics”. Date and time of the interviews were arranged with the participants who approved the conditions in the

inform consent form. Semi structured interviews were performed via an online communication tool called “Skype”. Skype is one of the most preferred application in online psychotherapy and health consultation services on the basis its data privacy and confidentiality policy (Online Therapy Institute, 2013; Hawker, & Hawker, 2016). Participants were reminded about optimal technical and practical conditions necessary for Skype interviews both via consent form and a separate e-mail. Participants were expected to meet some technical conditions as indicated in the informed consent form: These conditions are: (1) Being alone in a private room, (2) Having optimally qualified internet connection that minimized the risk of connection cut-off, and (3) Being in a room which was quiet and sound-proof as much as possible.

The researcher also conducted the meetings in a room that met the aforementioned conditions in terms of privacy and confidentiality. Moreover, participants were informed that sessions would be audio recorded. Recordings were kept in the researchers’ computer and protected by an encrypted program. In both face to face and online arrangements, semi-structured interviews ranged between 41 and 122 minutes, with an average of 64 minutes.

### 3.1.5. Data Analysis

Obtained data was analysed by Interpretative Phenomenological Analysis (IPA) to identify main themes representing depressive experiences of new fathers. Interviews were audio -recorded and were transcribed verbatim by the researcher (Usta). The transcripts were re-read several times by the researchers to become familiarized with the data. Additionally, the researcher’s notes about her observations regarding the

interviews, participants and her emotional impressions were also used during the conceptualization of themes. As consistent with the idiographic nature of the IPA (Howitt, 2010), each case analysed separately, and the analysis started with the first interview. For the first case, each meaningful unit of the participant's account were coded to construct sub-ordinate themes. Sub-ordinate themes that were related were used to develop more inclusive super-ordinate themes. Later, these themes were compared with the transcription to check whether they were valid reflections of the participant's account. After the analysis of the first case, this analytic process was conducted for each case one by one. Also, cross-case comparisons were performed between each case by the researchers until the super-ordinate and sub-ordinate themes reached their final format. Furthermore, for the credibility purposes, researchers (Usta, Ar-Karcı) analysed each transcript individually. After they created super-ordinate and sub-ordinate themes independently and later, they discussed the formation of recurrent themes together. Ultimately, the thesis advisor (Ar-Karcı) defined and formed the final shape of the master theme list.

### 3.1.6. Reflexivity

Qualitative researchers accept the subjectivity of the data (Morrow, 2005) and subjectivity is used as another source to increase the quality of the research (Platton, 2002). Accordingly, the researcher's own experiences and understandings were used while making sense of the participant's account. Thus, researcher's reflexivity while collecting, analysing and presenting data have great importance for the trustworthiness of the study (Willig, 2008; Patton, 2002). Reflexivity refers to the researcher's active and critical thinking of his/her position as a dynamic element in

the study (Howitt, 2010). In the light of this, researchers (Usta) had shared their personal and professional stance in relation to the topic investigated (Usta and Ar-Karcı).

“I am (Usta) a 26-year-old female psychologist, currently doing my master’s in Turkey. I was born in Trabzon, which is a patriarchal nationalist-conservative society. I used to live in Trabzon with my family until the age of 18. I am the only daughter, but I have 2 brothers. Family relations and kinship have great importance shaping living practises in the community that I have been raised in. Stereotypic gender-based role divisions were also greatly evident in my nuclear family although my mother has been working for years. I first encountered with the perspectives of traditional fatherhood in my early ages. My father used to work for long hours and used to come home around midnight. Thus, I could not spend time with him as much as my mother. Also, my father was the authority figure at our home resulting in an emotional distance. When I became 18, I moved Ankara to start the university. Ankara is a more secular city compared to Trabzon so I could meet with people having different perspectives. During this time, I had the opportunity to work with people from diverse ethnicities and socioeconomic backgrounds as part of my education and profession. All in all, seeing both conservative and secular geographies of Turkey provided me a more holistic perspective and empathic understanding about Turkish culture. My culture sensitive understanding helped me establish a strong rapport with the participants during the interviews and see the hidden meanings beneath father’s narratives. Apart from that, I used or showed my understanding through some religious or cultural phrases when appropriate (e.g., Karadenizlilik psikolojisi, inşallah) since such phrases were stated by the participants

during the interviews. I believe that this cultural relatedness provided genuineness between me and the fathers. During the data analysis and auditing, what I realized by the comments of my supervisor was (Ar-Karcı) that I usually tended to focus direct meanings in the narratives without contextualizing obtained accounts. During our discussions, I acknowledged that I should ask more exploratory questions and try to see the meanings beyond words during the interviews and while interpreting the narratives.

My thesis advisor, Assistant Professor Yagmur Ar-Karcı, is a clinical psychologist with a special interest on psychodynamic approach and also had expertise in qualitative research. She has been raised in a culturally conservative family where gender role divisions were highly apparent."

### 3.2. RESULTS

Four recurrent superordinate themes were identified according to the results of Interpretative Phenomenological Analysis across 12 cases. These themes were (1) motherhood as an idealised and overburdening phenomenon, (2) masculinity related pressures on fathers, (3) masculine expression of fatherhood related stress, and (4) compromisation of marital relationship (Table 2). Quotations were provided for each super-ordinate theme to enhance transparency of the results.

*Table 2*. Interpretative Phenomenological Analyses of Depressive Experiences of New Fathers During the Postpartum Period: Super-ordinate Themes.

| | |
|---|---|
| Theme I | **Motherhood as an Idealized yet Overburdening Phenomenon** |
| Theme II | **Masculinity Related Pressures on Fathers** |
| Theme III | **Masculine Expression of Fatherhood Related Stress** |
| Theme IV | **Compromisation of Couple Relationship due to Parenthood** |

### 3.2.1. Motherhood as an Idealized yet Overburdening Phenomenon

The first obtained theme was conceptualized as "motherhood as an idealized yet overburdening phenomenon". This super-ordinate theme indicated father's social and cultural attributions to motherhood, and how those attributions impacted on their positions in the family and their depressive experiences. Majority of fathers defined the bond between the mother and baby as "miraculous, indescribable, and divine", which, in turn, made them prioritize maternal needs. They believed that prioritizing mother's needs also enhanced baby's well-being. This was why they supported mothers and assumed responsibility to make them comforted. Nevertheless, prioritizing the needs of the mother and baby created an invisible barrier to express what they desired or needed. Thus, they preferred to inhibit their emotions not to overburden the new moms who had undergone profound biological and psychological changes. They also underlined that society only mentioned the difficulties that mothers experienced, dismissing the challenges faced by new fathers. To illustrate, Father 11 who had the highest depression score stated that:

> Fathers' situation is more critique than mothers. Yes, the mother goes through several biological changes, a very difficult process but the father experiences the troubles of that process, as well. I do not want to say that father is the over troubled or over-burdened, I do not want to say that. However, there is a perception that fathers do not do anything, mothers have all the burden… It is more common in our society… I think psychological process that fathers go through is far more difficult than mothers because they do everything that mothers want. They have to cheer up mothers regardless of how they feel. Also, they should not reflect their work-related problems at home, bla bla bla those kinds of things.

Interviewed fathers also stated that their wives' negative mood accentuates their depressive symptoms. This was the reason why they hide their negative emotions to boost the mental energy of their wives. Society's perception of parenthood seemed to create another barrier against new father's emotional expression, as well. They

somehow felt the pressure to remain happy as they had been sacred with a baby. For example, father 7 conveyed that:

> It was a challenging process for my wife regarding her mental health. Of course, this affected me automatically. You go and see a sad face, always crying, a person who is not happy and satisfied. Automatically, her unhappiness affects you. You became unhappy. Yet, I feel like we should not be unhappy. We cannot be unhappy in the phase of our life when we should be the happiest.

Several accounts indicated societal representation of motherhood put fathers in a position of being the sole supporter of the mother, rather than being the primary caregiver of the baby. Although they took as many responsibilities as they could, they stressed out their feeling as a secondary parent. The sense of feeling of "being secondary" or "isolated" were reinforced by the baby's preference for the mother especially in the first months following birth. According to the interviews, fathers believed that mother-baby bond develop earlier than father-baby bond which made them feel confused about their roles especially after the birth. One father, for example, stated that *"*I think father with a new-born does not do anything. I did not feel like doing anything. Of course, I love my baby, but you do not feel anything regarding fatherhood.". Similarly, participants 6 uttered that:

> It might be different in future, but I think it is not possible to compare being a mother and father at this stage. As working fathers, we have a very restricted time with the baby. Hence, the mother, especially if she does not work and has chance to spend more time with her baby, they share enormous amount of time… Consequently, fatherhood is abstract in this stage in terms of emotional connection.

In consistent with the idealized motherhood image, fathers also felt that their wives devalued their parenting skills. Accordingly, mothers seemed more prone to interfere with father's caregiving practices because they believed that they were the main caregiver, and they knew best for the baby. In relation to this, maternal dominance of caregiving activities perpetuated fathers' feelings of insecurity about their fathering

skills. To exemplify, father 12 stated that “mother is protective of her baby not only against father but also against everyone else…It burdens me that my wife does not show empathy because she takes care of children… I want her to open a space for me but this does not happen”. Interestingly, mother’s lack of appreciation for father’s caregiving created a threat for new father’s masculinity. Some fathers expressed their “wish to be a better husband and father” and felt desperate due to lack of emotional and material sources they could have provided for their wives and children. Besides, interviewed fathers stated that even though they sacrificed a lot; mothers were not satisfied even with the simple tasks of “changing diapers”. Thus, fathers themselves felt doubtful about what they could or could not do while providing care for their babies. To illustrate, father 10 conveyed that “I think I do not have big problems, but we should ask this to my wife. Although I take good care of my children, we share something together; my wife always think that I do not take care of them enough. However, it is obvious that the time I spend with my children is limited due to my job”.

Although all fathers accepted the enormous responsibilities that new mothers had assumed, some fathers had a tendency to devalue “divine position of motherhood” through undermining feminine roles. They described their wives as “fragile and weak” who needed a male figure for emotional and physical stamina. In other words, societal representation of fragile motherhood appeared as a shelter for father’s fragile masculinity:

> In truth (i.e., Vallahi), I should say that a child is not raised by only one person, it is raised by a couple. Thus, both parties should take responsibility of the child’s developmental process. For example, changing diapers… Nasal obstruction is very common among new-borns. Ladies (i.e., Bayanlar) cannot blow it enough since it is required a lot of strength.

### 3.2.2. Masculinity Related Pressures on Fathers

The second superordinate theme was titled “masculinity related pressures on fathers” covering unique concerns of fathers imposed by gender roles. It seems that new moms and dads had differential concerns regarding well-beings of the new-borns. Interviewed fathers’ concerns mainly centred around economic stability and protection of their children. Fathers had worries about guaranteeing the future of their infants and providing sufficient material source. Although some of the mothers continued their jobs, fathers still perceived themselves as mainly responsible for the economic decisions of the family. Some fathers also stated that their anxiety was provoked by the current socio-economic situation of Turkey. They continually thought about whether they would be able to provide good enough education opportunities for their babies:

> I think the biggest problem about fatherhood is responsibilities. Let us say the pressure of the responsibilities of both the baby and the mother… Of course, you had responsibilities when you were married but it increases dramatically after the child. Inevitably, you started to have questions and anxiety about future.

Similarly, Father 11 explained that:

> Unfortunately, in the current condition of our country, the first responsibility is economic because everyone wants to buy the best for their children, of course everyone wants. Secondly, pitiably, even in the garden of primary schools in Turkey, there are drug dealers with an increasing trend. People think how they can protect their children.

Although interviewed fathers defined themselves as egalitarian by saying “this baby is ours so we should take care of the baby together with my wife”, they still expressed their reluctance to perform “womanly tasks”. Fathers were prone to label some caregiving activities or house chorus as “womanly tasks” and they did not want outsiders to know that they were performing those tasks. Consistently, they reflected

their preferences for so called masculine caregiving practices such as being economic provider, supplier and entertainer. To exemplify, Father 4 compared the hardship of vacuum cleaning with the war by saying that "If you asked me to fight in a war, it will not be that much of responsibility (he smiled), but I vacuum cleaned the house…There are some things that I do but I do not prefer to do. For example, let's say, windows are too dirty. I can clean them perfectly, but I cannot stand others seeing me, so I tell my wife to hire someone for cleaning."

Another problem that our participants associated with manhood was taking diverse responsibilities in different settings such as work, couple relations, child raising and house chorus. The sense of juggling among multiple responsibilities lead to the perception of feeling torn apart. They had the impression that working while parenting created a unique burden for men and women did not understand what fathers had been going through. Fathers did several sacrifices as they had to pursue their balancing role in the family while saving money for the house. Father 7, who was observed as exhausted, bored and aggressive during the interview said, "you have the weight of the world on your shoulders, and still you have been given more responsibilities". Similarly, father 12 who struggled with academic career, job, home and family responsibilities simultaneously stated:

> You push hard both mentally and physically. For example, when I return to home from work, I need to study, read articles, doing translations, writing the thesis. However, there is no time. Thus, I sleep after staying with my family until 11-12 p.m. Then, I wake up around 2 a.m. to write or read. It is one of the biggest problems, I work between 2-5 a.m. I sleep from 5 a.m. to 7 a.m. and wake up to go to work. It is this kind of a life cycle, so it is extra hard. Consequently, it makes me exhausted.

Furthermore, taking several responsibilities lead to ambivalent feelings among fathers. On the one hand, fathers stated their feeling of incompetency due to not

meeting the high demands of fatherhood. To exemplify, father 4 mentioned that his child asked him to read a story, but the father preferred to sleep. After that he expressed his sense of guilt by stating that: “I felt remorse. A story would have taken only 5 minutes”. Similarly, another father described this situation as “suffering under the burden (i.e., yükün altında ezilme)”. Nevertheless, few fathers also expressed feeling powerful as a result of accomplishing multiple tasks at the same time which can be attributed to the omnipotence of their masculinity. Throughout the interviews, they had a tendency to compare motherhood with being a father and came to the conclusion that fathers’ burden was much more evident due to completing several tasks both at home and work. They also had the assumption that men by nature were ascribed with power to undertake more responsibilities. Father 7, for example conveyed that:

> You have to be strong because of the fatherhood glory (i.e., babalığın şanı). Sometimes it happens to mothers, some other times fathers. However, in general, fathers take more responsibilities and do the sacrifices. It can be a wrong saying, it can be said that men and women equal, but I think men can take more responsibilities because it is on their genes.

### 3.2.3. Masculine Expression of Fatherhood Related Stress

We conceptualized our third super-ordinate theme as “masculine expression of fatherhood related stress”. This theme mainly refers to how fathers’ experience and expression of depressive symptoms had been influenced by cultural expectations centred around masculinity and fatherhood. As consistent with their depression scores, interviewed fathers underlined that they felt distressed, exhausted and a sense of meaninglessness. For example, a father with a previous history of depression expressed his current psychological state as:

> I cannot do the things that I want. Secondly, exhaustion, really it is. Thirdly, my hope for life is decreasing. I mean, I used to want to do some stuff before, but now I see doing them meaningless. I do not want to wake up in the morning because of tiredness… I go to work but I cannot focus.

Besides typical symptoms of depression, fatherhood related stress was also expressed in a more masculine and extraverted way among men in our study. Rather than underlining depressive emotions like sadness and hopelessness, majority of fathers used phrases like "stressed, aggressive/hostile (i.e. saldırgan, öfkeli), tense (i.e. darlanmış), overwhelmed (i.e. bunalmış), and impatient (i.e. sabır düşüklüğü)" while describing their depressive experiences. They felt restricted, overwhelmed, and distracted and usually used anger as a vehicle to express their distress. Some fathers also stated that their emotions were "volatile and unstable". Low tolerance and restriction of freedom were particularly identified as the root causes of their aggression which was later followed by a sense of guilt. For example, a moderately depressed father stated that "When I am tired, I overreact to my kids…Sometimes my patience is so low. I get angry those times but after that I feel regret".

It was also observed that fathers expressed their depressive experiences with ambivalent emotions and had difficulty to define their feelings. Almost all fathers, fathers wanted to escape from the pressure, but this wish made them feel guilty. They felt stuck between wish for an escape and missing their babies. An emotional loop was evident among the feelings of sadness, anger, wish for escape and guilt. To illustrate father 4 conveyed that:

> When I go to work, and I miss my children, I think that it was wrong to think in that way (while referring his wish for going out from home), it was a shame. Nevertheless, you think in that way when you felt overwhelmed. Sometimes I told my wife to cook pasta so I can go out to buy ingredients. Sometimes you just try to go somewhere outside.

Although they felt depressed, fathers underlined that they could not share their depressive feelings with anyone. Their accounts indicated that society expected fathers to stay strong for the unity of family. Thus, stereotypical gender-based roles seem to create an internal barrier for the identification and expression of negative feelings among new fathers. Our participants had the impression that they had to silence their feelings to empower their vulnerable wives. For example, father 6 stated: "I am an anxious person, but she (referring to his wife) is more anxious than me. I believe that it might make her more anxious, has a negative effect on her, so I do not reflect myself.". Similarly, father 9 who referred himself as "the head of the household (i.e., evin reisi)" expressed his efforts to show emotional stamina as follows:

> There is manhood psychology, Black Sea people psychology (i.e., Karadenizlilik psikolojisi; There is a cultural understanding among people who are from Black Sea region of Turkey, that they see themselves as strong, aggressive and impatient, and patriarchy is dominant) so these can be the main reasons. If I say I do not cry, it would be a lie, but nobody sees me while I am crying. I should stay strong in any case, should seem strong. I mean, if we are not strong how we can support our wives, our families? Hence, we should repress (i.e., içine atmak) everything. I speak for myself. We repress, we try to help as much as we can.

Moreover, fathers also highlighted their feelings of loneliness and isolation in their accounts. They usually refrained from sharing their emotions because they had the impression that "others cannot understand their pain". For example, father 11 expressed his desperation and loneliness due to holding back his emotions as follows:

> I isolated myself from all my friends. I became completely introverted after I got married. I used to be extraverted before, but now I turned inward. Of course, others, others' opinions, I can help sometimes... However, I know better what I am getting through now, when I tell something to people, I avoid telling things to others… You (referring to the interviewer) might be the first one. Even now I cannot tell easily, I

> hold myself back. It was happened first time, unexpectedly. Actually, I am relieving right now. I cannot talk these topics with others.

### 3.2.4. Compromisation of Couple Relationship due to Parenthood

Our last super-ordinate was conceptualized as "compromisation of couple relationship due to parenthood". All fathers highlighted a significant decrease in the quality of relationship they had with their partners after the arrival of baby. Although not stated explicitly, fathers seem to blame their partners for the compromised sexual intimacy. They believed that their wives lost the passion and declined their sexual gestures since motherhood became the centre of their lives. For example, father 1 who had previous marital problems and used to travel a lot due to his job said: "Can a person not kiss someone that he loved? I cannot kiss my wife for 2 years. She says, 'please I do not like kissing'." Another example came from father 12: "We (referring to himself and his wife) used to hang out more, now it is less. Our dialog was more qualified although she says it is as same as before. However, I think it was better before… The reason is that couples cannot spend enough time for each other after the birth. No time, no dialogue…" Not surprisingly, fathers believed parenting overshadowed their roles as partners. They had to prioritize parenting responsibilities and perceived the baby as the root cause of decreased marital closeness. For instance, father 10 told the impact of decreased of sexual intimacy on his wellbeing as follows:

> So, I can say it in this way: when the emotional connection decreases between parents, parents move away from each other's. I mean, instead of being husband and wife, they focus on the problems of the children…Of course I cannot say it makes me feel good. Same for her, we talk with her sometimes. How can I say… When the beds are separated, the level of toleration gets low.

Furthermore, some fathers admitted continuing their marriage because of their babies. For these fathers, the baby was the rescuer of the marriage helping them

tolerate negative behaviours of their partners. Although they did not carry any hope for the improvement of their relations, they tried to compensate their bad marriage through loving their babies:

> Actually, your child compensates your emotional starvation that you have lost with your wife. It is the case. Of course, there are some other good things. We play together, we play hide and seek. A person become happy while playing with his child, inevitably.

### 3.3. Discussion

In our study, we interviewed 12 new fathers with moderate to high depression to delineate their postpartum experiences. We analysed obtained data through Interpretative Phenomenological Analysis (IPA) and came up with four themes. These themes were (1) Motherhood as an idealized yet overburdening phenomenon, (2) Masculinity related pressures on fathers, (3) Masculine expression of fatherhood related stress, (3) Compromisation of couple relationship due to parenthood. The most obvious finding to emerge from our analysis is that experience and expression of depression among new fathers were greatly influenced by cultural norms and values centred around masculinity and fatherhood.

#### 3.3.1. Motherhood as an Idealized yet Overburdening Phenomena

The first theme of our study was “Motherhood as an Idealized yet Overburdening Phenomena”. Without exception, all fathers in our study described motherhood as a “divine and sacred” experience. They expressed gratitude and acknowledged the responsibilities that their wives had assumed for childcare. Nevertheless, this idealized motherhood image created unique pressures leading depressed fathers to undermine and conceal their own distress. As it is the case with most cultures

(Basnyat & Dutta, 2012; Bhambhani & Inbanathan, 2018; Makinde, 2004), motherhood is a highly valued experience in Turkey (Kağıtçıbaşı, 1982). Women's status increases when they become a mother and mother-child relation is defined as more intimate when compared to the father-child bond. Although this understanding has been under transformation due to implementation of more egalitarian values, the role differentiation between mothers and fathers is still quite sharp (Kağıtçıbaşı & Sunar, 1992). Having been defined as the breadwinner and supporter of the family (Boratav et al., 2014), interviewed fathers had a tendency to question importance of their psychological needs. Coupled with society's expectation from men about remaining strong (Latalova et al., 2014; Seidler 2016), they were compelled to prioritize new mom and baby's emotional needs. Depressed fathers also felt alienated as they felt excluded from the close bond between the mother and the baby. (Darwin, 2017). Since emotional duties of the fathers are poorly defined by the society, fathers also seemed to have difficulty understanding what is expected from them particularly in emotional domains (Edborg et al., 2016). As a result, fathers overlooked their own distress during postpartum period and prioritized the psychological needs of the family. These results accord with the existing evidence showing that psychosocial needs of new fathers are undermined not only in family context, but also in health care system and national policies (Fisher, 2017; Lindberg, & Engström, 2013; Salman-Engin, 2014; Trivedi, & Bose, 2020). Consequently, depressed fathers remain invisible only being perceived as a support person rather than a subject with unique needs during postpartum period (Lindberg, & Engström, 2013; Thomas et al., 2011). However, a note to caution is due here. Women's so-called idealized position as a mother is also riddled with several problems. Mothers are left alone with

overwhelming caregiving responsibilities and consequently suffer from several gender inequality problems in society (Dessalegn et al., 2020; Boratav 2021; Fauci & Goodman, 2020; Olga et al., 2020). Still, our study further supports existing findings showing that men are not free from problems of gender biases although they are still entitled to an advantaged position (Bracke et al., 2020; Sorj & Fraga, 2020).

Consistent with the existing findings, majority of the participants also expressed the father-baby bond developed relatively slower when compared with that of new mom and the baby. In other words, fatherhood become realized once fathers started practicing it (Dallos, & Nokes, 2011; Darvin et al., 2017). Interviewed fathers expressed their feelings of being 'pushed out' by the closeness between their baby and the mother. Feeling of this exclusion might be once again explained by the overvaluation of motherhood practises immediately after birth (Timurtürkan, 2020; Wardrop & Popadiuk, 2013).

Furthermore, interviewed fathers stated that they had been negatively affected by the psychological state of mothers. This was counted as another reason why new fathers preferred to enhance their partner's psychological state. In fact, this finding further supported the established relation between maternal and paternal postpartum depression. Accordingly, maternal postpartum depression is one of the strongest predictors of paternal depression (Goodman, 2004). Partners of depressed mothers during perinatal period reported feelings of anger, helplessness, fear, and confusion. Providing constant care to the depressed partner was associated with stress, despair and fatigue among new fathers (Goodman, 2008).

Some fathers conveyed that critiques of mothers regarding their parenting efforts created conflicting messages for them. Maternal interference on paternal involvement in caregiving was explained with the term “maternal gatekeeping” in the related literature. Maternal gatekeeping is a relational phenomenon that exist in the intersection of parental roles and gender-based expectations (Allen & Hawkins, 1999). Maternal gatekeeping behaviours that encourage fathers to take active role in parenting (e.g., complementing) are called as gate opening behaviours, while mothers’ acts discouraging fathers’ parenting practices (e.g., criticising) are called as maternal gate closing behaviours (Schoppe-Sullivan et al., 2008). It has been shown that maternal gate opening behaviours reinforce father involvement in caregiving practices. By contrast, maternal gate closing behaviours lead fathers to withdraw from coparenting (Fagan & Cherson, 2015; Olsavsky et al., 2020). In our study, fathers’ accounts revealed that mothers expected them to take active roles in house chorus and caregiving practises. Nevertheless, mothers wanted fathers to perform these activities in the way they themselves desired. Consequently, our fathers explained feelings of incompetence due to not being a good enough parent and seek consistent approval from their partners. In fact, mothers’ over-controlling behaviours might be accounted by the fact that motherhood is one of the few ways that women can exert control and power over their partners (Hauser, 2012). Still, maternal gate closing behaviours have a toll on fathers increasing risk for parenthood stress and paternal postpartum depression (Buist et al., 2003; Darwin, 2017).

Interestingly, fathers devalued and minimized the importance of maternal caregiving practices in order to cope with the feelings of inadequacy regarding their parenting practises. Consistent with the gender stereotypes studies (Eagly & Steffen, 1984;

Prentice & Carranza, 2002; Rudman et al., 2012; Sakallı et al., 2018), they described their partners as weak, anxious and indecisive while referring themselves as strong and brave. It seems that mother's dominant position during postpartum period created a threat to their status quo, which was followed by the devaluation of maternal efforts. Competitive and devaluating attitudes of fathers might also indicate an envious unconscious response to their partner's generative role (Bruno, 2020). Thus, fathers both respected the divine position of motherhood, while at the same time devaluing it through femininization.

### 3.3.2. Masculinity Related Pressures on Fathers

Consistent with the stereotypical duties associated with fatherhood (Gregory & Milner, 2011; Kosakowska-Berezecka et al., 2016; Valiquette-Tessier et al., 2019), our participants' distress and anxiety mainly centred around economic concerns and protection of their children. In fact, traditional father role has been under transformation since the 1970s (Pleck 2004). Fathers started to get involved with childcare and household chore activities more and had more intimate relations with their children (Craig 2006; Lamb et al., 2004). Nevertheless, internalizing and displaying more egalitarian behaviours happens at a slower pace (Williams 2008). Fathers are still viewed as helpers instead of primary caretakers and are given the responsibility of breadwinning (Haas & O'Brien 2010). Their caretaking activities mostly include entertaining the child (Craig 2006; Lamb et al., 2004). Consistently, being the economic provider of the family seemed to create a unique burden for the interviewed fathers, overruling pressures of other parental duties. These accounts of fathers were also parallel with the perception of the traditional father figure in

Turkish society (ACEV, 2017). Being a father necessitates "being a provider, protector, and earner" even when the mothers are also part of the working life. This might be the reason why economic and political condition of the country creates extra burden for our fathers. Accordingly, working conditions of Turkey which include longer working hours and/or lower salaries compared to Europe might have deleterious impact on new fathers' wellbeing (ACEV, 2017).

Contrasting with the more distant father figure, majority of fathers in the current study reported to show affection and compassion towards their baby and wife. According to their accounts, they took responsibilities about childcare and house chorus, as well. Yet, perceiving themselves as the sole provider of the family made it difficult to establish a balance between their work and family life. Consistent with the literature, they felt torn apart because of the irregular work shifts and economic pressures (Reddick, 2012; Zhao et al., 2020). Proposed work- family conflict can be explained by the scarcity hypothesis that suggests multiple competing roles can drain limited energy leading lead to emotional and physical strain (Goode, 1960; Froberg et al., 1986; Strazdins et al., 2013). Therefore, absence of work regulations regarding paternal leave seems be an external barrier resulting in exhaustion and distress among depressed fathers (Kim & Swain, 2007).

Although they seemed willing to take active roles in caregiving and housekeeping activities, interviewed fathers had a tendency to view those responsibilities as womanly tasks in that they were just "helping" their wives. Although men's narratives indicated employment of more egalitarian values in family, dilemmas and contradictions were evident in their discourses. They interpreted childcare and house

cleaning as feminine duties and did not want outsiders to know that they were performing those tasks. In that regard, these so-called feminine duties seem to create a threat for the masculine identity of interviewed men (Blazina and Watkins 2000; Maurer and Pleck 2006). In that regard, fathers in our study might feel stuck between the traditional and modernist father ideals as they were still in a process of societal transition. In fact, this finding is also consistent with the existing literature stating that gender hierarchy still remains as a norm in Turkey, despite moving towards a more egalitarian stance (Fisek 1991; Sunar, & Fisek 2005, Boratav et al., 2017). Consequently, the meaning of being a man, father, and husband in a contested territory resulted in uncertainty and contradictions for the new fathers (Boratav et al.,2014).

