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Empathic Connection