### 3.3.3. Masculine Expression of Fatherhood Related Stress

The most striking finding of the current study was that both experience and expression of depressive symptoms was qualitatively different than the typical representation of depression for new fathers. Rather than sadness, which is the most central feature of depression, new fathers expressed their hopelessness, anhedonia, and despair through anger, ambivalence, isolation and intolerance. Particularly, anger was used as an emotional vehicle to express sadness and exhaustion. They admitted showing sudden aggressive acts which was followed by the feelings of guilt. Although their depressive scores were significant, none of the fathers used the word "depression" to refer their emotional state. Instead, they described their feelings through distress, isolation, feeling stuck and being torn apart. These results provided support for the existing literature. Accordingly, experience and manifestation of

depression differs across genders due to gender role stereotypes (Addis, 2008; Martin et al., 2013). Men have a tendency to display male typical symptoms of depression including irritability, violence, somatic complaints, sleeping problems, loss of interest, anhedonia, tiredness, and emotional ambivalence (Cochran & Rabinovitz, 1999; Martin et al., 2013). As consistent with the masculine depression phenomena, anger, frustration, isolation, irritability and anxiety are the most common externalised ways indicating paternal postpartum depression (Addis, & Cohane, 2005; Cochran & Rabinovitz, 1999; Karam et al., 2016). Preference for such externalizing symptoms might be attributed to the masculine norms favouring emotional stoicism and invulnerability among men. In fact, this emotional state is also referred as "masked depression". Men are prone to display externalizing symptoms to express their sadness, since internalizing symptoms are feminized decreasing power of manhood (Addis, 2008).

Although men experience their depression in a masculine way, they inherently suffered from internalizing symptoms such as crying and sadness (Cochran & Rabinowitz, 1999; Martin et al., 2013). However, majority of the fathers did not express those feelings directly even to the interviewer. Additionally, it was observed that fathers had problems in both understanding and identifying their emotions. They usually had a tendency to describe ambivalent and unstable feelings to refer to the emotional fluctuations they were experiencing. The reason behind lack of emotional repertoire can be because internalizing depressive symptoms contradict with the masculine ideals of power (Seidler et al., 2016). Consequently, efforts of men to maintain the illusion of strength might reduce their likelihood of help-seeking behaviour. Coupled with prioritizing emotional needs of the family, pressures related

with manhood might lead paternal postpartum depression to remain as a hidden diagnosis. Consistently, only one father took professional support because of his depression. However, he was also a mental health professional which could be associated with his self-awareness. Other fathers did not aware of their depression and did not take any support despite having high scores on BDI. Also, fathers talked about their cognitive symptoms more readily (e.g., lack of concentration) in line with the existing literature (Darwin, 2017). In that respect, trying to attain masculine ideals seems to create an internal barrier for fathers to ask formal and informal support from others (Darwin, 2017; Seidler et al., 2016).

### 3.3.4. Compromisation of Couple Relationship due to Parenthood

Majority of fathers' narratives indicated that their marital relationship started to suffer particularly after the baby was born. Most men referred to the domination of parent roles as the cause of their impaired relationship. It seems that responsibilities associated with having a new-born decreased the quality time couples had with each other. These findings were in line with the previous studies indicating that parenting might compromise marital relationships affecting wellbeing of the partners in a negative way (Darwin, 2017; Edhborgh et al., 2016). Accordingly, poor quality relationship between partners is one of the main risk factors of depression both for mothers and fathers (Ramchandani et al., 2011). Interestingly, interviewed fathers had a tendency to blame their partners for the decreased intimacy. This might be because they believed their partner's personality had changed because of the motherhood status (Atkinson et al., 2020).

Fathers also reported that birth of the child damaged their sexual life. According to the literature, rates of sexual dysfunction during and after pregnancy is high among both men and women (Paulson et al. 2010). Changes of couple's sexuality might be the consequence of depressed mood and decreased sexual desire (Johnson, 2011). Despite these findings, participants in our study did not specify any sexual reluctance on their behalf. By contrast, fathers became disappointed by their partner's unwillingness. Interestingly, fathers believed that motherhood shadowed their partner's sexual desire. This perception might be related to the desexualized mother image created by the society. Motherhood is usually described with caregiving traits such as nurturance and compassion depriving women of any sexual attribute (Johnston & Swanson, 2003). In fact, this might explain why new fathers had the impression that their partners became desexualized. The same perception might also be valid for the new moms. Of course, their lack of desire might also be reinforced by the overwhelming responsibilities associated with motherhood (Rahmani et al., 2021). Also, maternal depressed mood creates a barrier for sexual intimacy as well. Depressed mothers might experience lack of sexual desire, low self-esteem and negative impressions about their body (Holopainen, & Hakulinen 2019).

In the current study, some fathers perceived the baby as the responsible from the emotional distance they had with their partners. This finding is also in accord with the related literature. Psychodynamic theories proposed that paternal postpartum depression might be resulted from narcissistic disturbances and envious unconscious reactions of fathers towards the generative roles of their partner (Bruno et al., 2020). Fathers do not establish a bodily link with their child given by pregnancy, birth and breastfeeding. Narcissistic tendencies can be expressed via fear of growing older or

fear of losing the attention of the partner. Consequently, fathers might perceive the baby as a rival and feel jealous towards it. Accordingly, perceiving the baby as the "scape goat" in the relationship can be interpreted as father's jealousy towards the baby.

### 3.4. Conclusion and Implications

The main goal of the qualitative study was to develop a frame for a valid and reliable tool to measure paternal depression level during the postpartum period. In this sense, the study had a unique contribution to the literature. Additionally, fathers in our study experienced additional burden due to their roles as a father that was assigned by traditional patriarchal values in Turkey. Accordingly, it seems vital to understand new fathers' depression from a cultural standpoint. Accordingly, the current study serves as the first qualitative research examining paternal postpartum depression experiences outside the Western context.

A note to caution is that parenting requires transition process that includes substantial life changes for both mothers and fathers. Gender inequality and gender-based norms shaping parenting roles and responsibilities create difficulties for both parties at the individual, familial and societal level. In this sense, it gains utmost importance evaluating the whole process from a gender-sensitive perspective by considering welfare of both mothers and fathers as interrelated family units. Consequently, the findings of the current study indicated the importance of couple relationship on fathers' psychological condition. Also, there is a dynamic relation between the father's psychological condition and those of the mother and the baby. Hence, each subsystem of the family (mother-child subsystem, couple subsystem) should be

regarded as a whole for research purposes and providing services. Furthermore, the current study provided a culturally sensitive perspective about possible risk factors and outcomes of paternal postpartum depression. In this regard, possible parenting interventions can be tailored in a way that is more inclusive for both parents integrating components aiming to combat with the negative impacts of gender assigned duties.

In addition, governmental policies or mental health care strategies should be tailored by aiming at gender equality and pay more attention to fathers in this sense. For example, parental leave might be longer for fathers in Turkey as appeared in European counterparts. In this way, parenting would be a forced choice for neither mothers and fathers; and equality in opportunity in the work setting would become more accessible (Cools et al., 2015). All in all, prevention, intervention and research should approach paternal postpartum depression by considering the transactions within and beyond family relationships from a gender and culture-sensitive standpoint.

### 3.5. Limitations

The current study was not without any limitation. Firstly, Beck Depression Inventory was used to identify fathers having moderate to high depression. Although it has been still widely used in the related literature to define samples with depressive symptomology, BDI cannot be used as a single measure to diagnose paternal postpartum depression. (Edhborgh et al., 2016; Wang, & Gorenstein, 2013). Thus, future studies can be conducted with clinical populations on the grounds of detailed psychiatric consultation and observation. Secondly, even though some fathers had

clinical depression (i.e., BDI scores above 25) (Hisli, 1989), severely depressed fathers might not be interested in taking part in the study as consistent with the nature of the depression. In fact, this might affect the generalizability of the results to the clinical populations. Thirdly, cultural beliefs about sexuality and family privacy created an internal barrier for some fathers to talk about their sexual life during the interviews. Thus, this might create a bias regarding the intimate life of the partners. Fourthly, cultural heterogeneity exists within and between different regions of the country. In fact, although we conducted our interviews with fathers who live in different cities in Turkey that could represent the impact of cultural mosaic of the country; fathers in our study generally had conservative-religious perspectives. In fact, this might be why externalized symptoms of depression like alcohol and substance abuse were not evident in our results. Hence, further investigation is needed with participants from diverse cultural backgrounds.

# CHAPTER 4

## 4. STUDY 2: DEVELOPMENT AND PSYCHOMETRIC VALIDATION OF AN INSTRUMENT MEASURING FATHERS' DEPRESSIVE SYMPTOMS DURING POSTPARTUM PERIOD

In this chapter, the research questions, methodology and findings of the quantitative study was presented in detail along with a theoretical and practical discussion. In fact, the second study contained two stages within itself. Initially, an instrument aiming to measure paternal postpartum depression was developed and tested for its psychometric properties. Secondly, an explanatory model was proposed based on the findings of the first qualitative study and relevant literature findings which was later tested by a moderated mediation analysis. According to proposed model, parenting stress (M1) and marital satisfaction (M2) were expected to mediate the relation between fathers' attachment style (IV) and paternal postpartum depression (DV). Also, we hypothesized that maternal depression (W) would moderate the relationship between both parenting stress and paternal postpartum depression, and marital satisfaction and postpartum paternal depression (See Figure 2). Specifically:

1. Fathers with insecure attachment would have lower marital satisfaction and higher parenting stress scores which would be associated with increased paternal postpartum depression.
2. The mediating impacts of parental stress and marital satisfaction on the relationship between father attachment and paternal depression would change depending on different levels of maternal postpartum depression scores.

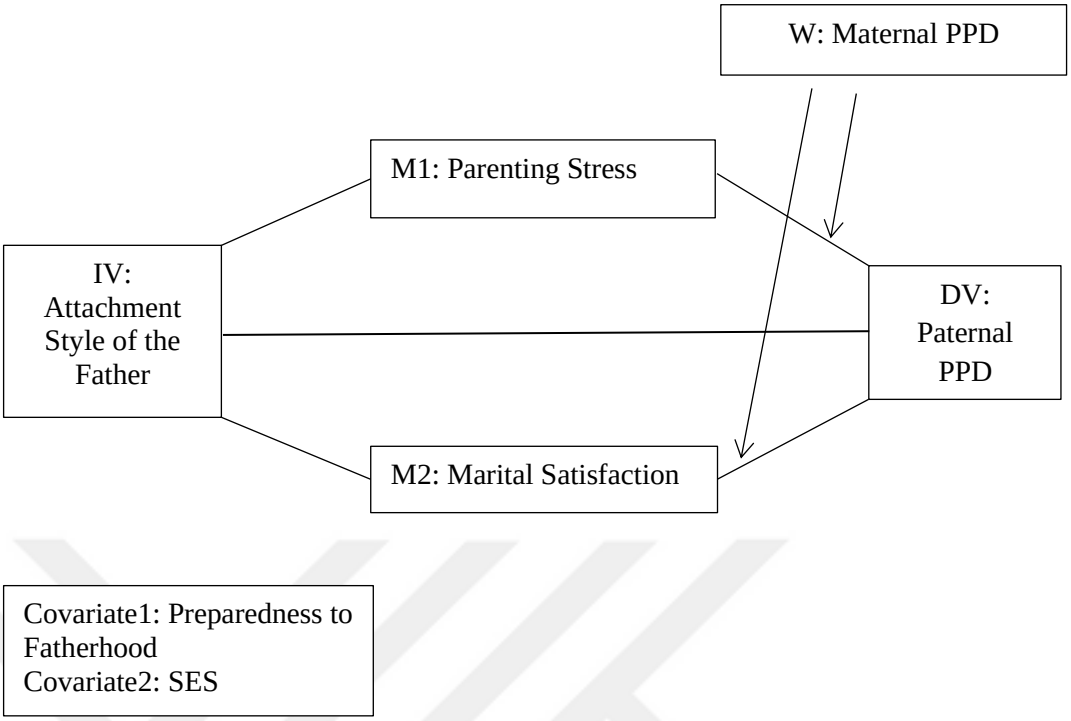


*Figure 2*: Proposed Moderated Mediation Model

## 4.1. Method

### 4.1.1. Participants

In this phase of the study, biological fathers and mothers of the new-born babies between 3-12 months were targeted. Participants were recruited through family health care centres, hospitals and social media platforms. In total, 324 mothers and 242 fathers had filled out the survey battery.

For the psychometric examination of the newly developed instrument measuring symptoms of paternal postpartum depression, data obtained from 242 fathers were inspected. Yet, 52 number of data excluded from the subsequent analysis because of outliers and missing values. All in all, 190 fathers composed of the participants of the psychometric validation stage. The mean age of the participants was 34, ranging

between 22 to 57 (*M* = 33,89, *SD* = 5,29). All of the fathers were married and 60,5 % of them had their first babies, the mean age of whom was 6 months (*M* = for the 6,21, *SD* = 0,20). Majority of the father were from middle SES and almost half of them had a university degree. Of 190 fathers, 6,3% of them suffered either psychiatric or medical health problems including panic attack, depression, hypoglycaemia, and hearth palpitations). New-borns of 11,1 % of fathers had complications during birth (*N*=21); and 22.6 % infants had compromised health after birth (*N*=43) (e.g., hepatitis, urinary system infection, anomalies etc.). Socio-demographic characteristics of the participants were presented in the table 3.

*Table 3.* Socio-demographic characteristics of the participants at psychometric validation stage.

| **Variable** | **f** | **%** | **M** | **SD** | **Range** |
|---|---|---|---|---|---|
| **Gender** | | | | | |
| Female | | | | | |
| Male | 190 | 100 | | | |
| **Age** | | | 33,89 | 5,29 | 22-57 |
| **Marital Status** | | | | | |
| Married | 190 | 100 | | | |
| Divorced | | | | | |
| Single | | | | | |
| **Educational Level** | | | | | |
| Primary School | 5 | 2,6 | | | |
| Secondary School | 19 | 10,0 | | | |
| High School | 51 | 26,8 | | | |
| University | 88 | 46,8 | | | |
| Master's Degree | 22 | 11,6 | | | |
| Doctoral Degree | 5 | 2,6 | | | |
| **Monthly Income Level** | | | | | |
| 1500TL and below | 9 | 4,7 | | | |
| 1500-2500TL | 11 | 5,8 | | | |
| 2500-3500TL | 49 | 25,8 | | | |
| 3500-5000TL | 43 | 22,6 | | | |
| 5000-7000TL | 35 | 18,4 | | | |
| 7000-10000TL | 25 | 13,2 | | | |
| 10000TL and above | 18 | 9,5 | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Having a psychiatric or physiologic history** | | | | | |
| Yes | 12 | 6,3 | | | |
| No | 178 | 93,7 | | | |
| **Having current psychiatric or physiologic problem** | | | | | |
| Yes | 8 | 4,2 | | | |
| No | 182 | 95,8 | | | |
| **Number of children** | | | | | |
| 1 | 115 | 60,5 | | | |
| 2 | 52 | 27,3 | | | |
| 3 | 15 | 7,9 | | | |
| 4 | 6 | 3,2 | | | |
| **Sex of the infant** | | | | | |
| Female | 75 | 39,5 | | | |
| Male | 115 | 60,5 | | | |
| **Infant's having a health condition after birth** | | | | | |
| Yes | 43 | 22,6 | | | |
| No | 147 | 77,4 | | | |
| **Infant's Age (Month)** | | | 6,21 | 0,20 | |
| **Infant's having a birth complication** | | | | | |
| Yes | 21 | 11,1 | | | |
| No | 169 | 88,9 | | | |
| **Planned pregnancy of wife** | | | | | |
| Planned | 158 | 83,2 | | | |
| Unplanned | 32 | 16,8 | | | |
| **BDI scores** | | | 6,63 | 6,59 | 0-30 |
| **EPDS scores** | | | 5, 06 | 4,35 | 0-20 |
| **PPDS scores** | | | 22, 79 | 25,90 | 8-35 |
| **SWLS scores** | | | 44,55 | 6,73 | 0 |

BDI: Beck Depression Inventory, EPDS: Edinburgh Postnatal Depression Scale, PPDS: Paternal Postpartum Depression Scale, SWLS: The Satisfaction with Life Scale

For the model testing part of quantitative study, both fathers and mothers' responses were considered. Initially, 242 number of father and 324 number of mother data had been obtained. Yet, 276 number of data was excluded from the subsequent analysis

due to incomplete responses or lack of mother-father data match. As a result, 145 father-mother dyads (290 participants in total) were included for the moderated mediation analysis.

Mean age of fathers was 34, ranging between 22 to 57 (*M* = 34,13, *SD* = 5,19). All of the fathers were married. Majority of the fathers had their infants as a first child and the mean age of the infants was the 6 months (*M* = 6,12, *SD* = 2,78). Almost half of the participants had a university degree (*N* = 70) and 7,6% of fathers had a history of either psychiatric or physical health problems (*N*= 11) (e.g., depression, palpitation etc.). Furthermore, 9,0 % of the infants had during (N=12) and 25,5% had after birth complications (*N*=37). Socio-demographic characteristics of the fathers can be seen from table 4.

As for mothers, mean age of the mothers was 30 ranging from 21 to 43 (*M* = 30,83, *SD* = 4,42). Majority of them had a university degree (*N* = 77) and 9,7 % of the mothers had current psychiatric or physiologic health problems (*N*= 14) (e.g., anxiety, depression, hypothyroid asthma). Edinburgh Postnatal Depression Scale (EPDS) scores of mothers ranged between 0 and 20 (*M* = 5,06, *SD* = 4,35). Socio-demographic characteristics of the mothers can be seen in the table 4.

*Table 4.* Socio-demographic characteristics of the participants at the model testing stage

| | Fathers | | | | | Mothers | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **f** | **%** | **M** | **SD** | **Range** | **f** | **%** | **M** | **SD** | **Range** |
| **Gender** | | | | | | | | | | |
| Female | | | | | | 145 | 100 | | | |
| Male | 145 | 100 | | | | | | | | |
| **Age** | | | 34,13 | 5,19 | 23-57 | | | 30,83 | 4,42 | 21-43 |
| **Marital Status** | | | | | | | | | | |
| Married | 145 | 100 | | | | 145 | 100 | | | |
| Divorced | | | | | | | | | | |
| Single | | | | | | | | | | |
| **Educational Level** | | | | | | | | | | |
| Primary School | 4 | 2,8 | | | | 4 | 2,8 | | | |
| Secondary School | 13 | 9,0 | | | | 10 | 6,9 | | | |
| High School | 36 | 24,8 | | | | 29 | 20 | | | |
| University | 70 | 48,3 | | | | 77 | 53,1 | | | |
| Master's Degree | 17 | 11,7 | | | | 18 | 12,4 | | | |
| Doctoral Degree | 5 | 3,4 | | | | 7 | 4,8 | | | |
| **Monthly Income Level** | | | | | | | | | | |
| 1500TL and below | 5 | 3,5 | | | | | | | | |
| 1500-2500TL | 10 | 6,9 | | | | | | | | |
| 2500-3500TL | 37 | 25,5 | | | | | | | | |
| 3500-5000TL | 28 | 19,3 | | | | | | | | |
| 5000-7000TL | 30 | 20,7 | | | | | | | | |
| 7000-10000TL | 22 | 15,2 | | | | | | | | |
| 10000TL and above | 13 | 9,0 | | | | | | | | |
| **Having a psychiatric** | | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **or physiologic history** | | | | | | | | | |
| Yes | 11 | 7,6 | | | | 17 | 11,7 | | |
| No | 134 | 92,4 | | | | 1128 | 88,3 | | |
| **Having current psychiatric or physiologic problem** | | | | | | | | | |
| Yes | 7 | 4,8 | | | | 14 | 9,7 | | |
| No | 138 | 95,2 | | | | 131 | 90,3 | | |
| **Number of children** | | | | | | | | | |
| 1 | 91 | 62,8 | | | | | | | |
| 2 | 39 | 26,9 | | | | | | | |
| 3 | 10 | 6,9 | | | | | | | |
| 4 | 5 | 3,4 | | | | | | | |
| **Sex of the infant** | | | | | | | | | |
| Female | 52 | 35,9 | | | | | | | |
| Male | 93 | 64,1 | | | | | | | |
| **Infant's having a health condition after birth** | | | | | | | | | |
| Yes | 37 | 25,5 | | | | | | | |
| No | 108 | 74,5 | | | | | | | |
| Infant's Age (Month) | | | 6,12 | 2,78 | | | | | |
| **Infant's having a birth complication** | | | | | | | | | |
| Yes | 13 | 9,0 | | | | | | | |
| No | 132 | 91,0 | | | | | | | |
| **Planned pregnancy of wife** | | | | | | | | | |
| Planned | 117 | 80,7 | | | | | | | |
| Unplanned | 28 | 19,3 | | | | | | | |
| **BDI scores** | | | 5,97 | 5,81 | 0-25 | | | | |
| **EPDS scores** | | | | | | | | 5, 06 | 4,35 | 0-20 |

BDI: Beck Depression Inventory, EPDS: Edinburgh Postnatal Depression Scale

### 4.1.2. Instruments

#### 4.1.2.1. Demographic Information Form

Two demographic information forms were developed by researchers both for mothers and fathers. Forms included questions regarding participants' age, gender, ethnicity, monthly income, duration of marriage and time of delivery of the last child. Father form also included questions aiming to gather information about before, during and after birth complications experienced by the new-born.

#### 4.1.2.2. Beck Depression Inventory (BDI)

BDI is a self-report questionnaire that includes 21 items measuring symptoms of depression (Beck et al., 1961; Beck et al., 1988). Participants are asked to rate their current emotional state on a 3-points Likert type scale format (e.g., 0 for "*I do not feel sad*"; 3 for "*I am so sad and unhappy that I cannot stand it*"). Higher scores indicate greater depression. While cut off score for moderate depression is 17, it is 30 for severe depression. BDI has high internal consistency for both psychiatric and non-psychiatric populations, coefficient alpha values ranging from .81 to .86. The scale was adapted to Turkish by Hisli in 1989. Turkish version of BDI showed moderate to high internal consistency ($\alpha$ = .74), while split- half reliability was reported as .80. BDI was filled by new fathers in both phases of the current project. The Cronbach alpha value of the scale was .83 in the current study. While it was used to determine moderate-to-severely depressed fathers in the pre-screening stage,

it was also filled out in the second quantitative phase for psychometric validation and model testing purposes.

#### 4.1.2.3. The Satisfaction with Life Scale (SWLS)

The Satisfaction with Life Scale (SWLS) measures global life satisfaction (Diener et al., 1985). It is a 7-point Likert type scale with five items (e.g., 1 for "*strongly disagree*"; 7 for "*strongly agree*"). Test-retest reliability of the scale was .85, while Cronbach alpha value was .97. Turkish adaptation of the scale was performed by Köker in 1991. Test-retest reliability of the Turkish version was .86, while Cronbach alpha value was .73 (Yetim, 1993). The Cronbach alpha value of the scale was .80 in the current study. SWLS was used to test construct validity of the paternal postpartum depression scale that was developed by the researchers. Hence, only new fathers filled out the scale in the second strand of the current project.

#### 4.1.2.4. Mother-Father Stress Scale (MFSS)

MFSS was originally developed to measure stress level of mothers and fathers in daily relations with their children **(**Özmen-Kaymak & Özmen, 2012). It is a 4-point Likert Type questionnaire (e.g., 1 for *"never";* 4 for *"always")* including 16 questions. Maximum score that can be received from the scale is 64 while the minimum score is 16. Higher scores indicate greater level of parenting stress. The original version of the scale is in Turkish. Cronbach Alpha value was reported as .85 while split half reliability was .82. In the current study, some expressions in the questionnaire were modified to capture fathers' experiences with new-borns. For example, "It is hard for me to make my child happy" was changed as "it is hard for

me to make my baby happy". The Cronbach alpha value of the scale was .87 in the current study. MFSS filled out by only new fathers in the second strand of the current research. Total scores were used to investigate the mediating role of parenting stress on the relationship between father's attachment styles and paternal postpartum depression symptoms.

#### 4.1.2.5. Dyadic Adjustment Scale (DAS)

DAS includes 32 items consisting of 4 factors, which are (1) Dyadic Satisfaction, (2) Dyadic Cohesion, (3) Dyadic Consensus and (4) Affectional Expression (Spainer, 1976). Items were answered on a 5, 6, or 7-point scale format for different sub-factors. Higher scores indicate perception of greater marital adjustment. Cronbach alpha coefficient for the entire scale was .96 and while the same value ranged between .73 and .94 for the subscales. Turkish version of the scale was also found to be reliable and valid. While Cronbach alpha value for the total scale was .92, split half reliability coefficient was reported as .86 (Fışıloğlu & Demir, 2000). For the current thesis Marital Satisfaction subscale was used to measure marital satisfaction. This subscale had the highest reliability scores with the value of .83 among other subscales (Fışıloğlu & Demir, 2000). The Cronbach alpha value of the Marital satisfaction subscale was .82 in the current study. Marital satisfaction subscale was filled out only by new fathers. Scores were used to investigate mediating role of marital satisfaction on the relationship between father's attachment and paternal postpartum depression.

#### 4.1.2.6. Edinburgh Postnatal Depression Scale (EPDS)

EPDS includes 10 items which are responded on a 3-point Likert type format. Greater scores reflect higher levels of depression. Clinicians suggested that scores above 15 indicate clinical post-natal depression. Cronbach alpha value for the original scale was .87. Turkish adaptation of the scale was conducted by Engindeniz et al. (1996). Internal consistency was reported as .79, while split half reliability was .80 for the Turkish version. In the current project, EPDS was filled out by both fathers and mothers. Data obtained from fathers were used to investigate construct validity of the newly developed paternal postpartum scale. Mothers' scores were utilized to investigate both construct validity of the new scale and moderating effect of maternal depression on the proposed moderated mediation model.

#### 4.1.2.7. Experiences in Close Relationships-Revised (ECR-R)

ECR-R was developed to measure attachment styles of the adults (Fraley et al., 2000). The scale includes 18 anxiety items (i.e., "*I'm afraid that I will lose my partner's love*") and 18 avoidance items (i.e., "*I prefer not to show a partner how I feel deep down*"). ECR-R is a 7-point Likert type scale. Test-retest reliability of the scale was calculated as .95 for avoidance dimension, while the same value was reported as .94 for anxiety dimension. Turkish adaption of the scale was conducted by Selçuk and his colleagues (2005). Test-retest reliability of the Turkish version was .82 for anxiety dimension and .81 for avoidance dimension. Besides, Cronbach alfa coefficients were .90 for anxiety and .86 for avoidance items. ECR-R was only filled out by new fathers in the second strand of the study. Obtained scores were used to test proposed mediation model and measure independent variable of the model.

#### 4.1.2.8. Preparedness to Fatherhood Form (PFF)

PFF was constructed for the current study in order to measure the level of preparedness of for fatherhood and parenting. It consists of 5 items answered on a 4 point Likert type scale. Scores obtained from PFF was used as covariate variable in the proposed moderated mediation model.

#### 4.1.2.9. Paternal Postpartum Depression Scale

Paternal Postpartum Depression Scale (PPDS) was developed by the researchers within the scope of this thesis. Items of PPDS were constructed and tested for psychometric properties following the guidelines proposed by DeVellis (2017). These steps mainly involved (1) theoretical definition of the interest construct, (2) reviewing the relevant literature and existing scales measuring the same or similar constructs, (3) generating an item pool, (4) specification of the items and scale format, (5) reviewing the items' relevancy and quality with an expert panel, (6) reduction of the item pool and tailoring the scale based on experts' feedbacks, (7) testing the scale, and (8) reliability and validity assessment of the scale.

In this regard, paternal postpartum depression literature and the properties of existing scales for the postnatal depression had been reviewed extensively. Additionally, semi-structured interviews were conducted with 12 fathers with new-born babies who had either moderate or high depression to delineate their depressive experiences during postpartum period. The interviews were transcribed verbatim and obtained data was analysed with IPA (Please see Chapter 3 for detailed information). In the light of these interviews, general conceptual themes reflecting experiences of fathers with postpartum depression were identified. The most reoccurring themes were used

to construct a baseline for the items of the questionnaire. Later, a question pool was constructed by the researchers considering both general themes in the narratives and the paternal postpartum depression literature. Particularly, sub-themes of "Masculine Expression of Fatherhood Related Stress" super-ordinate theme and existing literature findings were used as a reference point while generating our items. Accordingly, items covering symptoms of emotional fluctuation, anger/hostility, tension, isolation/alienation, pressure due to multiple responsibilities and emotional inhibition had been written by the research team. Although alcohol and substance misuse did not emerge as a theme in the qualitative part, some questions covering these symptoms were also added to the item pool taking into consideration the existing literature (Misri 2018; Singley & Edwards, 2015). Finally, questions representing the typical symptoms of depression (e.g., sadness, despair etc.) were also addressed in order not to miss commonly manifested depressive symptoms.

After finalizing the first template, items were evaluated by two Turkish literature instructors for grammar and wording check. After that, researchers sent the first template to three clinical psychologists to ask their feedbacks with regard to content and specification of the items. In particular, these professionals were asked to (1) give their professional opinions about each question, (2) rate the item relevancy and (3) provide suggestions for the individual items and total scale. The scale was finalized by the research team taking into consideration the feedbacks and scorings received from the expert panel. This scale was only distributed to fathers to inspect psychometric properties and later to be used to measure dependent variable in the proposed model.

### 4.1.3. Procedure

Before application of any procedures, initial ethical approval was received from TED University Human Subjects Ethics Committee. After that, official permissions were also obtained from Local Health Authority of Trabzon, Public Health Centres Authority in Ankara and Trabzon, and Karadeniz Technical University Faculty of Medicine Farabi Hospital. The official permissions were received from these public institutions to recruit parents during their routine controls in Gynaecology departments, Paediatric clinics, and family health care centres.

Mothers and fathers were initially informed by the health personnel or the researcher about the study procedures. Later the announcement text with survey link was shared email with couples who agreed to take part in the study. Additionally, possible participants were also reached through online platforms targeting new parents. Moderators of these platforms was sent a standardized e-mail to ask their support for data collection. Upon the permission of moderators, recruitment announcement and a poster were sent to the moderators to be posted in the target online platform. Also, recruitment announcement was shared via Facebook, Instagram and Twitter by the researchers. New mothers and fathers were asked to fill out survey battery via Qualtrics. Separate web-links were created for both mothers and fathers. Completion of the survey battery took approximately 30 minutes for fathers and 10 minutes for mothers.

To test hypothesis of the current study, data obtained from mothers and fathers should have been paired prior to data analysis. Thus, partners were asked to create a nickname that did not reveal their identity. In order to create this nickname, fathers

were asked to write the last two letters of their name, birth year of their partners and the first letter of the name of their new-borns, respectively. Similarly, mothers were asked to write the last two letters of their partner's first name, their own birth year and the first letter of the name of their new-born, sequentially. For example, if the name of the father was Ahmet; the birth year was 1980, the name of their new-borns was Ayşe; the nickname was created as "et1980a". Nickname creation process was explained in detail with an example in the informed consent form.

The study was continued with the couples who accepted to participate to the study by clicking on "I *agree*" option and created a bogus name. Beck Depression Inventory, Edinburgh Postnatal Depression Scale, Satisfaction with Life Scale, Mother-Father Stress Scale, Dyadic Adjustment Scale, Experiences in Close Relationship-Revised Scale, Preparedness to the Fatherhood Form, newly developed "Paternal Postpartum Depression Scale" and demographic information form were given to the fathers. Edinburgh Postnatal Depression Scale and demographic information form were filled out by mothers. Questionnaires were given in a randomized order for counterbalancing.

The survey links for mothers and fathers were presented in the study recruitment announcement forms as it was mentioned before. When one parent had completed the survey, the link for his/her partner was presented on the screen once again for sharing. In addition, partners were also informed that they could either complete the survey simultaneously by clicking their own links or at separate times. This information was provided to the participants in detail on the consent form, as well. Also, the contact information of the researchers was shared with the participants, and

they were thanked for their participation. Finally, participants who had clinical depression were referred to the psychiatric clinics of public hospitals.

### 4.1.4. Data Analysis

Prior to performing any statistical analyses, the basic assumptions of the data were evaluated in terms of data entry, outliers, collinearity, residual statistics, distribution of errors, and homoscesdacity. To pursue this aim, several regression analyses were conducted through SPSS. Participants who did not fill out the forms were initially eliminated from the data set. Also, outliers were identified through case wise diagnostic table. Listed responses was deleted from the data pool and the analysis was rerun. Residual statistics value was in between -3 and +3, Cook's distance was below 1, homoscedasticity was in between -3 and +3, VIF value was higher than 3 and errors were normally distributed. Thus, all of the assumptions had been met.

In order to test, whether our scale have the theoretically predicted associations with father's attachment style, parenting stress, marital satisfaction and maternal postpartum depression, a moderated mediation analysis was performed by using PROCESS software version 3.5.3 (2021) on SPSS. Specifically, the model 14 was used to test the model (Hayes, 2017). The effects of father's preparedness to parenthood, and socioeconomic status were controlled. Attachment style of the father added to the model as Independent Variable and paternal postpartum depression added as Dependent Variable. Parenting stress and marital satisfaction included as Mediators and maternal postpartum depression was treated as the Moderator. Preparedness to fatherhood scores and SES added to the model as covariates. Calculation based on 10.000 bootstrap samples was used. The confidence interval for

the index of moderated mediation was the criteria for the significance of the model (Hayes, 2017). Specifically, the effect was taken as statistically significant in the condition of the confidence interval did not include zero. In parallel with this, having p values below .05 was another criterion for the statistical significance for the effects. It should be noted that data for psychometric validation and model testing were collected simultaneously as the sample of the current project was difficult to reach because of the bureaucratic procedures in Turkey.

## 4.2. Results

### 4.2.1. Psychometric Validation of the Paternal Postpartum Depression Scale

Principal component analysis using oblimin rotation was performed to investigate the factor structure of PPDS and the loading of the items to the corresponding factor(s). A Kaiser-Meyer-Olkin (KMO) value of 0.93 and Bartlett's sphericity test ($\chi 2=4836$, $df=703$, $p<0.0001$) indicated that the data was suitable for performing exploratory factor analysis.

In order to decide the factor structure of PPDS, factors with an eigenvalue above 1 were identified, and elbows in the scree plot were evaluated. According to these two indicators, PPDS had an initial 6-factor structure explaining 63.62% of the variance (Table 5). In order to check for the 6-factor structure, parallel analysis was further performed via the script developed by O'Connor (2000). Eigen values obtained from parallel analysis and exploratory factor analysis was compared resulting in a 3-factor structure (Table 5).

Upon examination of the obtained 3 factors, it was decided to reconduct the analysis with two factors due to theoretical reasons. As indicated in the literature, the theoretical baseline of the interest construct should also be taken into account in addition to statistical reasoning while determining the number of sub-factors (Carpenter 2017; DeVellis, 2012). Accordingly, factor loadings and theoretical convergence of each factor was compared through EFA for both 2 and 3 factor structure. As a result, it was observed 2-factor structure was theoretically more sensible and provided a more comprehensive picture of paternal postpartum depression symptoms. According to that, 2-factor structure of the scale was also consistent with the postpartum depression literature suggesting that fathers might experience not only depressive symptoms but also fatherhood related distress during postpartum period (Carlberg et al., 2018; Zierau et al., 2002).

Consequently, Principal Component Analysis using oblimin rotation was conducted with fixed number of factors, and the factors were extracted to two. After that, number of items was reduced based on factor loading magnitudes (loadings below .32), cross loadings, communalities of the variables (below.30) and theoretical convergence (Carpenter, 2018). Having eliminated the items based on aforementioned criteria, the same statistical procedure was followed. Accordingly, a Kaiser-Meyer-Olkin (KMO) value of 0.92 and Bartlett's sphericity test ($\chi 2=3350$, $df=703$, $p<0.0001$) results showed once again that the data was suitable for EFA and the 2-factor structure explained 53.47% of the variance. All in all, two factors were conceptualized as (1) paternal depressive symptoms, and (2) pressures related to fatherhood. Factor loading values were in significant loading magnitude levels (Carpenter, 2018) and none of the items were cross loaded (Table 6).

*Table 5*: Eigenvalues obtained by exploratory factor analysis and parallel analysis

| **Factors** | **Eigenvalue obtained by factor analysis** | **Eigenvalue obtained by parallel analysis** | **Eigenvalue obtained by factor analysis with 2 factors** | **Decision** |
|---|---|---|---|---|
| Paternal depressive symptoms | 15,71 | 1,97 | 15,71 | Accepted |
| Pressure related fatherhood | 2,43 | 1,84 | 2,43 | Accepted |
| Factor 3 | 1,84 | 1,75 | | Declined |
| Factor 4 | 1,50 | | | Declined |
| Factor 5 | 1,42 | | | Declined |
| Factor 6 | 1,25 | | | Declined |

*Table 6:* Results of the Exploratory Factor Analysis for PPDS

| **Pattern Matrix[a]** | | |
|---|---|---|
| **Items and Subdimensions** | **Factor 1** | **Factor 2** |
| **Paternal Depressive Symptoms** | | |
| 1. Bebeğimiz doğduğundan beri kendimi mutsuz hissediyorum. | ,870 | |
| 2. Bebeğimiz doğduğundan beri kendimi tükenmiş hissediyorum. | ,823 | |
| 3. Bebeğimiz doğduğundan beri içimde bir boşluk hissediyorum. | ,821 | |
| 4. Bebeğimiz doğduğundan beri öfkemi kontrol etmekte zorlanıyorum. | ,796 | |
| 5. Bebeğimiz doğduğundan beri ne yaparsam yapayım duygusal olarak rahatlayamıyorum. | ,789 | |
| 6. Bebeğimiz doğduğundan beri çevreme eskisine kıyasla daha agresif tepkiler verebiliyorum. | ,782 | |
| 7. Bebeğimiz doğduğundan beri kendimi kontrol etmekte zorlanıyorum. Ani ve beklenmedik tepkiler verebiliyorum. | ,771 | |
| 8. Bebeğimiz doğduğundan beri öfkeli çıkışlarım oluyor. | ,767 | |

| | | |
|---|---|---|
| 9. Bebeğimiz doğduğundan beri kimsenin beni anlayamayacağını düşünüyorum. | ,757 | |
| 10. Bebeğimiz doğduğundan beri, kendimi yalnız hissediyorum. | ,753 | |
| 11. Bebeğimiz doğduğundan beri kendimi sıkışmış hissediyorum. | ,735 | |
| 12. Bebeğimiz doğduğundan beri, yaşadığım sıkıntılar karşısında tahammülüm azaldı. | ,711 | |
| 13. Bebeğimiz doğduğundan beri kendimi yaşlanmış hissediyorum. | ,659 | |
| 14. Bebeğimiz doğduğundan beri kendimi eskisine göre daha gergin hissediyorum. | ,644 | |
| 15. Bebeğimiz doğduğundan beri kendimi gelecekle ilgili umutsuz hissediyorum. | ,622 | |
| 16. Bebeğimiz doğduğundan beri beni yatıştıracağını düşündüğüm maddeleri (alkol, sigara vb.) daha çok kullanıyorum. | ,612 | |
| 17. Bebeğimiz doğduğundan beri kendimi rahatlatmak için daha çok veya daha az yemek yiyorum. | ,579 | |
| 18. Keşke bebeğimiz doğmadan önce hayallerimi gerçekleştirmiş olsaydım. | ,547 | |
| 19. Bebeğimiz doğduğundan beri, evdeki sorumluluklarımdan bunalmış hissediyorum. | ,543 | |
| 20. Bebeğimiz doğduğundan beri ani duygu dalgalanmaları yaşıyorum. | ,534 | |
| 21. Bebeğimiz doğduğundan beri duygularım oldukça değişken. Örneğin, bazen mutlu hissederken sonra hüzünlü hissedebiliyorum. | ,526 | 0.36 |
| 22. Bebeğimiz doğduğundan beri olumsuz duygularımı kendi içimde yaşıyorum. | ,497 | |
| **Pressures Related to Fatherhood** | | |
| 23. Bebeğimiz doğduğundan beri kendimi birçok sorumluluk arasında sıkışmış hissediyorum (örn., iş, bebek bakımı, ev sorumlulukları vb.) | | ,590 |

| | |
|---|---|
| 24. Bir baba olarak, eşimin ve bebeğimizin ihtiyaçlarına öncelik vermek zorunda hissediyorum. | ,588 |
| 25. Bebeğimiz doğduğundan beri iş ve aile sorumluluklarını (örn, bebek bakımı, eşime destek olma) eş zamanlı yerine getirmeye çalışmak beni yoruyor. | ,585 |
| 26. Kendi ihtiyaç ve isteklerimi ailem için feda ediyorum. | ,538 |
| 27. Bebeğimiz doğduğundan beri, eşime karşı daha hassas davranmam konusunda üzerimde bir baskı hissediyorum. | ,464 |

Extraction Method: Principal Axis Factoring.
Rotation Method: Oblimin with Kaiser Normalization.

a. Rotation converged in 5 iterations.

#### 4.2.1.1. Construct Validity of the PPDS

In order to examine the construct validity of PPDS, correlation values were calculated among Paternal Postpartum Depression Scale (PPDS), Beck Depression Inventory (BDI), Edinburgh Postnatal Depression Scale (EPDS) and The Satisfaction with Life Scale (SWLS) (Table 7). Accordingly, correlations between the sub-factors and total scores of PPDS was between 0.68 and 0.97, while the correlation coefficient between "Paternal Depressive Symptoms" and "Pressures Related to Fatherhood" subdimensions was 0.51. Total PPDS scores also showed a strong negative correlation with life satisfaction scores ($r$ = -.32, $p$<.001in line with the existing findings (Fergusson et al., 2015; Güney et al., 2010). As expected, PPDS showed significant moderate correlations with BDI ($r$ = .*66*, $p$<.001) and EPDS ($r$ = .68, $p$<.001). This moderate correlation was theoretically sensible as BDI and EPDS were criticized for not capturing masculine expression of depression in postnatal period (Carlberg et al., 2018; Madsen & Juhl, 2007).

*Table 7*: Correlations between PPDS subdimensions and other scales

| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1.PPDS Total | | ,978** | ,686** | ,664** | ,687** | -,320** |
| 2. Paternal Depressive Symptoms Subscale | | | ,518** | ,650** | ,671** | -,326** |
| 3. Pressures Related Fatherhood Subscale | | | | ,454** | ,475** | -,172* |
| 4. BDI | | | | | | -,347** |
| 5. EPDS | | | | | | |
| 6.SWLS | | | | | | |

*p<0.05, **p<0.001. PPDS Total: Paternal Postpartum Depression Scale. BDI: Beck Depression Inventory. EPDS: Edinburgh Postnatal Depression Scale. SWLS: Satisfaction with Life Scale

#### 4.2.1.2. Reliability Analyses

In order to establish the internal consistency for the overall PPDS and its subscales, Cronbach's alpha values were calculated. Results indicated that internal consistency coefficient was 0.94 for the total scale, .95 for the Paternal Depressive Symptoms Subscale and .75 for the Pressures Related to Fatherhood Subscale (Table 8). Also, the the split-half reliability of the scale was calculated as .88. These values indicated that the scale had sufficient internal consistency (DeVellis, 2012).

*Table 8*: Reliability for PPDS and subscales

| | Min | Max | Mean | Cronbach's alpha |
|---|---|---|---|---|
| PPDS Total | 0.48 | 2.94 | 1.06 | 0.94 |
| Paternal Depressive Symptoms Subscale | 0.48 | 1.28 | 0.85 | 0.95 |
| Pressures Related Fatherhood Subscale | 1.49 | 2.94 | 2.00 | 0.75 |

PPDS Total: Paternal Postpartum Depression Scale.

### 4.2.2. Testing the Moderated Mediation Model

#### 4.2.2.1. Preliminary Analyses

Prior to the main analyses, bivariate correlations among all variables of the proposed model were tested through SPSS 26.0. All of the variables in the proposed models had significant associations with each other in the expected directions, although magnitudes of the correlation coefficients values were small (See Table 9). Hence, the variables of the model showed relative independence that provided suitability for moderation analysis.

*Table 9:* Bivariate correlations among the study variables

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Attachment style of the father | 1 | -,061 | ,210* | -,348** | ,298** | ,142 | -,219** |
| Maternal postpartum depression | | 1 | -,074 | ,077 | ,011 | -,110 | -,083 |
| Parenting stress | | | 1 | -,471** | ,559** | ,390** | ,035 |
| Marital satisfaction | | | | 1 | -,363** | -,492** | ,073 |
| PPD | | | | | 1 | ,302** | -,046 |
| Covariates | | | | | | | |
| Preparedness to fatherhood | | | | | | 1 | ,000 |
| SES | | | | | | | 1 |

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

#### 4.2.2.2. The Moderating Role of Maternal Postpartum Depression on the Relationship between Father's Attachment Insecurity, Parenting Stress and Paternal Postpartum Depression

Results demonstrated that the moderated-mediation model (Figure 3) explained 18% of the variance in PPD when parenting stress was entered to the model as the mediator ($F$ (3, 141) = 10,44, $p < .05$). There was a significant positive relationship between paternal attachment insecurity and parenting stress ($\beta$= .87, $SE$= .39, $t$ = 2.21, p < .05; 95 % $CI$ [.09, 1.6]), and also between parenting stress and PPD ($\beta$= 1.5, $SE$= .23, $t$ = 6.49, $p < .05$; 95 % $CI$ [1.0, 1.9]). The direct effect of the father's insecure attachment on PPD was also found significant ($\beta$= 2.7, $SE$= 1.6, $t$ = 2.53, $p <$ .05; 95 % $CI$ [.59, 4.8]).

Father's insecure attachment scores had a significant main effect on the relationship between parenting stress and PPD ($\beta$= .12, $SE$= .05, $t$ = 2.3, $p > .05$; 95 % $CI$ [.01, .22]). Results also indicated that inclusion of maternal postpartum depression to the model as the moderator significantly explained 18% of the variance in the proposed model, when the parenting stress was entered as the mediator ($F$ (1, 136) = 5,34, $p <$ .05). Analysis of the moderation effect showed that the relationship between parenting stress and PPD was significant when father's attachment scores was low (minus 1 SD below the mean; $\beta$= .95, $SE$= .28, $t$ = 3.2, $p < .05$; 95% CI [.38, 1.5]). It was also significant when the value of the attachment was both moderate (mean; $\beta$= 1.5, $SE$= .23, $t$ =6.4, $p > .05$; 95% $CI$ [1.0, 1.9]) and high (plus 1 SD above the mean; $\beta$= 2.1, $SE$= .38, $t$ = 5.4, $p > .05$; 95% $CI$ [1.3, 2.8]; Fig. 3). Index of moderated mediation was also significant ($\beta$= .10, $SE$= .07, 95% $CI$ [.00, 1.3]), indicating that parenting stress mediated the relationship between father's attachment insecurity and PPD symptoms when the maternal postpartum depression was low ($\beta$= 1.3, $SE$= .34,

95% *CI* [.00, 2.6]); moderate (*β*= 1.8, *SE*= .68, 95% *CI* [-.03, .08]) and high (*β*= 1.8, *SE*= .34, 95 % *CI* [.00, 1.3]).

Readiness for becoming a parent, which was the first covariate in the model, significantly predicted parenting stress (*β*= 1.4, *SE*= .29, *t* = 4.7, *p* < .05; 95% *CI* [.82, 2.0]) but it did not significantly predict PPD (*β*= .69, *SE*= .89, *t* = .78, *p* < .05; 95% *CI* [-1.0, 2.4]). The second covariate SES did not significantly predict either parenting stress (*β*= .04, *SE*= .27, *t* = .15, p < .05; 95% *CI* [-.50, .59]) or PPD (*β*= -.13, *SE*= 1.0, *t* = -.12, *p* < .05; 95% *CI* [-2.1, 1.9]).

#### 4.2.2.3. The Moderating Role of Maternal Postpartum Depression on the Relationship between Father's Attachment Insecurity, Marital Satisfaction and Paternal Postpartum Depression

Results demonstrated that the moderated-mediation model (Figure 3) explained 32% of the variance in PPD when the marital satisfaction was entered to the model as mediator (*F* (3, 141) = 22,2 p < .05). There was a negative relationship between paternal attachment and marital satisfaction (*β*= -1.0, *SE*= .26, *t* = -3.91, *p* < .05; 95 % *CI* [-1.5, -.52]). Yet, no significant relationship was observed between marital satisfaction and PPD scores (*β*= .01, *SE*= .34, *t* = .02, p < .05; 95 % *CI* [-.67, -.69]).

Fathers' attachment scores did not have a significant main effect on the relationship between marital satisfaction and PPD (*β*= .15, *SE*= .08, *t* = 1.78, *p* > .05; 95 % *CI* [-.01, .22]. Analysis of the moderation effect indicated that the relationship between marital satisfaction and PPD was not significant, when paternal attachment scores was low (minus 1 SD below the mean; *β*= -.74, *SE*= .46, *t* =-1.6, *p* > .05; 95 % *CI* [-1.6, .17]), moderate (mean; *β*= .00, *SE*= .34, *t* =.02, *p* > .05; 95% *CI* [-.67, .69]) or

high (plus 1 SD above the mean; *β*= .75, *SE*= .61, *t* = -1.23, *p* > .05; 95% *CI* [-.45, 1.9]). Also, index of the moderated mediation was not significant (*β*= -.16, *SE*= .10, 95% *CI* [-.40, -.02]), indicating that marital satisfaction did not mediate the relationship between father's attachment insecurity and PPD when maternal postpartum depression was low (*β*= -.00, *SE*= .51, 95% *CI* [-1.9, .12]); moderate (*β*= .80, *SE*= 1.0, 95% *CI* [-3.8, .24]) or high (*β*= -.80, *SE*= .51, 95 % *CI* [-1.9, .12]).

Readiness for becoming a parent significantly predicted marital satisfaction (*β*= -1.31, *SE*= .20, *t* = -6.44, *p* < .05; 95% *CI* [-1.7, -.91]) as a covariate, yet SES, did not significantly predict marital satisfaction (*β*= .04, *SE*= .27, t = .15, *p* < .05; 95% *CI* [-.50, .59]).

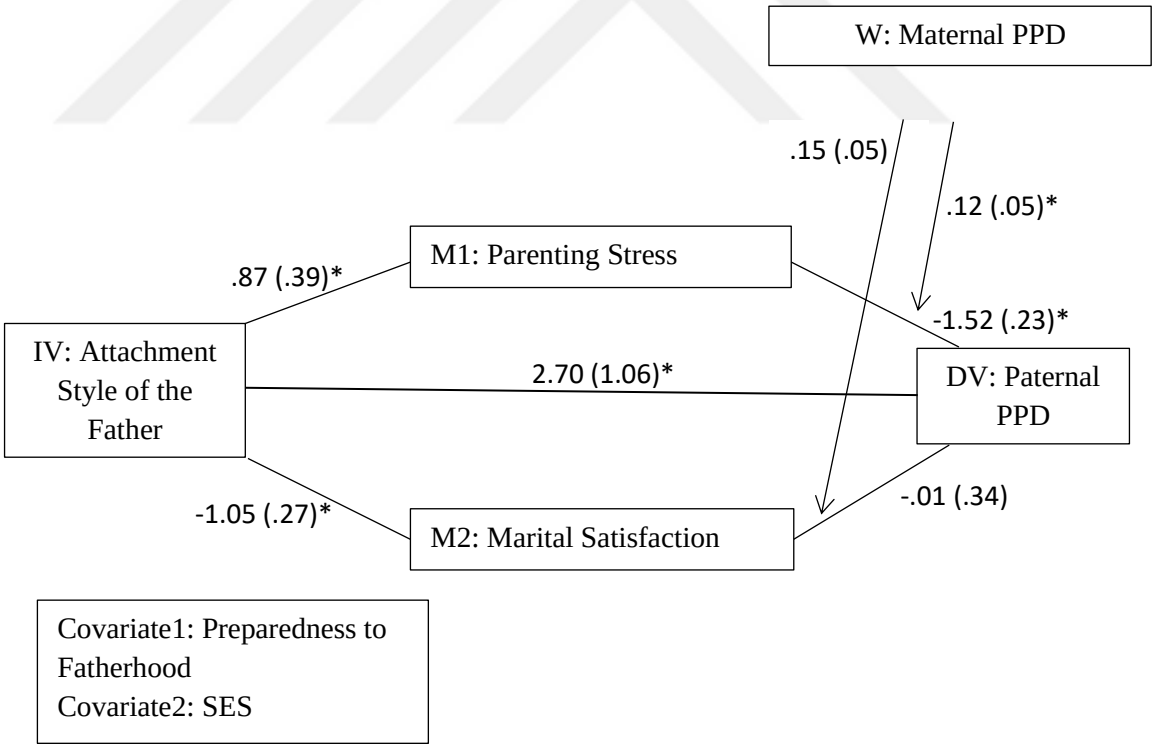


*Figure 3*. Moderated-Mediation model. All path coefficients are unstandardized regression weights. Standard errors are in the parentheses. Preparedness to fatherhood and SES are control variables. *p < .05.

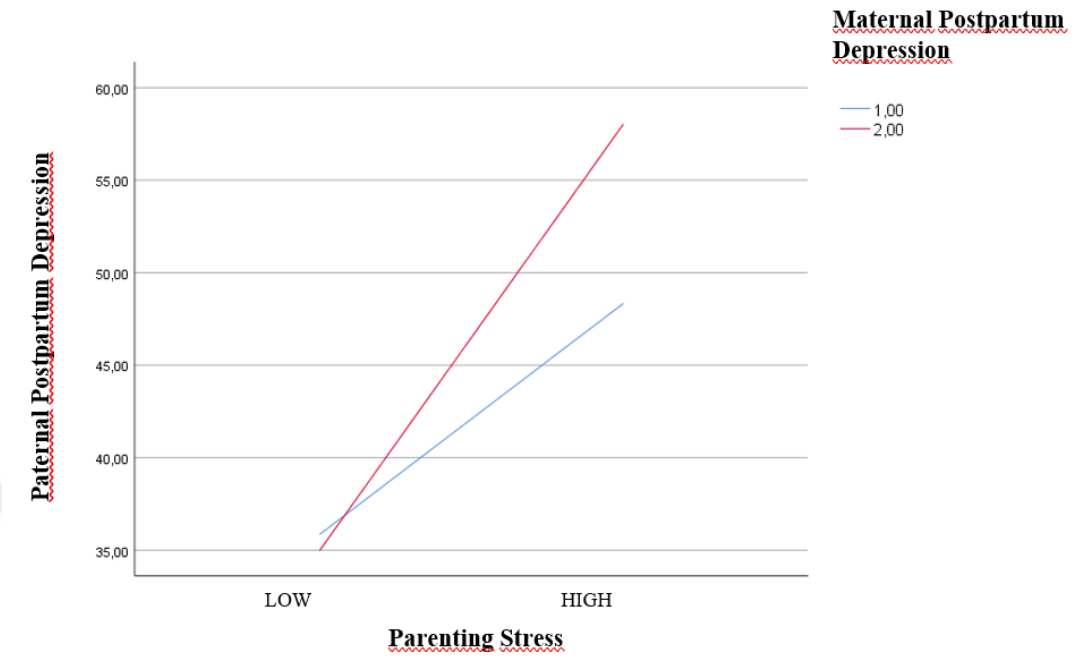


*Figure 4*. The moderating effect of maternal postpartum depression on the relationship between paternal postpartum depression and parenting stress.

### 4.3. Discussion

The quantitative part of the current thesis had two main purposes in itself. The main purpose was to develop and examine the psychometric properties of a "paternal postpartum depression scale (PPDS)". The second objective of the thesis was to test a moderated mediation model to account for psycho-social mechanisms underlying symptoms of PPD. In the following section, both analyses were discussed with respect to relevant literature.

#### 4.3.1. Psychometric validation of Paternal Postpartum Depression Scale

First of all, the main aim of the current study was to develop and test an indigenous assessment tool measuring fathers' depressive symptoms during postnatal

period. Results of the Exploratory Factor Analysis indicated that our scale fitted best to a 2-factor structure with 27 items, and obtained factors were theoretically consistent with the existing findings and narratives given by the depressed fathers in the first strand of the current project. Accordingly, respective factors were conceptualized as (1) Paternal Depressive Symptoms and (2) Distress Related to Fatherhood. Items of the first factor, "Paternal Depressive Symptoms" reflected both typical and so-called masculine expression of depression. Accordingly, feelings of unhappiness (e.g., item 1), burnout (e.g., item 2), emptiness (e.g., item 3), loneliness (e.g., item 10), regret (e.g., items 13 and 18) and hopelessness (e.g., item 15) had been captured by the items belonging to the first factor. In other words, some items in this subscale were closely related to the traditional experience and expression of depression across genders (Da Costa et al., 2017; Kim et al., 2007; Misri, 2018). In fact, this finding is in agreement with the propositions of the theorists, researchers and mental health professionals particularly working with depressed populations. These findings indicated that although gender roles might impose differential dynamics on the manifestation of depression, masculine expressions do not make men free from experiencing more introverted and typical symptoms of depression (Misri, 2018). Therefore, researchers and clinicians are suggested to employ a multidimensional assessment, including evaluation of both typical and atypical symptoms, while diagnosing men with clinical depression (Freitas et al., 2016).

The second subscale contained items covering particularly the masculine and more overt expression of depression, in line with the literature and findings of the qualitative part (Carlberg et al., 2018; Madsen & Juhl, 2007). These items mainly included feelings of being angry (e.g., items 4, 6 and 14), intolerant (e.g., items 7, 8

and 12), strained (e.g., items 11 and 19), uneasy (e.g., item 5), overwhelmed (e.g., item 19) and emotionally imbalanced (e.g., items 20, and 21). Items of this factor also covered emotional inhibition and use of alcohol/other substances as the extension of atypical depressive symptoms among new fathers. These results further supported the idea that men might be more comfortable with expressing their depressive states through symptoms more compatible with the societal ideals of manhood and fatherhood. There are several gender-based explanations for this pattern. Firstly, sadness, unhappiness, crying and guilt might be counted as more feminized manifestations of depression (Landrine, 1988; Oliver & Toner, 1990). Society allows women to express depression related emotions more readily since women are inherently perceived as vulnerable (Barrett & Bliss-Moreau, 2009). Hence, women's "already inferior position" does not carry the risk of being challenged as a consequence of showing psychological vulnerability (Krumm et al., 2017). By contrast, expressing such emotions might endanger hardly earned status and prestige of men (Krumm et al., 2017; O'Neil et al., 1986). According to precarious manhood hypothesis, manhood is an acquired position, and possible threats to this position leads to significant amount of distress and anxiety (Vandello & Bosson, 2013). Thereof, men over-compensate anxiety arousing from such threats through engaging in externalizing behaviors and aggression to guarantee maintenance of their manly prestige at society (Cochran & Rabinovitz, 1999; Karam, 2016). In fact, this might be one reason why men in our study felt more comfortable in the expression and manifestation of more atypical and externalizing symptoms of depression (e.g., low tolerance, frustration, anger attacks etc.) (Misri 2018; Herbst et al., 2014). Secondly, existing literature pointed out to the fact that even mental health

professionals dismiss such externalizing symptoms as an extension of depression among men (Afifi, 2007; Call & Schafer, 2018). Hence, men might be well-aware that society does not provide sufficient room for their sadness and guilt when compared to women (Addis, 2008; Darwin 2017). It seems that society does not want to see men crying and expressing their unhappiness, but rather expect them to display emotional invulnerability and stoicism (Seidler et al., 2016). This might be another mechanism explaining why men prefer isolation and emotional inhibition as they do not believe that their typical depressive symptoms would be appreciated by others.

Our second sub-factor was conceptualized as "Distress Related to the Fatherhood", the items of which particularly covered depressive symptoms arousing from expectations centered around fatherhood during postnatal period. Items mainly focused on two aspects, which were (1) feeling restrained due to multiple responsibilities (items 23 and 25) and (2) feeling stuck as a consequence of prioritizing the familial needs (items 24, 26 and 27). In fact, society expects qualitatively different roles and duties from mothers and fathers. For example, even though an increasing number of women are in now work force (Aldan, 2021; Shannon et al., 2019) fathers still believe they are the ones responsible for the economic well-being of the family (Valiquette-Tessier et al., 2019). Besides, they suffer from juggling among multiple responsibilities at home and work due to lack of paternal leaves in many countries (Edhborgh et al., 2016; Kramer & Kramer, 2021; St John et al., 2005; Ünlütürk Ulutaş, 2015). Accordingly, fathers are obliged to display physical, emotional and economic stamina during life crises to guarantee unity and harmony of family (Darwin et al., 2017; Freitas et al., 2016; Krumm et al., 2016). Interestingly, their psychological state is undermined as if they were immuned

to distress. Coupled with the depressive symptoms, insistence to display such emotional endurance as a father might increase the burden that our participants experienced. Consistent with the existing findings (Darwin, 2017; Seidler et al., 2016), negative emotions aroused from paternal responsibilities (e.g., establishing work-family balance, guaranteeing economic stability etc.). seems to be an important component while describing and assessing fathers' depression during postnatal period. We believe that presence of this sub-factor is significant at least for one theoretical reason. The existing scales in the literature developed to measure either post-partum depression (e.g., Edinburgh) or male depression (e.g., Goatland) are being criticized for not covering symptoms of paternal postpartum depression particularly related to the fatherly concerns. In that respect, these results will doubtless be valuable for being the first assessment tool of PPD including distress related to fatherhood.

Some of the items from the initial item pool were excluded from the final version of the scale due to statistical reasons. Firstly, although the "feelings of guilt" appeared in several interviews and also supported by the literature (Edhborgh et al., 2016; Misri, 2018), none of the items about guilt was statistically supported. One reason for the absence of guilt related items might be related with men's limited emotional repertoire. Although father expressed their concern over not being a good enough father or husband, they might not identify this feeling as "guilt" in the questionnaire. Another reason can be the ambiguity in the poorly defined paternal roles that might create an emotional or intellectual ambivalence for fathers (Edhborgh et al., 2016). Accordingly, fathers might not have evaluated themselves as incompetent or competent in terms of parenting since the reference point for being a good father has

not been clearly defined particularly in emotional aspects. Finally, the third plausible yet dreaded explanation might be related with social desirability. Although fathers uttered the feelings of guilt as a consequence of not being a good father, they might still have the implicit belief that being a good parent is the main responsibility of the mothersnot the fathers (Darwin, 2017).

Another item that was eliminated was related to sleeping problems. Even though fathers expressed negative changes in sleep quality, the item regarding sleep quality was not supported statistically. Despite sleeping problems are common in depressed patients (Bruno et al., 2020; Edhborgh et al., 2016), fathers' sleeping problems, as appeared in narratives, might have been perceived as a natural consequence of having a baby. Thus, sleep deprivation might not be perceived as a problem by our fathers. Another component that was seen in the narratives yet not supported by the further analysis was anxiety-related items. This finding might be associated with the high comorbidity between depression and anxiety (Goodwin, 2015). Accordingly, feeling “worried” might have not been apparent as a more internalized symptom compared to the other items. Lastly, in our study, fathers did not identify any suicidal ideation in contrast to the findings of the existing literature (Cochran & Rabinowitz, 2003). However, our sample size was relatively small and depression scores of the fathers were low to moderate in the second quantitative part of the study, which might explain the non-presence of suicidal ideation related items in the final version (Green et al., 2015).

The scale was also found to be reliable, with Cronbach's alpha values of 0.94 and .95 for the entire scale and its subdimensions. Although Cronbach's alpha value was very

high, it was still below the critical threshold, indicating an acceptable level of parsimony (Carpenter, 2017). Results of the validity analyses were theoretically sensible and consistent with the related literature (Carlberg et al., 2018; Matthey et al., 2001; Psouni et al., 2017). Consistent with our expectations, the correlations that our scale had with Beck Depression Inventory and EPDS were moderate. Although both BDI and EPDS were designed to measure depressive symptoms, they have been criticized for not reflecting masculine expressions of depression (Carlberg et al., 2018; Freitas et al., 2016; Madsen & Juhl, 2007). Thereof, the obtained moderate associations partially supported the idea that externalized symptoms are also part of the fathers' depressive experiences (Addis, 2008; Seidler et al., 2016; Zierau et al., 2002). Our scale also showed a lownegative correlation with Life Satisfaction Scale in consistent with the literature showing that grater depressive symptomatology is associated with lower quality of life (Galanakis et al., 2017; Howarth & Swain, 2020).

### 4.3.2. Discussion of the Moderated Mediation Model

The second aim of the quantitative strand of the current thesis was to test a moderated mediation model to delineate the underlying psychosocial factors associated with PPD. First of all, it was investigated whether parenting stress mediated the relationship between fathers' insecure attachment scores and PPD. As the statistical results suggested, parenting stress levels of the fathers mediated the relationship between fathers' insecure attachment scores and PPD symptoms. More specifically, fathers with higher insecure attachment scores had greater levels of PPD through increased levels of parenting stress. In contrast, securely attached fathers had

a lower risk for PPD through lower levels of parenting stress. This finding was consistent with the literature that implies parenting stress is a risk factor for the development of both maternal and paternal postpartum depression (Darwin et al., 2017; Edhborgh et al., 2016; Johansson et al., 2020; Yim et al., 2015). It was well-established in the literature that insecure attachment endangers quality of the interpersonal relations, and this negative effect is more pronounced in close relationships like the one between the parent and child (Baldoni, 2010; Johansson et al., 2020; Psouni & Eichbichler, 2020; Zwara et al., 2020). Accordingly, insecure and avoidant attachment styles were associated with the use of more dysfunctional parenting strategies (Lo et al., 2019; Nijssens et al., 2018), and lower parental efficacy (Johansson et al., 2020), which might account for the grater parental distress experienced by fathers with insecure attachments. Besides, extensive research has shown that insecure attachment styles are closely related with the development and maintenance of several mental problems including depression (Palitsky et al., 2013; Psouni & Eichbichler, 2020; Mullen 2019). Hence, it is theoretically sensible that new fathers with insecure attachment styles are more likely to display PPD, particularly when they have perceived parenting as more stressful.

Secondly, it was tested whether marital satisfaction mediated the relationship between fathers' attachment styles and PPD symptoms. Surprisingly, no significant effect was found regarding mediating role of marital satisfaction on the relationship between fathers' attachment styles and PPD. This effect remained non-significant considering the moderating impact of maternal postpartum depression. Although marital satisfaction was proposed as a risk factor for PPD by several studies (Duan et al., 2020; Bruno et al., 2020; Kim & Swain, 2007; Paulson, 2010), current model did

not display the same trend. This situation might be explained by a very recent study (Psouni & Eichbichler, 2020), which also found the mediating role of marital satisfaction on the relationship between fathers' insecure and anxious attachment styles and PPD as non-significant. Accordingly, PPD might be more prone to be influenced by particular components of marital satisfaction. For instance, it can be investigated role divisions and parenting related conflicts are associated with greater PPD symptoms. Thereof, use of a general measure to assess marital satisfaction might explain the absence of the proposed significant relationship.

The impact of maternal postpartum depression as the moderator variable was also investigated within the scope of the current research. Accordingly, maternal postpartum depression moderated the relationship between fathers' attachment scores and PPD through the mediating effect of parenting stress. More specifically, parenting stress mediated the relationship between father's attachment insecurity and PPD symptoms depending on the different levels of maternal postpartum depression. In fact, several studies have established that maternal PPD accentuated negative impacts of several psychosocial factors associated with PPD (Atkinson et al., 2020; Bruno et al., 2020; Edhborgh et al., 2016; Misri 2018; Ramchandani et al., 2011). Consistent with the narratives obtained in the qualitative strand, fathers' felt under pressure due to their responsibilities as a couple, as a father and as a breadwinner. In that respect, maternal postpartum depression might have accelerated fathers' parenting responsibilities creating an internal barrier for fathers to share those responsibilities with their partner.

Finally, maternal postpartum depression did not moderate the relationship between fathers' attachment scores and PPD through the mediating effect of marital satisfaction. One reason explaining the lack of the significant association might be related to not using a more specific marital satisfaction scale. Another reason might be related to the use of a non-clinical sample meaning that clinically non-significant depression levels might not have been an over-riding factor influencing the proposed relationship.

### 4.4. Limitations and Future Directions

There were some limitations necessitating cautious interpretations of the results obtained from this study. The main limitation of the study was its sample size. Although Kaiser-Meyer-Olkin (KMO) value and results of the Bartlett's sphericity test showed that the data was well suited for the analysis, conducting the aforementioned analyses with a greater number of participants would have increased power size of our findings. Additionally, test-retest reliability of the newly developed scale had not been performed due to practical reasons shedding doubt on the time related stability of the items. Also, the current study was conducted with a non-clinical population without the presence of an official depression diagnosis. Hence, future studies should be conducted with clinical populations to see the rates of true and false positivity of the results while identifying postpartum depression among fathers. Moreover, our sample only included heterosexual and married fathers in Turkey. Future studies can sample different populations such as non-traditional families, underrepresented communities, and ethnic minorities in Turkish culture. Also, the cross-cultural validity of the scale and the moderated mediation model can

be tested across different cultures considering the impacts of culture on paternal postpartum depression.

### 4.5. Clinical Implications

Although many researchers investigated short and long-term impacts of maternal depression on child mental health outcomes, much less is known about the dynamics of paternal postpartum depression. Existing evidence suggested that the prevalence of paternal depression is not negligible, and paternal depression might negatively affect offspring's psychosocial development. Still, relevant literature lacks a psychometrically robust tool measuring depressive symptoms specific to fathers' experiences. Besides, only a few studies have examined the psychosocial variables maintaining postpartum depression among new fathers. Accordingly, identifying both common and unique symptoms of paternal postpartum depression is a crucial step to assess and determine the prevalence and severity of this public health problem. Thereof, we believed that our newly developed scale with acceptable psychometric properties can be used as a new assessment tool by the researchers and clinicians to identify at risk fathers and to investigate familial factors associated with long-term impacts of paternal depression on child mental health outcomes (Bruno et al., 2020; Kim & Swain, 2007). Also, the current study highlighted the dynamic relationship among PPD, attachment styles, maternal postpartum depression and parenting stress. Consistently, future intervention programs or new parent groups should include fathers as an active agent of change by considering the family system as a whole (Bakermans-Kranenburg et al., 2003; Goldstein et al., 2020). In those programs, the interrelation between maternal and paternal postpartum depression and

their association with familial and parenting factors (e.g., parenting stress and attachment) are suggested to be targeted based on obtained findings of the study.

# CHAPTER 5

## 5. GENERAL DISCUSSION

In this chapter, findings of both qualitative and quantitative parts of the current thesis were discussed together in light of the current literature. After a general discussion, clinical and policy-related implications, limitations and proposed future directions were presented, respectively.

### 5.1. General Discussion

The main aim of the current thesis was to develop an instrument measuring paternal depression during post-partum period and identify psycho-social variables associated with PPD. In order to pursue this aim, a multi-method design was employed, and two studies sequential studies were conducted independently. The main purpose of the qualitative strand was to understand both common and unique experiences of depressed fathers in the postpartum period. Results revealed that representation of parenting roles and gender-based norms affected both expression and experiencing postpartum depression among fathers. In the second quantitative strand, a 27-item, psychometrically sound instrument was developed to measure PPD, and this newly developed scale was later used as the outcome variable in a moderated mediation model to investigate psychosocial factors associated with symptoms of PPD.

In general, findings of both studies indicated that men suffered from externalized symptoms of depression in addition to the more typical ones. These externalized symptoms (e.g., anger attacks, emotional disinhibition, low frustration tolerance and

emotional fluctuations) seem to be more compatible with the gender roles ascribed to manhood and fatherhood. Accordingly, it seems of utmost importance evaluating both internalizing and externalizing symptoms while identifying and assessing paternal postpartum depression. Secondly, paternal parenting stress emerged as an important psychosocial variable affecting PPD in both qualitative and quantitative strands. Particularly, cultural ideals favoring womanhood led fathers to become doubtful about their parenting strategies in the first study, while it mediated the relationship between fathers' attachment and PPD in the second quantitative study. Thirdly, although couple relationship emerged as a related theme the qualitative strand, no mediating effect was obtained in the model testing part. In fact, the reason for this non-significant finding might partially be reflected in the narratives of depressed fathers. Rather than mentioning a general deterioration in the partner relationship, majority of fathers highlighted how intimacy and sexuality had been affected by the arrival of the newborn. Hence, in the future studies, more specific domains of marital satisfaction might be tested to delineate which aspects of couple relationship are more closely related with maternal and paternal depressive symptoms. Last but not least, our project once again provided support for the Family System approach (Haefner, 2014). Accordingly, fathers' psychosocial experiences and mental states should not be separated from the family context as they are active agents, influencing and being influenced by the psychosocial and cultural dynamics surrounding the family context.

### 5.2. Clinical Implications

The current study has provided a theoretically driven baseline for the assessment and identification of PPD and its underlying mechanisms. Although the psychosocial wellbeing of fathers has an inevitable impact on other family members, existing intervention programs targeting postnatal period does not focus on paternal postpartum depression while exclusively focusing on improvement of maternal postpartum depression (Goldstein et al., 2020; Suto et al., 2017). In that respect, intervention strategies should be informed not to exclude fathers while targeting maternal and child mental health. Furthermore, the study marked the importance of informing multicomponent intervention programs through emphasizing the dynamic relations among mother, father and child in the family system. Also, the current study provided ground for the possible psychosocial prevention/intervention programs targeting to improve family psychological wellbeing especially during postpartum period. Accordingly, the newly developed scale encourages both researchers and health care practitioners to detect depressive symptomologies in fathers during the routine postpartum controls in the hospital. Accordingly, use of this measure is expected to mitigate the risk that paternal depression remain as a hidden diagnosis.

### 5.3. Policy Implications

The current study might increase awareness about the possible risks and outcomes of paternal postpartum depression, which, in turn, is expected to decrease new mothers' burden during postpartum period, as well. Through increased awareness about paternal postpartum depression, fathers might be encouraged to benefit more from

mental health care services by physicians and mental health professionals. Today, most European countries provide paternal or parental leave for fathers (Aydın & Demirkaya, 2017). However, Turkey falls behind these regulations and provide only five days of compassionate leave or limited unpaid leave after birth. Taking into consideration the debilitating impacts of shorter paternal leaves on parenting practices (Feldman et al., 2004), this study might inform possible social policies improving fathers' being active agents of parenting practices. In that respect, the study set the ground for future studies investigating the impact of paternal depression on family wellbeing and might increase public awareness for the possible cost-effective social policy implications (Asper et al., 2018).

### 5.4. Limitations and Directions for Future Research

Overall, the current study has some limitations. First of all, in the qualitative strand of the thesis, depressed fathers were identified through their BDI scores. Future studies can be conducted with clinical populations in the presence of a psychiatric consultation. Moreover, although the data was suitable for the analysis, sample size for the quantitative part was relatively small. Conducting the analysis of the second quantitative strand of this thesis with larger populations would provide more comphrenesive data particularly with regard to psychometric properties of PPD scale. Also, since experiences of both fatherhood and depression are influenced by cultural and social values (e.g., gender roles, individualistic/collectivistic texture of the country), future studies can be conducted in different cultures to identify different or similar experiences of fatherhood impacting on PPD. In addition to employing further analysis for the psychometric validation of the scale (e.g., test-retest

reliability), cross-cultural validation of the paternal postpartum scale can be applied to investigate cross-cultural validity of the scale.

### 5.5. Conclusion

The main aim of the current thesis was to understand the experiences of the depressed fathers during postpartum period and to develop a psychometrically robust instrument measuring paternal postpartum depression. Overall, the current thesis provided preliminary evidence for the psychometric evaluation of the newly developed PPD. Besides, the study revealed that societal representations of parenting and masculinity related norms impacted both the experience and the manifestation of depression among new fathers. In addition, insecure attachment of father, greater parenting stress and maternal postpartum depression seem to be important psychosocial variables affecting levels of PPD among new fathers. All in all, the current study provided a foundation for mental health practitioners and clinicians to include fathers in their prevention and intervention programs during postpartum period while targeting psychosocial well-being of family as a whole.

## REFERENCE


Abidin, R. R. (1995). Parenting Stress Index, 3rd Edn. Lutz, *FL: Psychological Assessment Resources.*

Addis, M. E. (2008). Gender and depression in men. *Clinical Psychology: Science and Practice*, *15*(3), 153-168. https://doi.org/10.1111/j.1468-2850.2008.00125.x

Addis, M. E., & Cohane, G. H. (2005). Social scientific paradigms of masculinity and their implications for research and practice in men's mental health. *Journal of clinical psychology*, *61*(6), 633-647. DOI: 10.1002/jclp.20099

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American psychologist*, *58*(1), 5. DOI: 10.1037/0003-066X.58.1.5

Afifi, M. (2007). Gender differences in mental health. *Singapore Medical Journal, 48*, 385-391. 10.1007/s11199-005-6762-3

Aldan, A. (2021). Rising Female Labor Force Participation and Gender Wage Gap: Evidence From Turkey. *Social Indicators Research*, 1-20. https://doi.org/10.1007/s11205-021-02631-9

Allen, S. M., & Hawkins, A. J. (1999). Maternal gatekeeping: Mothers' beliefs and behaviors that inhibit greater father involvement in family work. *Journal of Marriage and the Family*, 61(1), 199–212. https://doi.org/10. 2307/353894.

Allen, J., Fonagy, P., & Bateman, A. (2013). Klinik uygulamada zihinselleştirme. S. Yelkener, Çev.). *İstanbul: Psikoterapi Enstitüsü Eğitim Yayınları, 37*.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Asper, M. M., Hallén, N., Lindberg, L., Månsdotter, A., Carlberg, M., & Wells, M. B. (2018). Screening fathers for postpartum depression can be cost-effective: An example from Sweden. *Journal of affective disorders, 241*, 154-163.

Atkinson, J., Smith, V., Carroll, M., Sheaf, G., & Higgins, A. (2020). Perspectives of partners of mothers who experience mental distress in the postnatal period: A systematic review and qualitative evidence synthesis. *Midwifery, 93,* 102868. https://doi.org/10.1016/j.midw.2020.102868

Aydın, U. ve Demirkaya, S., (2017). Çalışma Yaşamında Aile Dostu İş Hukuku Uygulamaları, *İş ve Hayat, 3* (6), 72-104.

Azad, R., Fahmi, R., Shrestha, S., Joshi, H., Hasan, M., Khan, A. N. S., ... & Billah, S. M. (2019). Prevalence and risk factors of postpartum depression within one year after birth in urban slums of Dhaka, Bangladesh. *PloS one*, *14*(5), e0215735. https://doi.org/10.1371/journal.pone.0215735

Baldoni, F. (2010). Attachment, danger and role of the father in family life span. *Transilvanian Journal of Psychology (Erdélyi Pszichológiai Szemle, EPSZ), 4*, 375-402.

Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. Psychological Bulletin, 129, 195–215. http://dx.doi .org/10.1037/0033-2909.129.2.195

Basnyat, I., & Dutta, M. J. (2012). Reframing motherhood through the culture-centered approach: Articulations of agency among young Nepalese women. *Health Communication*, *27*(3), 273-283. 10.1080/10410236.2011.585444

Barnes, D. L. (2006). Postpartum depression: Its impact on couples and marital satisfaction. *Journal of Systemic Therapies, 25*(3), 25-42. DOI: 10.1521/jsyt.2006.25.3.25

Barrett, L. F., & Bliss-Moreau, E. (2009). She's emotional. He's having a bad day: Attributional explanations for emotion stereotypes. *Emotion, 9*(5), 649–658. https://doi.org/10.1037/a0016821

Beck, A. T., & Beamesderfer, A. (1974). Assessment of depression: The depression inventory. In P. Pichot & R. Olivier-Martin (Eds.), *Psychological measurements in psychopharmacology.* S. Karger. https://doi.org/10.1159/000395074

Beck, A. T., Steer, R.A., & Garbin, M.G. (1988) Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, 8(1), 77-100.

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571.

Bhambhani, C., & Inbanathan, A. (2018). Not a mother, yet a woman: Exploring experiences of women opting out of motherhood in India. *Asian Journal of Women's Studies*, *24*(2), 159-182. https://doi.org/10.1080/12259276.2018.1462932

Blazina, Christopher, and Clifton E. Watkins. 2000. ‘‘Separation/Individuation, Parental Attachment and Male Gender Role Conflict; Attitudes Toward the Feminine and the Fragile Masculine Self.’’ *Psychology of Men and Masculinity 1*:126–32. 10.1037//1524-9220.1.2.126

Bracke, P., Delaruelle, K., Dereuddre, R., & Van de Velde, S. (2020). Depression in women and men, cumulative disadvantage and gender inequality in 29 European countries. *Social Science & Medicine*, *267*, 113354. 10.1016/j.socscimed.2020.113354

Bruno, A., Celebre, L., Mento, C., Rizzo, A., Silvestri, M. C., De Stefano, R., ... & Muscatello, M. R. A. (2020). When fathers begin to falter: a comprehensive review on paternal perinatal depression. *International journal of environmental research and public health*, *17*(4), 1139. https://doi.org/10.3390/ijerph17041139

Boratav, H. B. (2021). Feminizm ve Psikoloji: Sıkıntılı bir İlişki Feminism and Psychology: A Troubled Relationship. *Reflective Journal of Social Science, 2*(1), 143-163. DOI: 10.47613/reflektif.2021.19

Boratav, H. B., Fişek, G. O., & Ziya, H. E. (2014). Unpacking masculinities in the context of social change: Internal complexities of the identities of married men in Turkey. *Men and Masculinities, 17*(3), 299-324. https://doi.org/10.1177/1097184X14539511

Bowlby J (1969) Attachment, Vol. 1 of Attachment and Loss. New York: Basic Books.

Broderick, P. C. (1998). Early adolescent gender differences in the use of ruminative and distracting coping strategies. *Journal of Early Adolescence,* 18, 173–191.

Buist, A., Morse, C. A., & Durkin, S. (2003). Men's adjustment to fatherhood: Implications for obstetric health care. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 32,* 172-180. 10.1177/0884217503252127

Call, J. B., & Shafer, K. (2018). Gendered manifestations of depression and help seeking among men. *American journal of men's health, 12*(1), 41-51. https://doi.org/10.1177/1557988315623993

Cast, A. D. (2004). Well-Being and the Transition to Parenthood: An Identity Theory Approach. *Sociological Perspectives, 47*(1), 55–78. https://doi.org/10.1525/sop.2004.47.1.55

Carlberg, M., Edhborg, M., & Lindberg, L. (2018). Paternal perinatal depression assessed by the Edinburgh postnatal depression scale and the Gotland male

depression scale: prevalence and possible risk factors. *American journal of men's health*, *12*(4), 720-729. https://doi.org/10.1177/1557988317749071

Carpenter, S. (2018). Ten Steps in Scale Development and Reporting: A Guide for Researchers. *Communication Methods and Measures*. 12:1, 25-44, 10.1080/19312458.2017.1396583

Chhabra, J., McDermott, B., & Li, W. (2020). Risk factors for paternal perinatal depression and anxiety: A systematic review and meta-analysis. *Psychology of Men & Masculinities 21*(4), 593–611. https://doi.org/10.1037/men0000259

Chapman, E., & Smith, J. A. (2002). Interpretive phenomenological analysis and the new genetic*s. Journal of Health Psychology*, *7*(2), 125-130. https://doi.org/10.1177/1359105302007002397

Cochran, S. V., & Rabinowitz, F. E. (1999). *Men and depression: Clinical and empirical perspectives*. Elsevier.

Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research and Practice*, 34, 132–140. doi:10.1037/0735-7028.34.2.132

Condon J.T., Boyce P., Corkindale C. J. (2004). The First-Time Fathers Study: a prospective study of the mental health and wellbeing of men during the transition to parenthood. *Psychiatry. Jan-Feb; 38(1-2):56-64*

Cools, S., Fiva, J. H., & Kirkebøen, L. J. (2015). Causal effects of paternity leave on children and parents. *The Scandinavian Journal of Economics*, *117*(3), 801-828.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *The British journal of psychiatry*, *150*(6), 782-786.

Da Costa, D., Zelkowitz, P., Dasgupta, K., Sewitch, M., Lowensteyn, I., Cruz, R., ... & Khalifé, S. (2017). Dads get sad too: Depressive symptoms and associated factors in expectant first-time fathers. *American journal of men's health*, *11*(5), 1376-1384.

Dallos, R., & Nokes, L. (2011). Distress, loss, and adjustment following the birth of a baby: a qualitative exploration of one new father's experiences. *Journal of Constructivist Psychology*, *24*(2), 144-167

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., & Gilbody, S. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: a qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC pregnancy and childbirth*, *17*(1), 45.

Davis, D. F., Golicic, S. L., & Boerstler, C. N. (2011). Benefits and challenges of conducting multiple methods research in marketing. *Journal of the academy of marketing science*, *39*(3), 467-479.

Davis, R. N., Davis, M. M., Freed, G. L., & Clark, S. J. (2011). Fathers' depression related to positive and negative parenting behaviors with 1-year-old children. *Pediatrics*, *127*(4), 612-618.

Deater-Deckard, K., Dodge, K. A., Bates, J. E., and Pettit, G. S. (1998). Multiple risk factors in the development of externalizing behavior problems: group and individual differences. *Dev. Psychopath. 10*, 469–493. doi: 10.1017/ S0954579498001709

Deater-Deckard, K. D. (2004). Parenting stress. New Haven, CT: Yale University Press.

Deater-Deckard, K., Smith, J., Ivy, L., & Petril, S. A. (2005). Differential perceptions of and feelings about sibling children: implications for research on parenting stress. *Infant and Child Development, 14(*2), 211–225. doi:10.1002/icd.389

deMontigny, F., Girard, M. E., Lacharite, C., Dubeau, D., & Devault, A. (2013). Psychosocial factors associated with paternal postnatal depression. *Journal of affective disorders*, *150*(1), 44-49.

DeMontigny, F., Lacharite´, C., Devault, A. (2012). Transition to fatherhood: modeling the experience of fathers of breastfed infants. *Advances in Nursing Science* 35, E11–E22

Dessalegn, M., Ayele, M., Hailu, Y., Addisu, G., Abebe, S., Solomon, H., ... & Stulz, V. (2020). Gender inequality and the sexual and reproductive health status of young and older women in the Afar Region of Ethiopia. *International Journal of Environmental Research and Public Health*, *17*(12), 4592.

DeVellis, R. F. (2012). Bölüm 5: Ölçek Geliştirme İlkeleri. In Totan. T. (Ed.), *Ölçek Geliştirme Kuram ve Uygulamalar* (3rd ed., pp. 108-110). Nobel Akademik Yayıncılık.

DeVellis, R. F. (2017). Scale Development: Theory and Applications (4th ed.). Thousand Oaks, CA: Sage.

Diener, E, Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with Life Scale. *Journal of Personality Assessment, 49*, 71-75. doi:10.1207/s15327752jpa4901_13 172 Cop

Duan, Z., Wang, Y., Jiang, P., Wilson, A., Guo, Y., Lv, Y., ... & Chen, R. (2020). Postpartum depression in mothers and fathers: a structural equation model. *BMC Pregnancy and Childbirth*, *20*(1), 1-6. https://doi.org/10.1186/s12884-020-03228-9

Eagly, A. H., & Steffen, V. (1984). Gender stereotypes stem from the distribution of women and men into social roles. *Journal of Personality and Social Psychology*, *46(*4), 735-754. http//dx.doi.org/10.1037//0022-3514.46.4.735

Edhborg, M., Carlberg, M., Simon, F., & Lindberg, L. (2016). "Waiting for better times" Experiences in the first postpartum year by Swedish fathers with depressive symptoms. *American journal of men's health*, *10*(5), 428-439.

Engindeniz, A. N., Küey, L. ve Kültür, S. (1996). Edinburgh Doğum Sonrası Depresyon Ölçeği Türkçe formu geçerlilik ve güvenilirlik çalışması. *Bahar Sempozyumları, 1*, 51-52.

Fagan, J., & Cherson, M. (2015). Maternal gatekeeping: The associations among facilitation, encouragement, and low-income fathers' engagement with young children. *Journal of Family Issues, 38(5)*, 633–653. https://doi. org/10.1177/0192513X15578007.

Fauci, J. E., & Goodman, L. A. (2020). “You don’t need nobody else knocking you down”: Survivor-mothers’ experiences of surveillance in domestic violence shelters. *Journal of family violence*, *35*(3), 241-254.

Feldman, R. (2007). Parent–infant synchrony and the construction of shared timing; physiological precursors, developmental outcomes, and risk conditions. *Journal of Child psychology and Psychiatry*, *48*(3-4), 329-354.

Feldman, R., Sussman, A. L., & Zigler, E. (2004). Parental leave and work adaptation at the transition to parenthood: Individual, marital, and social correlates. *Journal of Applied Developmental Psychology*, *25*(4), 459-479.

Fergusson, D., McLeod, G., Horwood, L., Swain, N., Chapple, S., & Poulton, R. (2015). Life satisfaction and mental health problems (18 to 35 years). *Psychological Medicine, 45*(11), 2427-2436. doi:10.1017/S0033291715000422

Fışıloğlu H, & Demir A. (2000). Applicability of the dyadic adjustment of marital quality with Turkish couples. *European Journal of Psychological Assessment, 16*(3), 214-218.

Fincham, Frank D., and Steven R. H. Beach.2010. “Marriage in the New Millennium: A Decade in Review. *Journal of Marriage and Family, 72*: 630–49. DOI:10.1111/j.1741–3737.2010.00722.x

Fisher, S. D. (2017). Paternal mental health: Why is it relevant? *American Journal of Lifestyle Medicine*, *11*, 200 –211. http://dx.doi.org/10.1177/1559827616629895

Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of personality and social psychology*, *78*(2), 350.

Freitas, C. J., Williams-Reade, J., Distelberg, B., Fox, C. A., & Lister, Z. (2016). Paternal depression during pregnancy and postpartum: An international Delphi study. *Journal of affective disorders*, *202*, 128-136. https://doi.org/10.1016/j.jad.2016.05.056

Froberg, D., Gjerdingen, D. K., & Preston, M. (1986). Multiple roles and women's mental and physical health: What have we learned?. *Women & health*, *11*(2), 79-96.

Galanakis, M., Lakioti, A., Pezirkianidis, C., Karakasidou, E., & Stalikas, A. (2017). Reliability and validity of the Satisfaction with Life Scale (SWLS) in a Greek sample. *International Journal of Humanities and Social Studies*, *5*(2), 120-127.

Garthus-Niegel, S., Staudt, A., Kinser, P., Haga, S. M., Drozd, F., & Baumann, S. (2020). Predictors and Changes in Paternal Perinatal Depression Profiles—Insights From the DREAM Study. *Frontiers in psychiatry*, *11*, 1127.

Glasser, S., & Lerner-Geva, L. (2019). Focus on fathers: paternal depression in the perinatal period. *Perspectives in public health*, *139*(4), 195-198.

Glasser, S., & Lerner-Geva, L. (2018). Focus on fathers: paternal depression in the perinatal period. *Perspectives in Public Health.*

Goode, W. J. (1960). A theory of role strain. *American sociological review*, 483-496.

Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of advanced nursing*, *45*(1), 26-35.

Goodman, J. H. (2008). Influences of maternal postpartum depression on fathers and on father–infant interaction. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, *29*(6), 624-643. DOI: 10.1002/imhj.20199

Goodwin G. M. (2015). The overlap between anxiety, depression, and obsessive-compulsive disorder. *Dialogues in clinical neuroscience*, *17*(3), 249–260. https://doi.org/10.31887/DCNS.2015.17.3/ggoodwin

Goldstein, Z., Rosen, B., Howlett, A., Anderson, M., & Herman, D. (2020). Interventions for paternal perinatal depression: A systematic review. *Journal of affective disorders*, *265*, 505-510.

Green, K. L., Brown, G. K., Jager-Hyman, S., Cha, J., Steer, R. A., & Beck, A. T. (2015). The predictive validity of the beck depression inventory suicide item. *The Journal of clinical psychiatry*, *76*(12), 1683-1686.

Gregory, A., & Milner, S. (2011). What is "new" about fatherhood? The social construction of fatherhood in France and the UK. *Men and masculinities*, *14*(5), 588-606.

Gutierrez-Galve, L., Stein, A., Hanington, L., Heron, J., Lewis, G., O'Farrelly, C., & Ramchandani, P. G. (2018). Association of Maternal and Paternal Depression

in the Postnatal Period With Offspring Depression at Age 18 Years. *JAMA Psychiatry*.doi:10.1001/jamapsychiatry.2018.3667

Güney, S., Kalafat, T., & Boysan, M. (2010). Dimensions of mental health: life satisfaction, anxiety and depression: a preventive mental health study in Ankara University students population. *Procedia-Social and Behavioral Sciences*, *2*(2), 1210-1213.

Haas, Linda, and Margaret O' Brien. 2010. ''New Observations on How Fathers Work and Care: Introduction to the Special Issue—Men, Work and Parenting—Part I.'' *Fathering 8:*271–75.

Haefner J. (2014). An application of Bowen family systems theory. *Issues in mental health nursing*, *35*(11), 835–841. https://doi.org/10.3109/01612840.2014.921257

Hayes, A. F. (2017). Introduction to mediation, moderation, and conditional process analysis: A regression-based approach. *Guilford publications.*

Halligan, S. L., Murray, L., Martins, C., & Cooper, P. J. (2007). Maternal depression and psychiatric outcomes in adolescent offspring: a 13-year longitudinal study. *Journal of affective disorders*, *97*(1-3), 145-154.

Hahn-Holbrook, J., Cornwell-Hinrichs, T., & Anaya, I. (2018). Economic and health predictors of national postpartum depression prevalence: a systematic review, meta-analysis, and meta-regression of 291 studies from 56 countries. *Frontiers in psychiatry*, *8*, 248.

Hauser, O. (2012). Pushing Daddy Away? A Qualitative Study of Maternal Gatekeeping. *Qualitative Sociology Review*, *8*(1).

Hawker, D., Hawker D. (2016). Skype therapy: More or less confidential than traditional therapy? *Clinical Psychology Forum.*

Herbst, D. M., Griffith, N. R., & Slama, K. M. (2014). Rodeo cowboys: Conforming to masculine norms and help-seeking behaviors for depression. *Journal of Rural Mental Health, 38*(1), 20–35. doi: 10.1037.

Hisli, N. (1989). Beck Depresyon Envanterinin Geçerliği Üzerine Bir Çalışma. *Psikoloji Dergisi, 22, 118-126. disorders*, *68*(2-3), 215-220.

Howitt, D. (2010). Introduction to qualitative methods in psychology. *Pearson.*

Howitt, D., and Cramer, D. (2008). Introduction to Research Methods in Psychology. Harlow: Pearson.

Holopainen, A., & Hakulinen, T. (2019). New parents' experiences of postpartum depression: a systematic review of qualitative evidence. *JBI Evidence Synthesis*, *17*(9), 1731-1769.

Howarth, A. M., & Swain, N. R. (2020). Predictors of postpartum depression in first-time fathers. *Australasian Psychiatry*, *28*(5), 552-554. https://doi.org/10.1177/1039856220924324

Johansson, M., Nordström, T., & Svensson, I. (2020). Depressive symptoms, parental stress, and attachment style in mothers and fathers two and a half

years after childbirth: Are fathers as affected as mothers? *Journal of child health care*, 1367493520942050.

Jones, D. J., Cassidy, J., and Shaver, P. R. (2015). Parents' self-reported attachment styles: a review of links with parenting behaviors, emotions, and cognitions. *Pers. Soc. Psychol. Rev. 19,* 44–76. doi: 10.1177/108886831454 1858

Johnson, C. E. (2011). Sexual health during pregnancy and the postpartum (CME). *The journal of sexual medicine*, *8*(5), 1267-1284..

Johnson, B., & Larry B. C. (2017). Educational research: Quantitative, qualitative, and mixed approaches. 6th Los Angeles: Sage

Johnston, D. D. & Swanson D. H. (2003) Undermining Mothers: A Content Analysis of the Representation of Mothers in Magazines. *Mass Communication and Society*, 6:3, 243-265, DOI: 10.1207/S15327825MCS0603_2

Kağıtçıbaşı, Ç., & Sunar, D. (1992). Family and socialization in Turkey. Parent-child relations in diverse cultural settings: Socialization for instrumental competency, 5, 75-88.

Kağıtçıbaşı, Ç. (1982). Old-age security value of children: Cross-national socioeconomic evidence. *Journal of Cross-Cultural Psychology*, *13(1*), 29-42.

Karam, F., Sheehy, O., Huneau, M. C., Chambers, C., Fraser, W. D., Johnson, D., ... & Bérard, A. (2016). Impact of maternal prenatal and parental postnatal stress on 1-year-old child development: results from the OTIS antidepressants in pregnancy study. *Archives of women's mental health*, *19*(5), 835-843.

Kamalifard, M., Bayati Payan, S., Panahi, S., Hasanpoor, S., & Babapour Kheiroddin, J. (2018). Paternal Postpartum Depression and Its Relationship With Maternal Postpartum Depression. *Journal of Holistic Nursing and Midwifery*, *28*(2), 115-120.

Kamalifard, M., Bayati Payan, S., Panahi, S., Hasanpoor, S., & Babapour Kheiroddin, J. (2018). Paternal Postpartum Depression and Its Relationship with Maternal Postpartum Depression. *Journal of Holistic Nursing And Midwifery*, *28*(2), 115-120.

Kerstis, B., Berglund, A., Engström, G., Edlund, B., Sylvén, S., & Aarts, C. (2014). Depressive symptoms postpartum among parents are associated with marital separation: A Swedish cohort study. *Scandinavian Journal of Public Health, 42*, 660-668.

Kleinman, A. (1987). Anthropology and psychiatry. *British Journal of Psychiatry, 151*(4), 447-454.

Kopala-Sibley, D. C., Jelinek, C., Kessel, E. M., Frost, A., Allmann, A. E., & Klein, D. N. (2017). Parental depressive history, parenting styles, and child psychopathology over 6 years: The contribution of each parent's depressive history to the other's parenting styles. *Development and psychopathology*, *29*(4), 1469-1482.

Kosakowska-Berezecka, N., Besta, T., Adamska, K., Jaśkiewicz, M., Jurek, P., & Vandello, J. A. (2016). If my masculinity is threatened I won't support gender equality? The role of agentic self-stereotyping in restoration of manhood and

perception of gender relations. *Psychology of Men & Masculinity, 17*(3), 274–284. https://doi.org/10.1037/men0000016

Köker, S. (1991). Normal ve sorunlu ergenlerin yaşam doyumu düzeyinin karşılaştırılması (Yüksek Lisans tezi). *Ankara Üniversitesi Sosyal Bilimler Enstitüsü*, Ankara.

Kramer, A., Kramer, K. Z. (2021) Putting the family back into work and family research. *Journal of Vocational Behavior* 126. https://doi.org/10.1080/13668803.2020.1804324

Krumm, S., Checchia, C., Koesters, M., Kilian, R., & Becker, T. (2017). Men's views on depression: a systematic review and metasynthesis of qualitative research. *Psychopathology*, *50*(2), 107-124. DOI: 10.1159/000455256

Lamb, Michael E., and Catherine S. Tamis-LeMonda. 2004. ‘‘The Role of Father: An Introduction.’’ *In The Role of the Father in Child Development*, edited by M. E. Lamb, 1–31. New York: Wiley.

Landrine, H. (1988). Depression and stereotypes of women: Preliminary empirical analyses of the gender-role hypothesis. *Sex Roles*, *19*(7-8), 527-541.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102–120. doi: 10.1191/1478088706qp062oa

Latalova, K., Kamaradova, D., & Prasko, J. (2014). Perspectives on perceived stigma and self-stigma in adult male patients with depression. *Neuropsychiatric disease and treatment*, *10*, 1399.

Lawrence, E., Rothman, A. D., Cobb, R. J., Rothman, M. T., & Bradbury, T. N. (2008). Marital satisfaction across the transition to parenthood. *Journal of family psychology*, *22*(1), 41.

Lindberg, I., & Engström, Å. (2013). A qualitative study of new fathers' experiences of care in relation to complicated childbirth. *Sexual & Reproductive Healthcare, 4*, 147-152.

Lo, C. K., Chan, K. L., & Ip, P. (2019). Insecure adult attachment and child maltreatment: A meta-analysis. *Trauma, Violence, & Abuse*, *20*(5), 706-719. https://doi.org/10.1177/1524838017730579

Lynch, J., Lynch, J. R., & Kilmartin, C. (2013). *Overcoming masculine depression: The pain behind the mask*. Routledge.

Madsen, S. A., & Juhl, T. (2007). Paternal depression in the postnatal period assessed with traditional and male depression scales. *Journal of Men's Health and Gender*, *4*(1), 26-31.

Makinde, T. (2004). Motherhood as a source of empowerment of women in Yoruba culture. *Nordic Journal of African Studies*, *13*(2), 11-11.

Martin, L. A., Neighbors, H. W., & Griffith, D. M. (2013). The experience of symptoms of depression in men vs women: analysis of the National Comorbidity Survey Replication. *JAMA psychiatry*, *70*(10), 1100-1106.

Matthey S, Barnett B, Ungerer J, Waters B J. (2000). Paternal and maternal depressed mood during the transition to parenthood. *Affect Disord. Nov; 60(2):75-85.*

Matthey, S., Barnett, B., Kavanagh, D. J., & Howie, P. (2001). Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with their partners. *Journal of affective disorders*, *64*(2-3), 175-184. https://doi.org/10.1016/S0165-0327(00)00236-6

Maurer, Trent W., and Joseph H. Pleck. 2006. ‘‘Fathers’ Caregiving and Breadwinning: A Gender Congruence Analysis.’’ *Psychology of Men and Masculinity 8*:101–12

Misri, S. (2018). Paternal Postnatal Psychiatric Illnesses A Clinical Casebook. *Springer*. 11-30

Moullec, G., Plourde, A., Lavoie, K. L., Suarthana, E., & Bacon, S. L. (2015). Beck Depression Inventory II: determination and comparison of its diagnostic accuracy in cardiac outpatients. *European journal of preventive cardiology*, *22*(5), 665-672.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*, 250–260.

Morse, C. A., Buist, A., & Durkin, S. (2000). First-time parenthood: influences on pre-and postnatal adjustment in fathers and mothers. *Journal of psychosomatic obstetrics & gynecology*, *21*(2), 109-120.

Mullen, G. (2019). Mapping evidence from systematic reviews regarding adult attachment and mental health difficulties: A scoping review. *Irish Journal of Psychological Medicine, 36*(3), 207-229. doi:10.1017/ipm.2017.27

Nagy, E., Molnar, P., Pal, A., & Orvos, H. (2011). Prevalence rates and socioeconomic characteristics of post-partum depression in Hungary. *Psychiatry Research*, *185*(1-2), 113-120.

Nielsen, A. C., & Williams, T. A. (1980). Depression in ambulatory medical patients: Prevalence by self-report questionnaire and recognition by nonpsychiatric physicians. *Archives of General Psychiatry*, *37*(9), 999-1004.

Nijssens, L., Bleys, D., Casalin, S., Vliegen, N., & Luyten, P. (2018). Parental attachment dimensions and parenting stress: the mediating role of parental reflective functioning. *Journal of Child and Family Studies*, *27*(6), 2025-2036. https://doi.org/10.1007/s10826-018-1029-0

Nolen-Hoeksema, S. (2002). Gender differences in depression. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of depression* (pp. 492–509). New York: Guilford Press.

Nolen-Hoeksema, S., & Jackson, B. (2001). Mediators of the gender difference in rumination. Psychology of Women Quarterly, 25, 37-47.

Norhayati, M. N., Hazlina, N. N., Asrenee, A. R., & Emilin, W. W. (2015). Magnitude and risk factors for postpartum symptoms: a literature review. *Journal of affective Disorders*, *175*, 34-52.

O'connor, B. P. (2000). SPSS and SAS programs for determining the number of components using parallel analysis and Velicer's MAP test. *Behavior research methods, instruments, & computers*, *32*(3), 396-402

Olga, Y., Potluri, R. M., Gulfiya, N., & Aizhan, S. (2020). Women's Unpaid Work as a Factor of Gender Inequality: A Case of Kazakhstan. *The Journal of Business Economics and Environmental Studies*, *10*(2), 17-21.

Oliver, S. J., & Toner, B. B. (1990). The influence of gender role typing on the expression of depressive symptoms. *Sex roles, 22*(11), 775-790.

Olsavsky, A. L., Yan, J., Schoppe-Sullivan, S. J., & Kamp Dush, C. M. (2020). New fathers' perceptions of dyadic adjustment: The roles of maternal gatekeeping and coparenting closeness. *Family process, 59*(2), 571-585.

O'Neil, J. M., Helms, B. J., Gable, R. K., David, L., & Wrightsman, L. S. (1986). Gender-Role Conflict Scale: College men's fear of femininity. *Sex Roles,* 14, 335–350.

Ongeri, L., Wanga, V., Otieno, P., Mbui, J., Juma, E., Vander Stoep, A., & Mathai, M. (2018). Demographic, psychosocial and clinical factors associated with postpartum depression in Kenyan women. *BMC psychiatry, 18*(1), 1-9.

Online Therapy Institute (2013). Skype & HIPAA: The Vexing Question. Retrieved from https://www.onlinetherapyinstitute.com/2013/10/02/skype-hipaa-vexing-question/

Osofsky, J. D., & Fitzgerald, H. E. (Eds.). (1999). *WAIMH Handbook of Infant Mental Health, Infant Mental Health in Groups at High Risk* (Vol. 4). Wiley.

Özmen-Kaymak, S., ve Özmen, A. (2012). Anne Baba Stres Ölçeğinin geliştirilmesi. *Milli Eğitim Dergisi, 42*(196), 20-35.

Palitsky, D., Mota, N., Afifi, T. O., Downs, A. C., & Sareen, J. (2013). The association between adult attachment style, mental disorders, and suicidality: findings from a population-based study. *The Journal of nervous and mental disease*, *201*(7), 579-586. doi: 10.1097/NMD.0b013e31829829ab

Patton, M. Q. (2002). Qualitative research and evaluation methods. *Thousand Oaks*, CA: Sage.

Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. *Jama*, *303*(19), 1961-1969.

Paulson, J. F., Bazemore, S. D., Goodman, J. H., & Leiferman, J. A. (2016). The course and interrelationship of maternal and paternal perinatal depression. *Archives of women's mental health*, *19*(4), 655-663.

Pleck, E. H. (2004). ‘‘Two Dimensions of Fatherhood: A History of the Good Dad/Bad Dad Complex.’’ In The role of the Father in Child Development, edited by M. E. Lamb, 32–57. New York: Wiley.

Prentice, D. A., & Carranza, E. (2002). What women and men should be, shouldn’t be, are allowed to be, and don’t have to be: The contents of prescriptive gender stereotypes. *Psychology of Women Quarterly*, 26(4), 269–281. http//dx.doi.org/10.1111/1471-6402.t01-1-00066

Psouni, E., Agebjörn, J., & Linder, H. (2017). Symptoms of depression in Swedish fathers in the postnatal period and development of a screening

tool. *Scandinavian journal of psychology*, *58*(6), 485-496. https://doi.org/10.1111/sjop.12396

Psouni, E., & Eichbichler, A. (2020). Feelings of restriction and incompetence in parenting mediate the link between attachment anxiety and paternal postnatal depression. *Psychology of Men & Masculinities, 21*(3), 416–429. https://doi.org/10.1037/men0000233

Rahmani, A., Fallahi, A., Allahqoli, L., & Grylka, S. (2021). Postpartum sexual quality of life in two cultures: a qualitative study. *Intersections: Gender and Sexuality in Asia and the Pacific*, *2021*(45). 10.21256/zhaw-22012

Ramchandani, P. G., Psychogiou, L., Vlachos, H., Iles, J., Sethna, V., Netsi, E., & Lodder, A. (2011). Paternal depression: An explanation of its links with father, child and family functioning in the postnatal period. *Depression and Anxiety, 28*, 471-477.

Rao, W. W., Zhu, X. M., Zong, Q. Q., Zhang, Q., Hall, B. J., Ungvari, G. S., & Xiang, Y. T. (2020). Prevalence of prenatal and postpartum depression in fathers: A comprehensive meta-analysis of observational surveys. *Journal of affective disorders*, *263*, 491-499. https://doi.org/10.1016/j.jad.2019.10.030

Reddick, R. J., Rochlen, A. B., Grasso, J. R., Reilly, E. D., & Spikes, D. D. (2012). Academic fathers pursuing tenure: A qualitative study of work-family conflict, coping strategies, and departmental culture. *Psychology of Men & Masculinity, 13*(1), 1.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring the lived experience. *The Psychologist, 18*, 20–23

Rudman, L. A., Greenwald, A. G., & McGhee, D. E. (2001). Implicit self-concept and evaluative implicit gender stereotypes: Self and ingroup share desirable traits. *Personality and Social Psychology Bulletin, 27(*9), 1164-1178. https://doi.org/10.1177/0146167201279009

Rudman, L., Moss-Racusin, C., Phelan, J., & Nauts, S. (2012). Status incongruity and backlash effects: Defending the gender hierarchy motivates prejudice against female leaders. *Journal of Experimental Social Psychology, 48(*1), 165-179. http//dx.doi.org/10.1016/j.jesp.2011.10.008

Sakallı, N., Türkoğlu Demirel, B., & Kuzlak, A. (2018). How are women and men perceived? Structure of gender stereotypes in contemporary Turkey.

Salman Engin, S. (2014). Coparenting processes in the US and Turkey: Triadic interactions among mothers, fathers, and grandmothers with 3-month-old infants.

Salokangas, R. K., Vaahtera, K., Pacriev, S., Sohlman, B., & Lehtinen, V. (2002). Gender differences in depressive symptoms: An artefact caused by measurement instruments?. *Journal of affective disorders*, *68*(2-3), 215-220.

Santona, A., Tagini, A., Sarracino, D., De Carli, P., Pace, C. S., Parolin, L., & Terrone, G. (2015). Maternal depression and attachment: the evaluation of mother–child interactions during feeding practice. *Frontiers in psychology*, *6*, 1235.

Schoonenboom, J., & Johnson, R. B. (2017). How to construct a mixed methods research design. *KZfSS Kölner Zeitschrift für Soziologie und Sozialpsychologie*, *69*(2), 107-131.

Schoppe-Sullivan, S. J., Brown, G. L., Cannon, E. A., Mangelsdorf, S. C., & Sokolowski, M. S. (2008). Maternal gatekeeping, coparenting quality, and fathering behavior in families with infants. *Journal of Family Psychology, 22*, 389–398. https://doi.org/10.1037/0893-3200.22.3.389.

Schwab, J., Bialow, M., Clemmons, R., Martin, P., & Holzer, C. (1967). The Beck depression inventory with medical inpatients. *Acta Psychiatrica Scandinavica*.

Shannon, G., Minckas, N., Tan, D., Haghparast-Bidgoli, H., Batura, N., & Mannell, J. (2019). Feminisation of the health workforce and wage conditions of health professions: an exploratory analysis. *Human resources for health*, *17*(1), 1-16. https://doi.org/10.1186/s12960-019-0406-0

Singley, D. B., & Edwards, L. M. (2015). Men's perinatal mental health in the transition to fatherhood. *Professional Psychology: Research and Practice*, *46*(5), 309.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological phenomenological analysis. *Journal of Community and Applied Social Psychology*, *12*, 194–209.

Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In G. M. Breakwell (Ed.), *Doing Social Psychology Research* (pp. 229-254).

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: a systematic review. *Clinical psychology review*, *49*, 106-118.

Selçuk, E., Günaydın, G., Sümer, N., ve Uysal, A. (2005). Yetişkin bağlanma boyutları için yeni bir ölçüm: Yakın ilişkilerde yaşantılar envanteri-II'nin Türk örnekleminde psikometrik açıdan değerlendirilmesi. *Türk Psikoloji Yazıları*, 8(16), 1-11.

Sethi, S., & Nolen-Hoeksema, S. (1997). Gender differences in internal and external focusing among adolescents. *Sex Roles,* 37, 687–700.

Simpson, J. A. & Rholes, W. S. (2012) Adult attachment orientations, stress, and romantic relationships. *In: Advances in Experimental Social Psychology*. Academic Press, Vol. 45, 279–328.

Sorj, B., & Fraga, A. (2020). Leave policies and social inequality in Brazil. *International Journal of Sociology and Social Policy*.

Slomian, J., Honvo, G., Emonts, P., Reginster, J. Y., & Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's Health*, *15*, 1745506519844044.

Smith, J. A., & Osborn, M. (2003). *Interpretative phenomenological analysis.* In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (p. 51–80). Sage Publications, Inc.v

Sroufe LA, Coffino B and Carlson EA (2010) Conceptualizing the role of early experience: lessons from the Minnesota longitudinal study. *Developmental Review 30*(1): 36–51.

Sunar, D., & Fisek. G. O. (2005). ‘‘Contemporary Turkish Families.’’ *In Families in Global Perspective*, edited by J. L. Roopnarine and U. Gielen, 169–83. Boston, MA: Pearson/Allyn and Bacon.

Suto, M., Takehara, K., Yamane, Y., & Ota, E. (2017). Effects of prenatal childbirth education for partners of pregnant women on paternal postnatal mental health and couple relationship: A systematic review. *Journal of affective disorders*, *210*, 115-121.

St John, W., Cameron, C., & McVeigh, C. (2005). Meeting the challenge of new fatherhood during the early weeks. *Journal of Obstetric Gynecologic and Neonatal Nursing, 34,* 180-189. doi:10.1177/0884217505274699

Tassakkori, A. & Teddle, C. (2003). Handbook of Mixed Methods in Social & Behavioral Research*. Sage Publications*: London.

Thomas, J. E., Bonér, A.-K., & Hildingsson, I. (2011). Fathering in the first few months. *Scandinavian Journal of Caring Sciences, 25,* 499-509 doi:10.11111/j.1471- 6712.2010.00856.x

Timurtürkan, M. (2020). Annelerin Emzirmeye İlişkin Instagram’da Paylaştıkları Görsellerin Heteronormatif Cinsiyet Kalıpları Açısından Değerlendirilmesi| Evaluation of the Visuals Shared By Mothers on Instagram About

Breastfeeding from the Point of Heteronormative Gender Patterns. *Akdeniz Kadın Çalışmaları ve Toplumsal Cinsiyet Dergisi*, *3*(1), 1-29.

Toth, S. L., Rogosch, F. A., Sturge-Apple, M., & Cicchetti, D. (2009). Maternal depression, children's attachment security, and representational development: An organizational perspective. *Child development*, *80*(1), 192-208.

Trivedi, S., & Bose, K. (2020). Fatherhood and roles of father in children's upbringing in Botswana: fathers' perspectives. *Journal of Family Studies*, *26*(4), 550-563.

Ünlütürk Ulutaş, Ç. (2015). İş Ve Aile Yaşamını Uzlaştırma Politikaları: Türkiye'de Yeni Politika Arayışları. *Ankara Üniversitesi SBF Dergisi,* 70 (3) , 723-750 . DOI: 10.1501/SBFder_0000002368

Vakfı, A. Ç. E. (2017). Türkiye'de ilgili babalık ve belirleyicileri. *İstanbul: AÇEV*.

Valiquette-Tessier, S. C., Gosselin, J., Young, M., & Thomassin, K. (2019). A literature review of cultural stereotypes associated with motherhood and fatherhood. *Marriage & Family Review*, *55*(4), 299-329.

Vandello, J. A., & Bosson, J. K. (2013). Hard won and easily lost: A review and synthesis of theory and research on precarious manhood. *Psychology of Men & Masculinity, 14(*2), 101–113. http://doi.org/10.1037/a0029826

Villodas, M. T., Bagner, D. M., & Thompson, R. (2018). A step beyond maternal depression and child behavior problems: the role of mother–child aggression. *Journal of Clinical Child & Adolescent Psychology*, *47*(4), 634-641.

Wang, Y. P., & Gorenstein, C. (2013). Assessment of depression in medical patients: a systematic review of the utility of the Beck Depression Inventory-II. *Clinics*, *68*(9), 1274-1287.

Wang, T., Xu, Y., Li, Z., & Chen, L. (2016). Prevalence of paternal postpartum depression in China and its association with maternal postpartum depression: A Meta-analysis. *Zhong nan da xue xue bao. Yi xue ban= Journal of Central South University. Medical sciences*, *41*(10), 1082-1089. 10.11817/j.issn.1672-7347.2016.10.012

Wardrop, A. A., & Popadiuk, N. E. (2013). Women's Experiences with Postpartum Anxiety: Expectations, Relationships, and Sociocultural Influences. *Qualitative Report*, *18*, 6.

Whitehead, D., & Schneider, Z. (2007). Mixed-methods research. *Nursing and Midwifery research: methods and appraisal for evidence-based practice*, 249-267.

Williams, S. (2008). ‘‘What is Fatherhood? Searching for the Reflexive Father.’’ *Sociology 42*, 487–502.

Willig, C. (2008). Introducing Qualitative Methods in Psychology: Adventures in Theory and Method (2nd Ed.). London: Open University Press.

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clinical psychology review*, *30*(2), 167-180.

Yetim, Ü. Life satisfaction: A study based on the organization of personal projects. *Soc Indic Res* 29**,** 277–289 (1993). https://doi.org/10.1007/BF01079516

Yim, I. S., Stapleton, L. R. T., Guardino, C. M., Hahn-Holbrook, J., & Schetter, C. D. (2015). Biological and psychosocial predictors of postpartum depression: systematic review and call for integration. *Annual review of clinical psychology*, *11*.

Zhang, Y. P., Zhang, L. L., Wei, H. H., Zhang, Y., Zhang, C. L., & Porr, C. (2016). Postpartum depression and the psychosocial predictors in first-time fathers from northwestern China. *Midwifery*, *35*, 47-52.

Zhao, Y., Cooklin, A. R., Richardson, A., Strazdins, L., Butterworth, P., & Leach, L. S. (2020). Parents' Shift Work in Connection with Work–Family Conflict and Mental Health: Examining the Pathways for Mothers and Fathers. *Journal of Family Issues*, 0192513X20929059.

Zierau, F., Bille, A., Rutz, W., & Bech, P. (2002). The Gotland Male Depression Scale: A validity study in patients with alcohol use disorder. *Nordic Journal of Psychiatry, 56(4),* 265–271. doi:10.1080/08039480260242750

Zvara, B. J., Lathren, C., Mills-Koonce, R., & Family Life Project Key Contributors. (2020). Maternal and paternal attachment style and chaos as risk factors for parenting behavior. *Family relations*, *69*(2), 233-246.https://doi.org/10.1111/fare.12423

# APPENDICES

## APPENDIX A: DEMOGRAPHIC INFORMATION FORM (QUALITATIVE STRAND)

1) Yaşınız: ……

2) Cinsiyetiniz: o Erkek o Kadın

3) Eğitim durumunuz (Son aldığınız diplomaya göre):

o İlkokul mezunu o Ortaokul mezunu o Lise mezunu o Üniversite mezunu o Yüksek lisans

o Doktora

4) Çalışıyor iseniz mesleğiniz (Doğum izninde iseniz lütfen belirtiniz): ……

4) Aylık geliriniz:

- o 1300 TL veya daha az
- o 2500 TL-3500 TL arası
- o 1300 TL – 1500 TL arası
- o 1500 TL-2500 TL arası
- o 3500 TL- 5000 TL arası
- o 5000 TL-10.000 TL arası
- o 10.000TL ve üstü

5) Medeni durumunuz:

o Evli (Kaçıncı evliliğiniz?) ……

o Bekar (Hiç evlenmemiş)

o Boşanmış

o Eşini kaybetmiş

o Diğer (Lütfen belirtiniz:.....)

6) Kaç çocuğunuz var? …….

13) Bebeğinizin doğum tarihi: ……

14) Bebeğinizin cinsiyeti: ……

15) Varsa diğer çocuklarınızın doğum tarihleri ve cinsiyetlerini yazınız.

1. Doğum tarihi: ……  Cinsiyeti: ……
2. Doğum tarihi: ……  Cinsiyeti: ……
3. Doğum tarihi: ……  Cinsiyeti: ……
4. Doğum tarihi: ……  Cinsiyeti: ……

7) Geçmişte doktor veya psikiyatrist tarafından tanı koyulan bir sağlık sorununuz oldu mu?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Hangi ilaçları kullandınız? .....

8) Şu an devam eden fiziksel veya psikolojik herhangi bir sağlık sorununuz var mı?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Güncel olarak kullandığınız bir ilaç var mı? .....

7) Eşinizin geçmişte doktor veya psikiyatrist tarafından tanı koyulmuş bir sağlık sorunu oldu mu?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadı? .....

Hangi ilaçları kullandı? .....

8) Eşinizin şu an devam eden fiziksel veya psikolojik herhangi bir sağlık sorunu var mı?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadı? .....

Güncel olarak kullandığı bir ilaç var mı? .....

9) Hamilelik esnasında eşiniz doktor kontrollerini yaptırdı mı? o Evet o Hayır

Evet ise:

o 28. Hamilelik haftasına kadar ne sıklıkla kontrole geldi?
.....

o 28.-36. Hamilelik haftaları arasında ne sıklıkla kontrole geldi?
.....

o 36. Hamilelik haftasından doğuma kadar ne sıklıkla kontrole geldi?
.....

10) Hamilelik süresince bebek ile ilgili herhangi bir sağlık problemi oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

11) Doğum esnasında bebek ile ilgili herhangi bir sağlık problemi veya doğum komplikasyonu oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

12) Doğum sonrasında bebek ile ilgili herhangi bir sağlık problemi oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

13) Eşiniz planlanmış bir gebelik mi geçirdi? o Evet o Hayır

**APPENDIX B: DEMOGRAPHIC INFORMATION FORM (FATHER, QUANTITATIVE STRAND)**

1) Yaşınız: ……

2) Cinsiyetiniz: o Erkek o Kadın

3) Eğitim durumunuz (Son aldığınız diplomaya göre):

o İlkokul mezunu o Ortaokul mezunu o Lise mezunu o Üniversite mezunu o Yüksek lisans

o Doktora

4) Çalışıyor iseniz mesleğiniz (Doğum izninde iseniz lütfen belirtiniz): ……

4) Aylık geliriniz:

- 1300 TL veya daha az
- 2500 TL-3500 TL arası
- 1300 TL – 1500 TL arası
- 1500 TL-2500 TL arası
- 3500 TL- 5000 TL arası
- 5000 TL-10.000 TL arası
- 10.000TL ve üstü

5) Medeni durumunuz:

o Evli

o Bekar (Hiç evlenmemiş)

o Boşanmış

o Eşini kaybetmiş

o Diğer (Lütfen belirtiniz:.....)

6) Kaç çocuğunuz var? …….

13) Bebeğinizin doğum tarihi: ……

14) Bebeğinizin cinsiyeti: ……

15) Varsa diğer çocuklarınızın doğum tarihleri ve cinsiyetlerini yazınız.

1. Doğum tarihi: ……  Cinsiyeti: ……

2. Doğum tarihi: …… Cinsiyeti: ……
3. Doğum tarihi: …… Cinsiyeti: ……
4. Doğum tarihi: …… Cinsiyeti: ……

7) Geçmişte doktor veya psikiyatrist tarafından tanı koyulan bir sağlık sorununuz oldu mu?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Hangi ilaçları kullandınız? .....

8) Şu an devam eden fiziksel veya psikolojik herhangi bir sağlık sorununuz var mı?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Güncel olarak kullandığınız bir ilaç var mı? .....

9) Hamilelik esnasında eşiniz doktor kontrollerini yaptırdı mı? o Evet o Hayır

Evet ise:

o 28. Hamilelik haftasına kadar ne sıklıkla kontrole geldi?
.....

o 28.-36. Hamilelik haftaları arasında ne sıklıkla kontrole geldi?
.....

o 36. Hamilelik haftasından doğuma kadar ne sıklıkla kontrole geldi?
.....

10) Hamilelik süresince bebek ile ilgili herhangi bir sağlık problemi oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

11) Doğum esnasında bebek ile ilgili herhangi bir sağlık problemi veya doğum komplikasyonu oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

12) Doğum sonrasında bebek ile ilgili herhangi bir sağlık problemi oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

13) Eşiniz planlanmış bir gebelik mi geçirdi? o Evet o Hayır

## APPENDIX C: DEMOGRAPHIC INFORMATION FORM (MOTHER, QUANTITATIVE STRAND)

1) Yaşınız: ……

2) Cinsiyetiniz: o Erkek o Kadın

3) Eğitim durumunuz (Son aldığınız diplomaya göre):

o İlkokul mezunu o Ortaokul mezunu o Lise mezunu o Üniversite mezunu o Yüksek lisans

o Doktora

4) Çalışıyor iseniz mesleğiniz (Doğum izninde iseniz lütfen belirtiniz): ……

4) Aylık geliriniz:

- 1300 TL veya daha az
- 2500 TL-3500 TL arası
- 1300 TL – 1500 TL arası
- 1500 TL-2500 TL arası
- 3500 TL- 5000 TL arası
- 5000 TL-10.000 TL arası
- 10.000TL ve üstü

5) Medeni durumunuz:

o Evli

o Bekar (Hiç evlenmemiş)

o Boşanmış

o Eşini kaybetmiş

o Diğer (Lütfen belirtiniz:.....)

6) Kaç çocuğunuz var? …….

13) Bebeğinizin doğum tarihi: ……

14) Bebeğinizin cinsiyeti: ……

15) Varsa diğer çocuklarınızın doğum tarihleri ve cinsiyetlerini yazınız.

1. Doğum tarihi: ……  Cinsiyeti: ……

2. Doğum tarihi: …… Cinsiyeti: ……
3. Doğum tarihi: …… Cinsiyeti: ……
4. Doğum tarihi: …… Cinsiyeti: ……

7) Geçmişte doktor veya psikiyatrist tarafından tanı koyulan bir sağlık sorununuz oldu mu?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Hangi ilaçları kullandınız? .....

8) Şu an devam eden fiziksel veya psikolojik herhangi bir sağlık sorununuz var mı?

o Evet o Hayır

Evet ise:

Hangi sorunları yaşadınız? .....

Güncel olarak kullandığınız bir ilaç var mı? .....

9) Hamilelik esnasında doktor kontrolleri yaptırdınız mı? o Evet o Hayır

Evet ise:

o 28. Hamilelik haftasına kadar ne sıklıkla kontrole geldiniz?
.....

o 28.-36. Hamilelik haftaları arasında ne sıklıkla kontrole geldiniz?
.....

o 36. Hamilelik haftasından doğuma kadar ne sıklıkla kontrole geldiniz?
.....

10) Hamilelik süresince bebek ile ilgili herhangi bir sağlık problemi oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

11) Doğum esnasında bebek ile ilgili herhangi bir sağlık problemi veya doğum komplikasyonu oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

12) Doğum sonrasında bebek ile ilgili herhangi bir sağlık problemi oldu mu? o Evet o Hayır

Varsa lütfen açıklayınız:

13) Planlanmış bir gebelik mi geçirdiniz? o Evet o Hayır

## APPENDIX D: BECK DEPRESSION INVENTORY

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir.
Her madde bir çeşit ruh durumunu anlatmaktadır. Her maddede o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir
hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi bulunuz. Daha sonra, o maddenin yanındaki harfin üzerine (X) işareti koyunuz.

1)
a. Kendimi üzgün hissetmiyorum
b. Kendimi üzgün hissediyorum
c. Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum
d. Öylesine üzgün ve mutsuzum ki dayanamıyorum

2)
a. Gelecekten umutsuz değilim
b. Gelecek konusunda umutsuzum
c. Gelecekten beklediğim hiç bir şey yok
d. Benim için bir gelecek olmadığı gibi bu durum değişmeyecek

3)
a. Kendimi başarısız görmüyorum
b. Herkesten daha fazla başarısızlıklarım oldu sayılır
c. Geriye dönüp baktığımda, pek çok başarısızlıklarımın olduğunu görüyorum
d. Kendimi bir insan olarak tümüyle başarısız görüyorum

4)
a. Her şeyden eskisi kadar doyum (zevk) alabiliyorum
b. Her şeyden eskisi kadar doyum alamıyorum
c. Artık hiçbir şeyden gerçek bir doyum alamıyorum
d. Bana doyum veren hiçbir şey yok. Her şey çok sıkıcı

5)
a. Kendimi suçlu hissetmiyorum
b. Arada bir kendimi suçlu hissettiğim oluyor
c. Kendimi çoğunlukla suçlu hissediyorum
d. Kendimi her an için suçlu hissediyorum

6)
a. Cezalandırılıyormuşum gibi duygular içinde değilim
b. Sanki bazı şeyler için cezalandırılabilirmişim gibi duygular içindeyim

c. Cezalandırılacakmışım gibi duygular yaşıyorum
d. Bazı şeyler için cezalandırılıyorum
7)
a. Kendimi hayal kırıklığına uğratmadım
b. Kendimi hayal kırıklığına uğrattım
c. Kendimden hiç hoşlanmıyorum
d. Kendimden nefret ediyorum
8)
a. Kendimi diğer insanlardan daha kötü durumda görmüyorum
b. Kendimi zayıflıklarım ve hatalarım için eleştiriyorum
c. Kendimi hatalarım için her zaman suçluyorum
d. Her kötü olayda kendimi suçluyorum
9)
a. Kendimi öldürmek gibi düşüncelerim yok
b. Bazen kendimi öldürmeyi düşünüyorum ama böyle bir şey yapamam
c. Kendimi öldürebilmeyi çok isterdim
d. Eğer bir fırsatını bulursam kendimi öldürürüm
10)
a. Herkesten daha fazla ağladığımı sanmıyorum
b. Eskisine göre şimdilerde daha çok ağlıyorum
c. Şimdilerde her an ağlıyorum
d. Eskiden ağlayabilirdim. Şimdilerde istesem de ağlayamıyorum
11)
a. Eskisine göre daha sinirli veya tedirgin sayılmam
b. Her zamankinden biraz daha fazla tedirginim
c. Çoğu zaman sinirli ve tedirginim
d. Şimdilerde her an için tedirgin ve sinirliyim
12)
a. Diğer insanlara karşı ilgimi kaybetmedim
b. Eskisine göre insanlarla daha az ilgiliyim
c. Diğer insanlara karşı ilgimin çoğunu kaybettim
d. Diğer insanlara karşı hiç ilgim kalmadı
13)
a. Eskisi gibi rahat ve kolay kararlar verebiliyorum
b. Eskisine kıyasla şimdilerde karar vermeyi daha çok erteliyorum
c. Eskisine göre karar vermekte oldukça güçlük çekiyorum
d. Artık hiç karar veremiyorum
14)
a. Eskisinden daha kötü bir dış görünüşüm olduğunu sanmıyorum
b. Sanki yaşlanmış ve çekiciliğimi kaybetmişim gibi düşünüyor ve üzülüyorum
c. Dış görünüşümde artık değiştirilmesi mümkün olmayan ve beni çirkinleştiren değişiklikler olduğunu hissediyorum

d. Çok çirkin olduğumu düşünüyorum
15)
a. Eskisi kadar iyi çalışabiliyorum
b. Bir işe başlayabilmek için eskisine göre daha çok çaba harcıyorum
c. Ne olursa olsun, yapabilmek için kendimi çok zorluyorum
d. Artık hiç çalışamıyorum
16)
a. Eskisi kadar kolay ve rahat uyuyabiliyorum
b. Şimdilerde eskisi kadar kolay ve rahat uyuyamıyorum
c. Eskisine göre bir veya iki saat erken uyanıyor, tekrar uyumakta güçlük çekiyorum
d. Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum
17)
a. Eskisine göre daha çabuk yorulduğumu sanmıyorum
b. Eskisinden daha çabuk ve kolay yoruluyorum
c. Şimdilerde neredeyse her şeyden, kolayca ve çabuk yoruluyorum
d. Artık hiçbir şey yapamayacak kadar yorgunum
18)
a. İştahım eskisinden pek farklı değil
b. İştahım eskisi kadar iyi değil
c. Şimdilerde iştahım epey kötü
d. Artık hiç iştahım yok
19)
a. Son zamanlarda pek fazla kilo kaybettiğimi/aldığımı sanmıyorum
b. Son zamanlarda istemediğim halde iki buçuk kilodan fazla kaybettim/aldım
c. Son zamanlarda beş kilodan fazla kaybettim/aldım
d. Son zamanlarda yedi buçuk kilodan fazla kaybettim/aldım
20)
a. Sağlığım beni pek endişelendirmiyor
b. Son zamanlarda ağrı, sızı, mide bozukluğu, kabızlık gibi sıkıntılarım var
c. Ağrı sızı gibi bu sıkıntılarım beni çok endişelendiriyor
d. Bu tür sıkıntılar beni öylesine endişelendiriyor ki başka bir şey düşünemiyorum
21)
a. Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok
b. Eskisine göre cinsel konularla daha az ilgileniyorum
c. Şimdilerde cinsellikle pek ilgili değilim
d. Artık cinsellikle hiç bir ilgim kalmadı

## APPENDIX E: THE SATISFACTION WITH LIFE SCALE

Aşağıdaki ifadelere katılıp katılmadığınızı görüşünüzü yansıtan rakamı maddenin başındaki boşluğa yazarak belirtiniz. Doğru ya da yanlış cevap yoktur. Sizin durumunuzu yansıttığını düşündüğünüz rakam bizim için en doğru yanıttır. Lütfen, açık ve dürüst şekilde yanıtlayınız.

7 = Kesinlikle katılıyorum
6 = Katılıyorum
5 = Çok az katılıyorum
4 = Ne katılıyorum ne de katılmıyorum
3 = Biraz katılmıyorum
2 = Katılmıyorum
1 = Kesinlikle katılmıyorum

_____ Pek çok açıdan ideallerime yakın bir yaşamım var

_____ Yaşam koşullarım mükemmeldir

_____ Yaşamım beni tatmin ediyor

_____ Şimdiye kadar, yaşamda istediğim önemli şeyleri elde ettim

_____ Hayatımı bir daha yaşama şansım olsaydı, hemen hemen hiçbir şeyi değiştirmezdim

## APPENDIX F: MOTHER-FATHER STRESS SCALE

| | **ABSÖ**<br><br>**Sevgili Babalar,**<br><br>Aşağıda sizlerin babalığa ilişkin duygu ve düşünceleriniz ile ilgili ifadeler yer almaktadır. Lütfen aşağıdaki her ifadeyi okuyunuz ve size en uygun gelen seçeneği işaretleyiniz. Lütfen hiçbir soruyu boş bırakmayınız. Teşekkürler. | Her zaman | Bazen | Sık sık | Hiçbir zaman |
|---|---|---|---|---|---|
| 1. | Bebeğimi mutlu etmek benim için çok zor. | | | | |
| 2. | Bebeğimin bakımıyla ilgili sorumluluklarım beni öyle yoruyor ki başka bir şey yapmaya isteğim olmuyor. | | | | |
| 3. | Baba olmanın zor olduğunu düşünüyorum. | | | | |
| 4. | Bebeğimin ağlaması beni kızdırıyor. | | | | |
| 5. | Bebeğim doğduğundan beri kendime vakit ayıramıyorum. | | | | |
| 6. | Bebek sahibi olduğumdan beri kendimi daha yaşlı hissediyorum. | | | | |
| 7. | Bebeğim yatışmadığında bundan kendimi sorumlu tutuyorum. | | | | |
| 8. | Bebeğime kızdığımda davranışlarımı kontrol etmekte zorlanıyorum. | | | | |
| 9. | Babalığa ilişkin sorumluluklarım beni psikolojik açıdan zorluyor. | | | | |
| 10. | Bebeğimin diğer bebeklere göre daha zor bir bebek olduğunu düşünüyorum. | | | | |
| 11. | Hayal ettiğim gibi bir baba olamadığımı düşünüyorum. | | | | |
| 12. | Bebeğimin istekleri karşısında tutarsız davranabiliyorum. | | | | |
| 13. | Bebeğimin isteklerini yeterince karşılayamadığımı hissediyorum. | | | | |
| 14. | Hayatımdaki en temel stres kaynağı çocuk sahibi olmaktır. | | | | |
| 15. | Çocuğumu eğitmek konusunda kendimi yetersiz buluyorum. | | | | |
| 16. | Başarısız bir baba olduğumu düşünüyorum. | | | | |

# APPENDIX G: DYADIC ADJUSTMENT SCALE

**Birçok insanın ilişkilerinde anlaşmazlıkları vardır. Lütfen aşağıda verilen maddelerin her biri için siz ve eşiniz arasındaki anlaşma veya anlaşmama ölçüsünü aşağıda verilen altı düzeyden birini seçerek belirtiniz.**

| | Her zaman anlaşırız | Hemen hemen her zaman anlaşırız | Nadiren anlaşamayız | Sıkça anlaşamayız | Hemen hemen her zaman anlaşamayız | Her zaman anlaşamayız |
|---|---|---|---|---|---|---|
| 1. Aileyle ilgili parasal işlerin idaresi | | | | | | |
| 2. Eğlenceyle ilgili konular | | | | | | |
| 3. Dini konular | | | | | | |
| 4. Muhabbet-sevgi gösterme | | | | | | |
| 5. Arkadaşlar | | | | | | |
| 6. Cinsel yaşam | | | | | | |
| 7. Geleneksellik (doğru veya uygun davranış) | | | | | | |
| 8. Yaşam felsefesi | | | | | | |
| 9. Anne, baba ya da yakın akrabalarla ilişkiler | | | | | | |
| 10. Önemli olduğuna inanılan amaçlar, hedefler ve konular | | | | | | |
| 11. Birlikte geçirilen zaman miktarı | | | | | | |
| 12. Temel kararların alınması | | | | | | |
| 13. Ev ile ilgili görevler | | | | | | |
| 14. Boş zaman ilgi ve uğraşları | | | | | | |
| 15. Mesleki kararlar | | | | | | |

| | Her zaman | Hemen hemen her zaman | Zaman zaman | Ara sıra | Nadiren | Hiçbir zaman |
|---|---|---|---|---|---|---|
| 16. Ne sıklıkla boşanmayı, ayrılmayı ya da ilişkinizi bitirmeyi düşünür ya da tartışırsınız? | | | | | | |
| 17. Ne sıklıkla siz veya eşiniz kavgadan sonra evi terk edersiniz? | | | | | | |
| 18. Ne sıklıkla eşinizle olan ilişkinizin genelde iyi gittiğini düşünürsünüz? | | | | | | |
| 19. Eşinize güvenir misiniz? | | | | | | |
| 20. Evlendiğiniz için hiç pişmanlık duyar mısınız? | | | | | | |
| 21. Ne sıklıkla eşinizle münakaşa edersiniz? | | | | | | |
| 22. Ne sıklıkla birbirinizin sinirlenmesine neden olursunuz? | | | | | | |

| | Her gün | Hemen hemen Her gün | Ara sıra | Nadiren | Hiçbir zaman |
|---|---|---|---|---|---|
| 23. Eşinizi öper misiniz? | | | | | |

| | Hepsine | Çoğuna | Bazılarına | Çok azına | Hiçbirine |
|---|---|---|---|---|---|
| 24. Siz ve eşiniz ev dışı etkinliklerinizin ne kadarına birlikte katılırsınız? | | | | | |

**Aşağıdaki olaylar siz ve eşiniz arasında ne sıklıkta geçer?**

| | Hiçbir zaman | Ayda birden az | Ayda bir veya iki defa | Haftada bir veya iki kere | Günde bir defa | Günde birden fazla |
|---|---|---|---|---|---|---|
| 25. Teşvik edici fikir alışverişlerinde bulunmak | | | | | | |
| 26. Birlikte gülmek | | | | | | |
| 27. Bir şeyi sakince tartışmak | | | | | | |
| 28. Bir iş üzerinde birlikte çalışmak | | | | | | |

**Eşlerin bazı zamanlar anlaştıkları, bazen anlaşamadıkları konular vardır. Eğer aşağıdaki maddeler son birkaç hafta içinde siz ve eşiniz arasında görüş farklılığı veya problem yaratıyorsa belirtiniz (Evet veya Hayır'ı işaretleyiniz)**

| | Evet | Hayır |
|---|---|---|
| 29. Seks için çok yorgun olmak | | |
| 30. Sevgi göstermemek | | |

31. Aşağıda ilişkinizdeki farklı mutluluk düzeyleri gösterilmektedir. Orta noktadaki "mutlu" birçok ilişkide yaşanan mutluluk düzeyini gösterir. İlişkinizi genelde değerlendirdiğinizde mutluluk düzeyinizi en iyi şekilde belirtecek olan seçeneği lütfen işaretleyiniz.

[ ] Aşırı mutsuz [ ] Oldukça mutsuz [ ] Az mutsuz [ ] Mutlu [ ] Oldukça mutlu [ ] Aşırı mutlu [ ] Tam anlamıyla mutlu

32. Aşağıda belirtilen cümlelerden ilişkinizin geleceği hakkında ne hissettiğinizi en iyi şekilde tanımlayan ifadeyi lütfen işaretleyiniz.

[ ] İlişkimin başarılı olmasını çok fazla istiyorum ve bunun için yapamayacağım hiçbirşey yoktur.
[ ] İlişkimin başarılı olmasını çok istiyorum ve bunun için yapabileceklerimin hepsini yapacağım.
[ ] İlişkimin başarılı olmasını çok istiyorum ve bunun için payıma düşeni yapacağım.
[ ] İlişkimin başarılı olması güzel olurdu, fakat bunun için şu anda yaptıklarımdan daha fazlasını yapamam.
[ ] İlişkimin başarılı olması güzel olurdu, fakat bunun için şu anda yaptıklarımdan daha fazlasını yapmayı reddederim.
[ ] İlişkim asla başarılı olmayacak ve ilişkimin yürümesi için benim daha fazla yapabileceğim bir şey yok.

## APPENDIX H: EDINBURGH POSTNATAL DEPRESSION SCALE

Yakın zamanlarda bebeğiniz oldu. Sizin son hafta içindeki duygularınızı öğrenmek istiyoruz. Böylelikle size daha iyi yardımcı olabileceğimize inanıyoruz. Lütfen, yalnızca bugün değil son 7 gün içinde, kendinizi nasıl hissettiğinizi en iyi tanımlayan ifadeyi işaretleyiniz.

**Son 7 gündür;**

*1) Gülebiliyor ve olayların komik tarafını görebiliyorum.*

□Her zaman olduğu kadar

□Artık pek okadar değil

□Artık kesinlikle okadar değil

□Artık hiç değil

**Son 7 gündür;**

*2) Geleceğe hevesle bakıyorum.*

□Her zaman olduğu kadar

□Her zamankinden biraz daha az

□Her zamankinden kesinlikle daha az

□Hemen hemen hiç

**Son 7 gündür;**

*3) Birşeyler kötü gittiğinde gereksiz yere kendimi suçluyorum.*

□Evet, çoğu zaman

□Evet, bazen

□Çok sık değil

□Hayır, hiç bir zaman

**Son 7 gündür;**

*4) Nedensiz yere kendimi sıkıntılı ya da endişeli hissediyorum.*

□Hayır, hiç bir zaman

Çok seyrek

Evet, bazen

Evet, çoğu zaman

**Son 7 gündür;**

*5) İyi bir nedeni olmadığı halde, korkuyor ya da panikliyorum.*

Evet, çoğu zaman

Evet, bazen

Hayır,çok sık değil

Hayır, hiç bir zaman

**Son 7 gündür;**

*6) Her şey giderek sırtıma yükleniyor.*

Evet, çoğu zaman hiç başa çıkamıyorum

Evet, bazen eskisi gibi başa çıkamıyorum

Hayır,çoğu zaman oldukça iyi başa çıkamıyorum

Hayır, her zamanki gibi başa çıkabiliyorum

**Son 7 gündür;**

*7) Öylesine mutsuzum ki uyumakta zorlanıyorum.*

Evet, çoğu zaman

Evet, bazen

Çok sık değil

Hayır, hiç bir zaman

**Son 7 gündür**

*8) Kendimi üzüntülü ya da çökkün hissediyorum.*

□Evet, çoğu zaman

□Evet, oldukça sık

□Çok sık değil

□Hayır, hiç bir zaman

**Son 7 gündür**

*9) Öylesine mutsuzum ki ağlıyorum.*

□Evet, çoğu zaman

□Evet, oldukça sık

□Çok seyrek

□Hayır, asla

**Son 7 gündür**

*10) Kendime zarar verme düşüncesinin aklıma geldiği oldu.*

□Evet, oldukça sık

□Bazen

□Hemen hemen hiç

□Asla

## APPENDIX I: EXPERIENCES IN CLOSE RELATIONSHIPS- REVISED

Aşağıdaki maddeler romantik ilişkilerinizde hissettiğiniz duygularla ilgilidir. Bu araştırmada sizin ilişkinizde yalnızca şu anda değil, genel olarak neler olduğuyla ya da neler yaşadığınızla ilgilenmekteyiz. Maddelerde sözü geçen "birlikte olduğum kişi" ifadesi ile romantik ilişkide bulunduğunuz kişi kastedilmektedir. Eğer halihazırda bir romantik ilişki içerisinde değilseniz, aşağıdaki maddeleri bir ilişki içinde olduğunuzu varsayarak cevaplandırınız. Her bir maddenin ilişkilerinizdeki duygu ve düşüncelerinizi ne oranda yansıttığını karşılarındaki 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

1----------2----------3----------4----------5----------6----------7

Hiç katılmıyorum — Kararsızım/ fikrim yok — Tamamen katılıyorum

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Birlikte olduğum kişinin sevgisini kaybetmekten korkarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Gerçekte ne hissettiğimi birlikte olduğum kişiye göstermemeyi tercih ederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Sıklıkla, birlikte olduğum kişinin artık benimle olmak istemeyeceği korkusuna kapılırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. Özel duygu ve düşüncelerimi birlikte olduğum kişiyle paylaşmak konusunda kendimi rahat hissederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Sıklıkla, birlikte olduğum kişinin beni gerçekten sevmediği kaygısına kapılırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. Romantik ilişkide olduğum kişilere güvenip inanmak konusunda kendimi rahat bırakmakta zorlanırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Romantik ilişkide olduğum kişilerin beni, benim onları önemsediğim kadar önemsemeyeceklerinden endişe duyarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Romantik ilişkide olduğum kişilere yakın olma konusunda çok rahatımdır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. Sıklıkla, birlikte olduğum kişinin bana duyduğu hislerin benim ona duyduğum hisler kadar güçlü olmasını isterim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Romantik ilişkide olduğum kişilere açılma konusunda kendimi rahat hissetmem. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. İlişkilerimi kafama çok takarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. Romantik ilişkide olduğum kişilere fazla yakın olmamayı tercih ederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. Benden uzakta olduğunda, birlikte olduğum kişinin başka birine ilgi duyabileceği korkusuna kapılırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14. Romantik ilişkide olduğum kişi benimle çok yakın olmak istediğinde rahatsızlık duyarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15. Romantik ilişkide olduğum kişilere duygularımı gösterdiğimde, onların benim için aynı şeyleri hissetmeyeceğinden korkarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. Birlikte olduğum kişiyle kolayca yakınlaşabilirim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. Birlikte olduğum kişinin beni terk edeceğinden pek endişe duymam. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. Birlikte olduğum kişiyle yakınlaşmak bana zor gelmez. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. Romantik ilişkide olduğum kişi kendimden şüphe etmeme neden olur. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. Genellikle, birlikte olduğum kişiyle sorunlarımı ve kaygılarımı tartışırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21. Terk edilmekten pek korkmam. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22. Zor zamanlarımda, romantik ilişkide olduğum kişiden yardım istemek bana iyi gelir. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23. Birlikte olduğum kişinin, bana benim istediğim kadar yakınlaşmak istemediğini düşünürüm. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24.Birlikte olduğum kişiye hemen hemen her şeyi anlatırım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 25. Romantik ilişkide olduğum kişiler bazen bana olan duygularını sebepsiz yere değiştirirler. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26. Başımdan geçenleri birlikte olduğum kişiyle konuşurum. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27. Çok yakın olma arzum bazen insanları korkutup uzaklaştırır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28. Birlikte olduğum kişiler benimle çok yakınlaştığında gergin hissederim. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 29. Romantik ilişkide olduğum bir kişi beni yakından tanıdıkça, “gerçek ben”den hoşlanmayacağından korkarım. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30. Romantik ilişkide olduğum kişilere güvenip inanma konusunda rahatımdır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31. Birlikte olduğum kişiden ihtiyaç duyduğum şefkat ve desteği görememek beni öfkelendirir. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32. Romantik ilişkide olduğum kişiye güvenip inanmak benim için kolaydır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 33. Başka insanlara denk olamamaktan endişe duyarım | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34. Birlikte olduğum kişiye şefkat göstermek benim için kolaydır. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 35. Birlikte olduğum kişi beni sadece kızgın olduğumda önemser. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36. Birlikte olduğum kişi beni ve ihtiyaçlarımı gerçekten anlar. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## APPENDIX J: PREPAREDNESS TO FATHERHOOD FORM

Aşağıdaki soruları bebeğinizin doğumu öncesindeki durumunuzu düşünerek cevaplayınız. Lütfen kendinize en uygun olan seçeneği işaretleyiniz.

1. **Bebek sahibi olmanızda sizin kararınız ne kadar etkiliydi?**

A) Tamamen etkiliydi.
B) Kısmen etkiliydi.
C) Hiçbir etkim yoktu.

2. **Ebeveyn olmaya psikolojik olarak ne kadar hazırsınız?**

A) Bütünüyle hazır olduğumu düşünüyorum
B) Endişelerim olsa da kendimi hazır hissediyorum
C) Yeterince hazır olmadığımı düşünüyorum
D) Kesinlikle hazır değilim

3. **Bebek bakımı ile ilgili gerekli bilgiye ne ölçüde sahip olduğunuzu düşünüyorsunuz?**

A) Gerekli bilgiye tamamen sahibim.
B) Gerekli bilgiye kısmen sahibim.
C) Gerekli bilgiye sahip değilim.

4. **Bebeğiniz doğduğunda <u>bir çift olarak</u> ebeveynliğe ne kadar hazır olduğunuzu düşünüyorsunuz?**

A) Eşim ve ben bebek sahibi olmaya tamamen hazırdık.
B) Eşim ve ben bebek sahibi olmaya kısmen hazırdık
C) Eşim ve ben bebek sahibi olmaya kesinlikle hazır değildik.

5. **Bebek beklediğinizi öğrendiğinizdeki hislerinizi genel olarak nasıl tanımlarsınız?**

A) Çok olumlu
B) Olumlu
C) Ne olumlu ne olumsuz
D) Olumsuz

**APPENDIX K: HEALTH PERSONNEL** INFORMATION **FORM**

Sayın Sağlık Personeli,

Ben TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta. Öğrencisi olduğum program çerçevesinde Dr. Öğr. Üyesi Yağmur Ar-Karcı süpervizörlüğünde yürüttüğüm "Yeni Ebeveyn Olmuş Babalarda Depresif Belirtileri Değerlendiren Bir Ölçüm Aracının Geliştirilmesi" isimli tezim için yenidoğan ebeveynleri ile görüşmem gerekmektedir. Çalışmanın amacı bebeğin doğumundan sonraki süreçte babaların psikolojik durumunu anlamak üzere bir ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin babalar üzerindeki etkisini gözlemlemektir. Katılımcıların 3-6 aylık yeni doğan bebekleri olması gerekmektedir. Gönüllü olmak isteyen katılımcılara ulaşmak amacı ile desteğinizi rica etmekteyim.

Katılımcı anne ve babaları sizlere ulaştırdığım bilgilendirilmiş onam formlarını vererek bilgilendirebilirsiniz. Onaylayıp imzalamaları durumunda size ulaştırdığım araştırma materyallerini onlara verebilirsiniz. **Katılımcılar materyalleri hastane ortamında bireysel bir şekilde doldurabilir veya en geç bir hafta içerisinde size ulaştırabilir**. Gizlilik ilkesinin karşılanabilmesi için doldurulan formları gizli bir bölmede tutmanız ve cevapları paylaşmamanız oldukça önemlidir. Tamamlanan formlar kliniğinizden tarafımızca teslim alınacaktır. Çalışma hakkında daha fazla bilgi almak için benimle iletişime geçebilirsiniz (E-Posta: elif.usta@tedu.edu.tr, telefon: X).

Desteğiniz için teşekkür eder, kolaylıklar dilerim.

Elif Usta

TED Üniversitesi

Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi

## APPENDIX L: HEALTH PERSONNEL INFORMATION FORM (SEMI-STRUCTURED INTERVIEWS)

Sayın Sağlık Personeli,

Ben TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta. Bulunduğum program çerçevesinde Dr. Öğr. Üyesi Yağmur Ar Karcı danışmanlığında yürüttüğüm "Yeni Ebeveyn Olmuş Babalarda Depresif Belirtileri Değerlendiren Bir Ölçüm Aracının Geliştirilmesi" konulu tezim için yenidoğan ebeveynleri ile görüşmem gerekmektedir. Çalışmanın amacı bebeğin doğumundan sonraki süreçte babaların psikolojik durumunu anlamak üzere bir ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin babalar üzerindeki etkisini gözlemlemektir. Gönüllü olmak isteyen katılımcılara ulaşmak amacı ile desteğinizi istemekteyim. Katılımcıların 3-8 aylık yeni doğan bebekleri olması gerekmektedir. Araştırmanın ilk aşamasında, 3-8 aylık yeni doğan bebeği olan babalarla yaklaşık bir saat sürecek görüşmeler yapmayı planlamaktayım. Bu görüşmelerde babaların psikolojik durumlarını anlamaya yönelik bir takım sorular soracağım.

Katılmak isteyen babaları sizlere ulaştırdığım bilgilendirilmiş onam formlarını vererek bilgilendirebilirsiniz. Onaylayıp imzalamaları durumunda iletişim bilgilerini alabilirsiniz. İletişim bilgisini aldığınız katılımcı tarafımca aranacak ve kendisi ile görüşme gerçekleştirilecektir. Çalışma hakkında daha fazla bilgi almak için benimle iletişime geçebilirsiniz (E-Posta: elif.usta@tedu.edu.tr, telefon: X).

Desteğiniz için teşekkür eder, kolaylıklar dilerim.

Elif Usta

TED Üniversitesi

Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi

## APPENDIX M: INFORMED CONSENT FORM (IDENTIFICATION OF THE ELIGIBLE FATHERS FOR INTERVIEWS)

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğinizin doğumundan sonraki süreçte siz babaların psikolojik deneyimlerini anlamak üzere ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimi gözlemlemektir. Çalışmada babaların psikolojik durumu ve ilişkileri ile ilgili çeşitli sorular sorulacaktır.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Bu formda size demografik bilgileriniz ve güncel ruh haliniz ile ilgili sorular sorulacaktır. Formların tamamlanması yaklaşık olarak 10 dakika sürmektedir. Sizden beklenen kişisel tecrübelerinizden hareketle soruları samimiyetle cevaplamanızdır. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz. Gerekli kriterleri sağlamanız durumunda çalışmanın ikinci aşaması için sizinle iletişime geçilecektir. İkinci aşamada sizinle yüz yüze ya da çevrimiçi bir iletişim aracılığıyla görüşülecek ve size babalık tecrübeleriniz ile ilgili sorular sorulacaktır.

Çalışma süresince sizden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Çalışmanın ikinci aşamasında bilgi kaybı yaşanmaması için ses kaydınız alınacaktır. Bu kayıtlar araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulacak, tüm yanıtlarınız ve görüşme kaydınız şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların açıklık ile yanıtlanması oldukça önemlidir. Soruların doğru ya da yanlış cevapları bulunmamaktadır. Katılımcıdan kendi tecrübelerini en gerçekçi biçimde yansıtacak cevaplar seçmesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Elif Usta (E-Posta: elif.usta@tedu.edu.tr, telefon: X) ile iletişime geçebilirsiniz.

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Yukarıdaki şartları okudum. Kriterlere uymam halinde benimle çalışmanın sonraki aşamaları için iletişime geçilmesini kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Tarih: ….

Çalışmanın sonraki aşamaları ile ilgili size ulaşabilmemiz için aşağıdaki bilgileri doldurunuz. Eğer sizinle irtibata geçilmesini istemiyorsanız lütfen bu alanı boş bırakınız.

Size ulaşabileceğimiz bir email adresi: ….

## APPENDIX N: SEMI STRUCTURED INTERVIEW QUESTIONS

1. Eşinizin hamile olduğunu öğrendiğinizde neler hissettiniz? (Bebek sahibi olma kararını nasıl verdiniz? Baba olmaya kendinizi ne kadar hazır hissediyordunuz? Sizce eşiniz anne olmaya ne kadar hazırdı? Sizce bir çift olarak ebeveyn olmaya ne kadar hazırdınız?)

2. Yeni bebeği olmuş bir baba kendini nasıl hisseder, biraz tarif eder misiniz? (Yeni bebek sahibi olmuş bir babanın görevleri ve sorumlulukları nelerdir? Yeni bebek sahibi olmuş bir anne ve babanın psikolojik durumları arasında ne gibi farklar ve benzerlikler vardır? Yeni bebek sahibi olan bir ebeveyn olmanın zorlukları var mı, varsa nelerdir? Peki, yeni bebek sahibi olan bir baba olmanın babalığa özgü zorlukları nelerdir?)

3. Bebeğiniz doğduktan sonra hayatınızda ne gibi değişiklikler oldu? *(Olumlu ya da olumsuz)*

4. Yeni bebeği olan bir baba olarak ne gibi sıkıntı ve zorluklar yaşıyorsunuz? (Bu dönemde özellikle babalar annelerden farklı olarak ne gibi sıkıntılar yaşıyorlar?)

5. Peki, size uyguladığım testte bir miktar mutsuz/ üzgün/ depresif olduğunuz görülüyor. Bu dönemde; mutsuzluğunuzu (ya da üzüntünüzü) nasıl yaşıyorsunuz (anlıyorsunuz; neler size mutsuz/ üzgün olduğunuzu düşündürtüyor)?

6. Peki, eşiniz bu dönemde sıkıntısını/ üzüntüsünü nasıl yaşıyor? Onun üzüntüsünü yaşayışı ile sizin yaşayışınız arasında farklılıklar var mı?

7. (Farklılıklar var ise) Peki anne ve babalar sizce neden üzüntülerini/ depresyonlarını farklı yaşıyor, bunun sebepleri neler olabilir?

8. Sizce kadın ve erkekler üzüntülerini farklı yaşıyorlar mı?

9. (Farklılıklar var ise) Nasıl? Bunun sebebi neler olabilir?

10. Bu süreçte eşinizle ilişkinizde nasıl değişimler oldu? Bu değişimler sizi nasıl etkiledi, nasıl hissettiniz?

11. Ailenizle ve/veya yakın çevrenizle ilişkinizde nasıl değişimler oldu? Bu değişimler size nasıl hissettirdi?

12. Bir baba olarak bu süreçte ailedeki rolünüzden bahseder misiniz? Bu rolleri almak size nasıl hissettiriyor? Bir baba olarak daha farklı roller alabilmek ister miydiniz? Nasıl?

13. Yeni bebeği olan bir anne olarak eşiniz ne gibi sıkıntılar yaşıyor? Neler hissediyor? Siz onun bu durumunda nasıl etkileniyorsunuz? Sizce yeni bebeği olan bir anne ve babanın yaşadığı sıkıntılarda farklılaşma var mı? Bunlar neler? Bu farklılıklar neden kaynaklanıyor olabilir?

14. Nasıl bir baba olduğunuzu düşünüyorsunuz? Kendinizi kötü hissettiğiniz/suçladığınız durumlar oldu mu? Bu durumlarla baş etmek için neler yapıyorsunuz?

15. Baba olmak ile ilgili size olumlu gelen yanlar nelerdir? Baba olmak ile ilgili size olumsuz gelen yanlar nelerdir? Bu olumsuzluklarla nasıl başa çıkıyorsunuz? Babalık sürecinde size ne yapmak iyi geliyor?

16. Zaman zaman desteğe ihtiyacınız olduğunu hissettiniz mi? Bu ihtiyaç ne kadar karşılandı? Tüm bu süreç boyunca çevrenizden destek alabildiniz mi?

17. Bir baba olarak daha farklı olmasını dilediğiniz tecrübeler yaşadınız mı? Bebeğinizden önceki sizle şimdiki sizi karşılaştırırsanız neler farklı olurdu? Önceki halinizle konuşma şansınız olsaydı ona ne söylerdiniz?

## APPENDIX O: INFORMED CONSENT FORM (SEMI STRUCTURED INTERVIEW)

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğinizin doğumundan sonraki süreçte siz babaların psikolojik durumunu anlamak üzere ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin babalar üzerindeki etkisini gözlemlemektir. Çalışmada babaların psikolojik durumu ve ilişkileri ile ilgili çeşitli sorular sorulacaktır.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Bu araştırmada size ilişkileriniz ve bebeğinizin doğumu sonrasındaki tecrübeleriniz ile ilgili açık uçlu sorular sorulacaktır. Sizden beklenen kişisel tecrübelerinizden hareketle soruları samimiyetle cevaplamanızdır. Görüşmenin yaklaşık bir saat sürmesi beklenmektedir. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz.

Çalışma süresince sizden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Çalışma esnasında bilgi kaybı yaşanmaması için ses kaydınız alınacaktır. Bu kayıtlar araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların açıklık ile yanıtlanması oldukça önemlidir. Soruların doğru ya da yanlış cevapları bulunmamaktadır. Katılımcıdan kendi tecrübelerini en gerçekçi biçimde yansıtacak cevaplar seçmesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Elif Usta (E-Posta: elif.usta@tedu.edu.tr, telefon: X) ile iletişime geçebilirsiniz.

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Yukarıdaki şartları okudum. Görüşmeler sırasında ses kaydı alınmasını kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Ad Soyad: İmza: Tarih:

## APPENDIX P: ANNOUNCEMENT TEXT FOR SOCIAL MEDIA MODERATORS

Merhabalar,

Ben Psikolog Elif Usta. Öncelikle size kendimden bahsetmek isterim. Ben Orta Doğu Teknik Üniversitesi Psikoloji Bölümü mezunuyum. Şimdi ise TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi alanında yüksek lisans yapmaktayım. Dr. Öğr. Üyesi Yağmur Ar-Karcı danışmanlığında yürüttüğüm tez çalışmam kapsamında yeni baba olmuş bireylerin ebeveynlik deneyimlerini anlamayı amaçlıyoruz. Bu kapsamda, bebek sahibi ebeveynlerin yer aldığı sosyal platformları araştırırken sizin moderatörlüğünü yaptığınız X isimli gruba rastladım. Sizden tez çalışmam için desteğinizi rica ediyorum.

Bu amaçla eğer onaylarsanız araştırmamın duyuru metnini sizinle paylaşabilirim. Araştırmamıza katılmak isteyen gönüllü ebeveynlere sizin aracılığınız ile erişme imkanımız olursa çok sevinirim. Bilimsel araştırmamız konusunda daha fazla bilgi almak isterseniz e-posta veya telefon yoluyla benimle iletişime geçebilirsiniz. Ayrıca talep etmeniz durumunda araştırmamızın etik ilkelere uygunluğunu onaylayan etik kurul kararını ve soruların bir kopyasını sizinle paylaşabilirim. Yanıtınızı sabırsızlıkla bekliyor olacağım.

Saygılarımla,

Elif Usta

Email: elif.usta@tedu.edu.tr

Tel: 05054496661

## APPENDIX Q: SOCIAL MEDIA ANNOUNCEMENT TEXT FOR PARTICIPANTS (ONLINE SEMI STRUCTURED INTERVIEW)

Merhaba,

Ben, TED Üniversitesi gelişim odaklı klinik psikoloji yüksek lisans programı öğrencisi Elif Usta. TED Üniversitesi Psikoloji Bölümü öğretim üyesi Dr. Yağmur Ar-Karcı danışmanlığında yürüttüğüm tez çalışmamda yeni baba olmuş erkeklerin psikolojik deneyimlerini anlamayı amaçlıyorum. Bu kapsamda da **3-8 aylık bebeği olan babalara** ulaşmayı hedefliyorum.

Araştırmaya katılacak **babalar** için gerekli koşullar şu şekildedir:

a) 3-8 aylık bebek sahibi olmak (Bebeğin doğum sıralamasının önemi bulunmamaktadır. Bebeğiniz 1., 2. 3... çocuğunuz olabilir)
b) Araştırmaya gönüllü olarak katılmayı kabul etmek

Araştırmaya katılmayı kabul ettiğiniz takdirde sizden kimliğinizi belli etmeden bazı demografik bilgileriniz istenecek ve güncel ruh haliniz ile ilgili sorular sorulacaktır. Anketi tamamlamanız yaklaşık 5 dakika sürecektir. Elde edilen veriler araştırmacıların kişisel bilgisayarlarında anonim bir şekilde muhafaza edilecek ve şifreli bir program vasıtasıyla korunacaktır.

Araştırmadan faydalı sonuçların elde edilebilmesi için lütfen soruları yalnız ve sakin bir ortamda doldurunuz; eşinizin de böyle bir şekilde doldurduğundan emin olunuz.

**ÖNEMLİ NOT:** Araştırmanın ikinci aşamasında kriterlere uygun olmanız durumunda ve onaylamanız halinde sizinle çevrimiçi görüntülü görüşme gerçekleştirmek için iletişime geçilecektir. Görüntülü görüşmelerde size babalık tecrübeleriniz hakkında sorular sorulacaktır. Bu görüşmeler araştırmacı tarafından yapılacak ve yaklaşık bir saat sürecektir.

Araştırma ile ilgili ayrıntılı bilgiye sizin için belirtilen anket linkine tıklayarak ulaşabilirsiniz.

**BABALAR için anket linki:** *(Burada qualtricste oluşturulan anket linki kullanılmıştır).*

Herhangi bir sorunuz olursa bize aşağıda belirtilen iletişim adreslerimizden ulaşabilirsiniz.

**Dr. Öğr. Üyesi Yağmur Ar-Karcı**
e-posta: yağmur.ar@tedu.edu.tr

**Psk. Elif Usta**
e-posta: elif.usta@tedu.edu.tr

Değerli desteğiniz için şimdiden çok teşekkür ederiz.

## APPENDIX R: INFORMED CONSENT FORM (ONLINE SEMI STRUCTURED INTERVIEWS)

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar-Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğinizin doğumundan sonraki süreçte siz babaların psikolojik durumunu anlamak üzere ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin babalar üzerindeki etkisini gözlemlemektir. Bu amaçla size, yeni doğan bebek sahibi olan babaların psikolojik durumu ve ilişkilerini anlamayı hedefleyen bazı açık uçlu sorular sorulacaktır.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Bu araştırmada size ilişkileriniz ve bebeğinizin doğumu sonrasındaki tecrübeleriniz ile ilgili birtakım açık uçlu sorular sorulacaktır. Sizden beklenen kişisel tecrübelerinizden hareketle soruları samimiyetle cevaplamanızdır. Görüşmenin yaklaşık bir saat sürmesi beklenmektedir. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz. Bu durumda vermiş olduğunuz bilgiler çalışmada kullanılmayacak ve verileriniz araştırmacılar tarafından silinecektir.

Çalışma süresince sizden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Çalışma esnasında bilgi kaybı yaşanmaması için görüşmenin ses kaydı alınacaktır. Bu kayıtlar araştırmacıların bilgisayarında katılımcının ismi belirtilmeksizin saklanacak ve şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların açıklık ile yanıtlanması oldukça önemlidir. Soruların **DOĞRU ya da YANLIŞ cevapları bulunmamaktadır**. Katılımcıdan kendi tecrübelerini en gerçekçi yansıtacak cevapları vermesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Psk. Elif Usta (e-posta: elif.usta@tedu.edu.tr, telefon: 05054496661) ile iletişime geçebilirsiniz.

Görüşmelerimiz çevrimiçi (online) olarak gerçekleştirilecektir. Araştırmacı sizin bu formu onaylamanız halinde sizinle belirttiğiniz e-posta adresi üzerinden iletişime geçecek ve uygunluk durumunuzu göz önüne alarak bir görüşme saati ayarlayacaktır. Görüşme tarih ve saatinizin size iletildiği bu e-postada ayrıca araştırmacının Skype adresi de yer alacaktır. Lütfen görüşmeye başlamadan önce:

1. Bilgisayarınıza ya da telefonunuza Skype isimli programı indirin.
2. Görüşme yaptığınız odada yalnız olun.
3. Odanızın sessiz olmasına özen gösterin.
4. Bulunduğunuz odadan dışarıya ses gitmeyeceği ve dışarıdan sizi rahatsız edecek ses gelmediğinden emin olun.
5. İnternet bağlantınızın görüşmeyi sürdürebilecek düzeyde olmasına dikkat edin.

**ÖNEMLİ NOT:** Araştırmacı e-posta ile belirlenen görüşme tarihinde sizi belirttiğiniz adres üzerinden Skype aracılığıyla görüntülü olarak arayacaktır. Ses kaydı sizden sözel onay aldıktan sonra başlatılacaktır.

Lütfen sizinle iletişime geçmemizi istediğiniz e-posta adresini belirtiniz:
_____

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Yukarıdaki şartları okudum. Görüşmeler sırasında ses kaydı alınmasını kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Tarih:

*Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr eposta adresinden ulaşabilirsiniz.*

## APPENDIX S: INFORMED CONSENT FORM (FATHER)

Gönüllü Katılım Formu

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğinizin doğumundan sonraki süreçte siz babaların psikolojik durumunu anlamak üzere bir ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin babalar üzerindeki etkisini gözlemlemektir. Bu çalışmada babaların psikolojik durumu ve ilişkileri ile ilgili sorular sorulacaktır.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Bu araştırmada size ilişkileriniz ve bebeğinizin doğumu sonrasındaki tecrübeleriniz ile ilgili sorular sorulacaktır. Soruları bireysel tecrübelerinize dayanarak, yardım almadan yalnız bir şekilde cevaplamanız gerekmektedir. Anket sorularının tamamlanması ortalama 30 dakikanızı alacaktır. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz.

Çalışma süresince sizden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Tüm bilgiler araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların samimiyetle doldurulması ve hiçbir sorunun boş bırakılmaması oldukça önemlidir. Soruların doğru ya da yanlış cevapları bulunmamaktadır. Katılımcıdan kendi tecrübelerini en gerçekçi biçimde yansıtacak cevaplar seçmesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Elif Usta (E-Posta: elif.usta@tedu.edu.tr, telefon: 05054496661) ile iletişime geçebilirsiniz.

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Ad Soyad: İmza:

Tarih:

## APPENDIX T: INFORMED CONSENT FORM (MOTHER)

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğin doğumundan sonraki süreçte babaların psikolojik durumunu anlamak üzere ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin babalara etkisini gözlemlemektir. Çalışmada size psikolojik durumunuz ile ilgili sorular sorulacaktır.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Anketin tamamlanması ortalama 5 dakikanızı alacaktır. Bu araştırmada size güncel ruh haliniz ile ilgili sorular sorulacaktır. Soruları bireysel tecrübelerinize dayanarak, yardım almadan yalnız bir şekilde cevaplamanız gerekmektedir. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz.

Çalışma süresince sizden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Tüm bilgiler araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların samimiyetle doldurulması ve hiçbir sorunun boş bırakılmaması oldukça önemlidir. Soruların doğru ya da yanlış cevapları bulunmamaktadır. Katılımcıdan kendi tecrübelerini en gerçekçi biçimde yansıtacak cevaplar seçmesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Elif Usta (E-Posta: elif.usta@tedu.edu.tr, telefon: 05054496661) ile iletişime geçebilirsiniz.

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Ad Soyad:

İmza:

Tarih:

**APPENDIX U: POSTER**

# 3-8 AY ARASINDA BEBEĞİ OLAN EBEVEYNLER

**Yeni ebeveyn olmuş babaların psikolojik deneyimlerini anlamaya yönelik yürüttüğümüz çalışmamızda destekleriniz çok değerli! Bu kapsamda yeni doğan sahibi anne ve babalara ulaşmaya çalışıyoruz.**

## Sevgili ebeveynler, sizlerin de sesini duymak ve duyurmak istiyoruz! Lütfen araştırmamıza destek olun!

**Ayrıntılı bilgi için:**

"elif.usta@tedu.edu.tr" ye yazın!

## APPENDIX V: SOCIAL MEDIA ANNOUNCEMENT TEXT (SECOND PHASE)

**Anne ve Babalar için Çevrimiçi Anket Ön Duyuru Metni**

Merhaba,

Ben, TED Üniversitesi Gelişim Odaklı Çocuk ve Ergen Klinik Psikoloji Yüksek Lisans Programı öğrencisi Elif Usta. TED Üniversitesi Psikoloji Bölümü öğretim üyesi Dr. Yağmur Ar-Karcı danışmanlığında yürüttüğüm tez çalışmamda yeni baba olmuş erkeklerin psikolojik deneyimlerini anlamayı amaçlıyorum. Bu kapsamda da **3-8 aylık bebeği olan babalara ve annelere** ulaşmayı hedefliyorum.

Araştırmaya katılacak anne ve babalar için gerekli koşullar şu şekildedir:

a) 3-8 aylık bebek sahibi olmak (Bebeğin doğum sıralamasının önemi bulunmamaktadır. Bebeğiniz 1., 2. 3... çocuğunuz olabilir)
b) Araştırmaya gönüllü olarak katılmayı kabul etmek
c) Eşinizin de araştırmaya gönüllü olarak katılmayı kabul etmesi

Araştırmaya katılmayı kabul ettiğiniz takdirde sizden ve eşinizden ebeveynlik tecrübeleriniz ile ilgili bazı soruları yanıtlamanız istenecektir. Babaların anketi tamamlaması yaklaşık 30 dakika, annelerin ise 10 dakika sürecektir. Elde edilen veriler araştırmacıların kişisel bilgisayarlarında anonim bir şekilde muhafaza edilecek ve şifreli bir program vasıtasıyla korunacaktır.

Anne ve babaların kendilerine ait sorularınıb yer aldığı iki ayrı link aşağıda belirtilmiştir. Annelerin annelere ait linkte yer alan soruları, babaların ise babalara ait linkte yer soruları yanıtlamaları gerekmektedir.

Araştırmadan faydalı sonuçların elde edilebilmesi için lütfen soruları yalnız ve sakin bir ortamda doldurunuz; eşinizin de anketi aynı koşullarda doldurduğundan emin olunuz. **Anketi her iki ebeveynin de tamamlaması araştırma sonuçları açısından oldukça önemlidir.** Eşler anketi aynı anda doldurmak zorunda değildir. Dilerseniz araştırma sorularını yanıtlamadan önce ya da soruları tamamladıktan sonra eşiniz ile ilgili linki paylaşabilirsiniz.

Araştırma ile ilgili ayrıntılı bilgiye sizin için belirtilen anket linkine tıklayarak ulaşabilirsiniz.

**ANNELER için anket linki:** *(Burada qualtricste oluşturulan anket linki kullanılacaktır).*

**BABALAR için anket linki:** *(Burada qualtricste oluşturulan anket linki kullanılacaktır).*

Herhangi bir sorunuz olursa bize aşağıda belirtilen iletişim adreslerinden bize ulaşabilirsiniz.

**Dr. Öğr. Üyesi Yağmur Ar-Karcı**
e-posta: yağmur.ar@tedu.edu.tr

**Psk. Elif Usta**
e-posta: elif.usta@tedu.edu.tr

Değerli desteğiniz için şimdiden çok teşekkür ederiz.

## APPENDIX W: INFORMED CONSENT FORM (FATHER- ONLINE SURVEY)

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar-Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğinizin doğumundan sonraki süreçte siz babaların psikolojik durumunu anlamak üzere bir ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin ebeveynler üzerindeki etkisini gözlemlemektir. Bu amaçla hem babalardan hem de annelerden veri toplanması hedeflenmektedir.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Anketin tamamlanması ortalama 30 dakikanızı alacaktır. Eşinizin anketi doldurması ise yaklaşık 10 dakika sürecektir. Bu araştırmada size güncel ruh haliniz ile ilgili sorular çevrimiçi ortamda sorulacaktır. Soruları bireysel tecrübelerinize dayanarak, yardım almadan, sessiz bir ortamda yalnız bir şekilde cevaplamanız gerekmektedir. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz.

Çalışma süresince sizden kimliğinizi açık bir şekilde belli eden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Tüm bilgiler araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların samimiyetle doldurulması ve hiçbir sorunun boş bırakılmaması oldukça önemlidir. Soruların DOĞRU ya da YANLIŞ cevapları bulunmamaktadır. Katılımcılardan kendi tecrübelerini en gerçekçi yansıtan seçenekleri seçmesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Elif Usta (E-Posta: elif.usta@tedu.edu.tr, telefon: 05054496661) ile iletişime geçebilirsiniz.

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Tarih:

**Araştırma sonrasında sizin ve eşinizin cevaplarını eşleştirerek analiz edebilmemiz için sizden bir rumuz oluşturmanız beklenmektedir.**

Lütfen (1) isminizin son iki harfini, (2) eşinizin doğum yılını ve (3) son doğan bebeğinizin adının ilk harfini sırasıyla yazarak bir rumuz oluşturunuz. (Eğer iki isminiz var ise lütfen kimliğinizde belirtilen ilk isme göre düşününüz. Eğer bebeğinizin iki ismi var ise, lütfen kimliğinde belirtilen ilk isme göre düşününüz).

**Örneğin:**
İsim: Ahm**et**; eşinizin doğum yılı **1980**; Son doğan bebeğin adı: **A**yşe
Rumuz: et1980a

**Lütfen şimdi kendi rumuzunuzu yazınız: ……**

Az önce gördüğünüz üzere **eşinizin yanıtlamasını beklediğimiz anket linki duyuru metninde** yer almaktadır. Ayrıca, siz anketi tamamladıktan sonra **eşinizin doldurması beklenen aynı link ekranınızda** belirecektir. Bir diğer deyişle, duyuru metninde yer alan ve anketinizin sonunda eşinizin doldurması için yer alan link aynıdır. Söz konusu linki eşinizle duyuru metninin tamamını ileterek paylaşabileceğiniz gibi, ekranınız da çıkan linki kopyala-yapıştır seçeneğiyle de eşinize iletebilirsiniz. Eşinizin yanıtlaması gereken soruları kapsayan bu linki sizin için en pratik yoldan paylaşmanız faydalı olacaktır (örn, sosyal medya mesaj seçenekleri, whatsapp, e-posta, mesaj v.b.). Araştırma için her ikinizin de kendinize ait linklere tıklayarak soruları yanıtlamanız oldukça önemlidir**.**

**ÖNEMLİ NOT:** Siz anketi tamamladıktan sonra verdiğiniz yanıtları eşinizin görmesi mümkün değildir.

**Değerli desteğiniz için tekrar çok teşekkür ederiz.**

*Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr eposta adresinden ulaşabilirsiniz.*

## APPENDIX X: INFORMED CONSENT FORM (MOTHER-ONLINE SURVEY)

Sayın Katılımcı,

Bu çalışma Dr. Öğr. Üyesi Yağmur Ar Karcı danışmanlığında TED Üniversitesi Gelişim Odaklı Klinik Çocuk ve Ergen Psikolojisi Yüksek Lisans Programı öğrencisi Elif Usta tarafından yürütülmektedir. Çalışmanın amacı bebeğin doğumundan sonraki süreçte babaların psikolojik durumunu anlamak üzere ölçek geliştirmek ve doğum sonrasında anne, baba ve bebek arasındaki etkileşimin ebeveynler üzerindeki etkisini gözlemlemektir. Bu amaçla hem babalardan hem de annelerden veri toplanması hedeflenmektedir.

Çalışmanın etik ilkelere uygunluğu, TED Üniversitesi İnsan Araştırmaları Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır. Anketin tamamlanması ortalama 10 dakikanızı alacaktır. Eşinizin kendine ait soruları yanıtlaması ise yaklaşık 30 dakika sürecektir. Bu araştırmada size güncel ruh haliniz ile ilgili sorular çevrimiçi ortamda sorulacaktır. Soruları bireysel tecrübelerinize dayanarak, yardım almadan, sessiz bir ortamda yalnız bir şekilde cevaplamanız gerekmektedir. Çalışmaya devam etmek istemediğinizde araştırmayı yarıda bırakmakta serbestsiniz.

Çalışma süresince sizden kimliğinizi açık bir şekilde belli eden herhangi bir kişisel bilgi istenmeyecektir. Vermiş olduğunuz bilgiler yalnızca bilimsel amaçlar için kullanılacak ve diğer katılımcıların bilgileriyle bütün olarak değerlendirilecektir. Tüm bilgiler araştırmacının bilgisayarında katılımcının ismi belirtilmeksizin tutulup, şifreli bir program aracılığı ile korunacaktır.

Çalışma sonuçlarının faydalı olabilmesi için soruların samimiyetle doldurulması ve hiçbir sorunun boş bırakılmaması oldukça önemlidir. Soruların doğru ya da yanlış cevapları bulunmamaktadır. Katılımcıdan kendi tecrübelerini en gerçekçi biçimde yansıtacak cevaplar seçmesi beklenmektedir. Çalışma hakkında daha fazla bilgi almak için Elif Usta (E-Posta: elif.usta@tedu.edu.tr, telefon: 05054496661) ile iletişime geçebilirsiniz.

Yukarıdaki şartları okudum. Bu araştırmaya gönüllü olarak katılmayı kabul ediyorum.

o Onaylıyorum o Onaylamıyorum

Tarih:

**Araştırma sonrasında sizin ve eşinizin cevaplarını eşleştirerek analiz edebilmemiz için sizden bir rumuz oluşturmanız beklenmektedir.**

Lütfen (1) eşinizin (bebeğin babasının) isminin son iki harfini, (2) kendi doğum yılınınızı ve (3) son doğan bebeğinizin adının ilk harfini sırasıyla yazarak bir rumuz oluşturunuz. (Eğer eşinizin iki ismi var ise lütfen kimliğinde belirtilen ilk isme göre düşününüz. Eğer bebeğinizin iki ismi var ise, lütfen kimliğinde belirtilen ilk isme göre düşününüz).

Örneğin:

İsim: Ahm**et**; kendi doğum yılım **1980**; Son doğan bebeğin adı: **A**yşe

Rumuz: et1980a

**Lütfen şimdi kendi rumuzunuzu yazınız: ……**

Az önce gördüğünüz üzere **eşinizin yanıtlamasını beklediğimiz anket linki duyuru metninde** yer almaktadır. Ayrıca, siz anketi tamamladıktan sonra **eşinizin doldurması beklenen aynı link ekranınızda** belirecektir. Bir diğer deyişle, duyuru metninde yer alan ve anketinizin sonunda eşinizin doldurması için yer alan link aynıdır. Söz konusu linki eşinizle duyuru metninin tamamını ileterek paylaşabileceğiniz gibi, ekranınız da çıkan linki kopyala-yapıştır seçeneğiyle de eşinize iletebilirsiniz. Eşinizin yanıtlaması gereken soruları kapsayan bu linki sizin için en pratik yoldan paylaşmanız faydalı olacaktır (örn, sosyal medya mesaj seçenekleri, whatsapp, e-posta, mesaj v.b.). Araştırma için her ikinizin de kendinize ait linklere tıklayarak soruları yanıtlamanız oldukça önemlidir**.**

**ÖNEMLİ NOT:** Siz anketi tamamladıktan sonra verdiğiniz yanıtları eşinizin görmesi mümkün değildir.

Değerli desteğiniz için tekrar çok teşekkür ederiz.

*Araştırmaya katılımınız ve haklarınızın korunmasına yönelik sorularınız varsa ya da herhangi bir şekilde risk altında olduğunuza veya strese maruz kalacağına inanıyorsanız TED Üniversitesi İnsan Araştırmaları Etik Kurulu'na (0312 585 00 05) telefon numarasından veya iaek@tedu.edu.tr eposta adresinden ulaşabilirsiniz.*

## APPENDIX Y: PERMISSION FOR SCALES

**Dyadic Adjustment Scale:**

**elif usta <elifhusta@gmail.com>** 26 Haziran Çar 23:43

Alıcı: fisil

Saygıdeğer Hürol Hocam,

Ben Orta Doğu Teknik Üniversitesi psikoloji bölümü mezunu; şu anda da TED Üniversitesi gelişim odaklı klinik çocuk ve ergen psikolojisi alanında yüksek lisans yapmakta olan Elif Usta. Hatırlarsanız Ankara'da düzenlediğiniz son eğitiminizde sizinle tanışma fırsatımız olmuştu. Sağladığınız tüm bilgiler için çok teşekkür ederim, oldukça ilham verici bir deneyimdi.

Sizinle iletişime geçme sebebim ise daha farklı bir konu ile ilgili. Türk kültürüne adapte ettiğiniz "Dyadic Adjustment Scale" için yüksek lisans tez çalışmamda kullanmak üzere izin istiyorum. Tez çalışmam genel hatları ile babaların duygu durumu ile aile içi ilişkileri araştırmak üzerine olacak. Eğer ölçek kullanımı konusunda izin verir ve ölçeği paylaşabilirseniz gerçekten çok mutlu olurum. Cevabınızı sabırsızlıkla bekliyorum. Kolaylıklar dilerim.

Saygılarımla,

Elif Usta

**fisil@metu.edu.tr** 3 Temmuz Çar 16:02

Alıcı: ben

Merhaba,
Olumlu yanıtına da ben teşekkür ederim. Ekli dosyalarda gerekli dokümanlar var.
Çalışmalarında tekrar başarılar dilerim.
İyi günler dilerim

**İzinleri belirtilmeyen diğer ölçekler; ölçeği geliştiren kişiler tarafından araştırmacılara kullanması için izin verildiği belirtilen, tüm sorularına internet ortamından erişilebilen ölçeklerdir.**

## APPENDIX Z: SCALE ITEMS EVALUATION FORM THAT WAS SENT TO THE CLINICAL PSYCHOLOGY PROFESSIONALS

***"Yeni Ebeveyn Olmuş Babalarda Doğum Sonrası Depresyonu" ölçmek için kullanılacak ölçeğin taslağı aşağıda yer almaktadır. Aşağıdaki form alandaki profesyonellerin görüşlerini alarak ölçeğe son halini vermek adına hazırlanan belgedir. Ölçek sorularında 3 klinik psikoloji profesyoneli tarafından puanlanarak ve biçimsel önerileri dinlenerek değişiklikler yapılacaktır. Ancak soru içeriği konusunda belirgin bir değişiklik olmayacaktır. İzin kurulu için sorulara dair bir taslak oluşturması açısından bu form sizinle paylaşılmıştır.***

### DOĞUM SONRASI BABA DEPRESYONU ÖLÇEĞİ

Yeni doğan sahibi annelerin doğum sonrası depresyonunu ölçmek için kullanılan ölçekler (örn., Edinburgh Postnatal Depression Scale [EPDS]) doğum sonrası baba depresyonunu ölçmek için de kullanılmaktadır. Öte yandan, söz konusu ölçüm araçları yeni doğan sahibi babaların tecrübe edebileceği "erkeklik ve babalık" algısı ile yakından ilişkili maskelenmiş depresif özelliklere değinmediği için eleştirilmektedir.[1,2,3] Benzer şekilde, erkeklerde görülen depresif belirtileri ölçmeyi hedefleyen ölçekler ise (örn., Gotland Male Depression Scale) "babalık" bileşenini içermediği için bu kavramı değerlendirmede yeterli görülmemektedir.[4,5]

Literatürde gözlenen bu ihtiyaç ışığında; yeni doğan bebek sahibi babaların tecrübe edebileceği ebeveynliğe özgü depresif semptomları içeren bir ölçüm aracı geliştirilmesi hedeflenmiştir. **Aşağıda yer alan sorular, 3-8 ay arasında yeni doğan bir bebeği olan, orta ve şiddetli seviyede depresif belirtiler gösteren 12 baba ile yapılan görüşmelerin yorumlayıcı fenomenolojik analiz ile değerlendirilmesi yoluyla oluşturulmuştur.** Oluşturulan sorular ile "doğum sonrası baba depresyonu" kavramının ölçülmesi hedeflenlenmektedir. Bu nedenle, aşağıda göreceğiniz maddeler, genel bir babalık depresyonu ölçmeyi hedeflememektedir. Bu ölçüm aracının amacı yeni doğan sahibi babaların doğum sonrası depresif belirtilerini değerlendirmeyi hedeflemektedir.

**ÖNEMLİ NOT:** Literatür bulguları yeni doğan sahibi babaların, depresyonun tipik belirtilerinin yanı sıra (örn., üzüntü, umutsuzluk vb.) babalık ve erkeklik algısı ile ilişkili özgül bazı semptomlara da sahip olabileceğini işaret etmektedir (örn, sinirlilik, kaygı, içe çekilme, öfke patlamaları, sıkışmış hissetme vb).

Oluşturduğumuz soruları bu bağlamda değerlendirerek hem içerik ile ilgili hem de biçimsel önerilerde bulunursanız çok memnun oluruz. Tablonun sol tarafında bizim oluşturduğumuz maddeler yer almaktadır. Bu kapsamda size yolladığımız maddeleri iki kriter dahilinde değerlendirmenizi rica ediyoruz:

1. Lütfen her bir maddenin “doğum sonrası baba depresyonu” kavramını ne derece ölçtüğünü değerlendiriniz. Söz konusu değerlendirmeyi ilk sütunda yer alan “maddenin kavramla ilişkisi” sütununa 1 ile 5 arasında bir puan vererek gerçekleştirmenizi bekliyoruz. Söz konusu ölçümde 5 puan “madde kavramı oldukça iyi yansıtıyor”, 1 puan ise “madde kavramı kesinlikle yansıtmıyor” şeklinde değerlendirilmelidir.

2. “Öneri” sütununda ise maddelerle ilgili biçimsel düzeltme önerilerinizi belirtmenizi rica ediyoruz.


1. Cochran, S. V., & Rabinowitz, F. E. (1999). *Men and depression:Clinical and empirical perspectives*. Elsevier.
2. Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *The British journal of psychiatry*, *150*(6), 782-786.
3. Addis, M. E. (2008). Gender and depression in men. Clinical Psychology: Science and Practice, 15(3), 153-168.
4. Carlberg, M., Edhborg, M., & Lindberg, L. (2018). Paternal perinatal depression assessed by the Edinburgh postnatal depression scale and the Gotland male depression scale: prevalence and possible risk factors. *American journal of men's health*, *12*(4), 720-729.
5. Zierau, F., Bille, A., Rutz, W., & Bech, P. (2002). The Gotland Male Depression Scale: A validity study in patients with alcohol use disorder. *Nordic Journal of Psychiatry, 56(4)*, 265–271. doi:10.1080/08039480260242750


| ÖNERİ MADDELER | MADDENİN KAVRAMLA İLİŞKİSİ | ÖNERİLEN DEĞİŞİKLİK |
|---|---|---|
| 1.Bebeğimiz doğduğundan beri kendimi birçok rol arasında sıkışmış hissediyorum (örn, iş, bebek bakımı, ev sorumlulukları vb.) | | |
| 2. Bebeğimiz doğduğundan beri kendimi daha gergin hissediyorum. | | |
| 3. Üzgün hissetmeme rağmen bunu dışarıya yansıtmakta zorlanıyorum. | | |
| 4. İş ve aile sorumluluklarını (örn, bebek bakımı, eşe destek olma) eş zamanlı yerine getirmeye çalışmak beni yoruyor. | | |
| 5. Bebeğim doğduğundan beri ekonomik meseleler ile ilgili daha kaygılıyım. | | |
| 6. Bebeğim doğduğundan beri ani duygu değişimleri yaşıyorum. | | |

| | | |
|---|---|---|
| 7. Mutsuzluğumu daha çok gerginlik olarak yaşıyorum. | | |
| 8. Yeterince iyi bir baba olmadığımı düşünerek üzülüyorum. | | |
| 9. Bebeğimiz doğduğundan beri strese toleransım azaldı. | | |
| 10. Üzgün olduğumda öfkeli tepkiler verebiliyorum/ kendimi sinirli hissediyorum. | | |
| 11. Uykularım çok düzensiz (örn, uyuyamama, geç uykuya dalma ya da aşırı uyumu isteği vb) | | |
| 12. Bazen o kadar mutsuz hissediyorum ki gerginliğimi kontrol edemiyorum. | | |
| 13. Bebeğimiz doğduğundan beri üzüntü ve gerginlik arasında gidip geliyorum. | | |
| 14. Bebeğimiz doğduğundan beri ruh halim oldukça değişken. Bazen üzgün hissederken sonra hemen gergin/öfkeli hissedebilirim. | | |
| 15. Kendimi tutmaya çalışsam bile ani çıkışlarım olabiliyor. | | |
| 16. İş ve aile sorumluluklarımın yoğunluğu dikkatimin kolayca dağılmasına neden oluyor. | | |
| 17. Bebeğimiz doğduğundan beri kendime ayıracak zaman bulamadığımdan çok yorgun hissediyorum. | | |
| 18. Bebeğimiz doğduğundan beri eşimle istediğimiz gibi vakit geçiremiyoruz. | | |
| 19. Sinirli çıkışlarımın ardından kendimi suçlu hissediyorum. | | |
| 20. Daha iyi bir baba olamadığım için kendimi suçluyorum. | | |

| | | |
|---|---|---|
| 21. Bebeğimiz doğduğundan beri eşime daha toleranslı davranmak zorunda hissetmek beni yoruyor. | | |
| 22. Duygularımı dışarı yansıtmakta sorun yaşıyorum (örn, mutsuzluk, suçluluk, stres v.b.) | | |
| 23. Bir baba olarak, eşimin ve bebeğin ihtiyaçlarına öncelik vermek zorunda hissediyorum. | | |
| 24. Eşimin ve bebeğin ihtiyaçlarına öncelik verme baskısı duygularımı bastırmama neden oluyor (örn, üzüntü, mutsuzluk) | | |
| 25. Keşke bebeğimiz doğmadan önce hayallerimi gerçekleştirseydim. | | |
| 26. Olumsuz duygularımı içime atıyorum. | | |
| 27. Bebeğim doğduğundan beri başkalarının beni anlayamayacağını düşünmek kendimi yalnız hissettiriyor. | | |
| 28. Bazen her şeyi bırakıp kaçıp gitmek istiyorum. | | |
| 29. Bebeğimin geleceğini düşünmek beni kaygılandırıyor. | | |
| 30. Bebeğimiz doğduğundan beri kendimi sıkışmış hissediyorum. | | |
| 31. Bebeğimiz doğduğundan beri evden ve sorumluluklarımdan uzaklaşma isteğim bana kendimi suçlu hissettiriyor. | | |
| 32. Bebeğimiz doğduğundan beri ne yaparsam yapayım deşarj olamıyorum. | | |
| 33. Bebeğimiz doğduğundan beri kendimi gelecekle ilgili umutsuz hissediyorum. | | |
| 34. Bebeğim doğduğundan beri kendimi yaşlanmış ve yorgun hissediyorum | | |

## APPENDIX. AA. PATERNAL POSTPARTUM DEPRESSION SCALE FIRST VERSION

Aşağıdaki maddelerde, yeni doğan sahibi babaların bebekleri doğduktan sonra yaşayabilecekleri birtakım durumlar yer almaktadır. Lütfen her bir maddeyi dikkatle okuyun ve her bir cümlenin sizin **SON 1 AY** içerisindeki duygu ve düşüncelerinizi ne oranda yansıttığına karar verin.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Beni kesinlikle yansıtmıyor | Beni yansıtmıyor | Karasızım | Beni yansıtıyor | Beni tamamıyla yansıtıyor |

| **Babalık ile İlişkili Stres (Fatherhood Related Distress)** | | | | | | |
|---|---|---|---|---|---|---|
| 1 | Bebeğimiz doğduğundan beri kendimi birçok sorumluluk arasında sıkışmış hissediyorum (örn., iş, bebek bakımı, ev sorumlulukları vb.) | 1 | 2 | 3 | 4 | 5 |
| 2 | Bebeğimiz doğduğundan beri iş ve aile sorumluluklarını (örn, bebek bakımı, eşime destek olma) eş zamanlı yerine getirmeye çalışmak beni yoruyor. | 1 | 2 | 3 | 4 | 5 |
| 3 | Bir baba olarak kendimi yetersiz hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 4 | Daha iyi bir baba olamadığım için kendimi suçluyorum. | 1 | 2 | 3 | 4 | 5 |
| 5 | Bebeğimiz doğduğundan beri, eşime karşı daha hassas davranmam konusunda üzerimde bir baskı hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 6 | Kendi ihtiyaç ve isteklerimi ailem için feda ediyorum. | 1 | 2 | 3 | 4 | 5 |
| 7 | Bir baba olarak, eşimin ve bebeğimizin ihtiyaçlarına öncelik vermek zorunda hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 8 | Bebeğimin geleceğini düşünmek beni kaygılandırıyor. | 1 | 2 | 3 | 4 | 5 |
| 9 | Bebeğimiz doğduğundan beri, evdeki sorumluluklarımdan bunalmış hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 10 | Bebeğimizle ilgili sorumluluklarımı yapmak istemediğimde ya da aksattığımda kendimi suçlu hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 11 | Bebeğimiz doğduğundan beri aile içinde kendimi ikinci plana atılmış hissediyorum. | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 12 | Bebek sahibi olduktan sonra geleceğe ilişkin maddi kaygılarımın arttığını hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| **Depresif Semptomlar (Depressive Symptoms)** | | | | | | |
| 13 | Bebeğimiz doğduğundan beri kendimi eskisine göre daha gergin hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 14 | Bebeğimiz doğduğundan beri gelecek beni daha kaygılandırır oldu. | 1 | 2 | 3 | 4 | 5 |
| 15 | Bebeğimiz doğduğundan beri ani duygu dalgalanmaları yaşıyorum. | 1 | 2 | 3 | 4 | 5 |
| 16 | Bebeğimiz doğduğundan beri, yaşadığım sıkıntılar karşısında tahammülüm azaldı. | 1 | 2 | 3 | 4 | 5 |
| 17 | Bebeğimiz doğduktan sonra, uykularım çok düzensiz hale geldi (örn, uyuyamama, geç uykuya dalma ya da aşırı uyumu isteği vb). | 1 | 2 | 3 | 4 | 5 |
| 18 | Bebeğimiz doğduğundan beri duygularım oldukça değişken. Örneğin, bazen mutlu hissederken sonra hüzünlü hissedebiliyorum. | 1 | 2 | 3 | 4 | 5 |
| 19 | Bebeğimiz doğduğundan beri, dikkatim eskisine göre daha kolay dağılır oldu. | 1 | 2 | 3 | 4 | 5 |
| 20 | Bebeğimiz doğduğundan beri kendimi eskisine göre daha yorgun hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 21 | Bebeğimiz doğduğundan beri öfkeli çıkışlarım oluyor. | 1 | 2 | 3 | 4 | 5 |
| 22 | Keşke bebeğimiz doğmadan önce hayallerimi gerçekleştirmiş olsaydım. | 1 | 2 | 3 | 4 | 5 |
| 23 | Bebeğimiz doğduğundan beri, kendimi yalnız hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 24 | Bebeğimiz doğduğundan beri kendimi sıkışmış hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 25 | Bebeğimiz doğduğundan beri ne yaparsam yapayım duygusal olarak rahatlayamıyorum. | 1 | 2 | 3 | 4 | 5 |
| 26 | Bebeğimiz doğduğundan beri kendimi yaşlanmış hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 27 | Bebeğimiz doğduğundan beri kendimi gelecekle ilgili umutsuz hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 28 | Bebeğimiz doğduğundan beri kendimi tükenmiş hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 29 | Bebeğimiz doğduğundan beri içimde bir boşluk hissediyorum. | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 30 | Bebeğimiz doğduğundan beri öfkemi kontrol etmekte zorlanıyorum. | 1 | 2 | 3 | 4 | 5 |
| 31 | Bebeğimiz doğduğundan beri kendimi mutsuz hissediyorum. | 1 | 2 | 3 | 4 | 5 |
| 32 | Bebeğimiz doğduğundan beri olumsuz duygularımı kendi içimde yaşıyorum. | 1 | 2 | 3 | 4 | 5 |
| 33 | Bebeğimiz doğduğundan beri kendimi kontrol etmekte zorlanıyorum. Ani ve beklenmedik tepkiler verebiliyorum. | 1 | 2 | 3 | 4 | 5 |
| 34 | Bebeğimiz doğduğundan beri çevreme eskisine kıyasla daha agresif tepkiler verebiliyorum. | 1 | 2 | 3 | 4 | 5 |
| 35 | Bebeğimiz doğduğundan beri ailemi etkilememek için yaşadığım olumsuz duyguları içimde tutuyorum. | 1 | 2 | 3 | 4 | 5 |
| 36 | Bebeğimiz doğduğundan beri kimsenin beni anlayamayacağını düşünüyorum. | 1 | 2 | 3 | 4 | 5 |
| 37 | Bebeğimiz doğduğundan beri kendimi rahatlatmak için daha çok veya daha az yemek yiyorum. | 1 | 2 | 3 | 4 | 5 |
| 38 | Bebeğimiz doğduğundan beri beni yatıştıracağını düşündüğüm maddeleri (alkol, sigara vb.) daha çok kullanıyorum. | 1 | 2 | 3 | 4 | 5 |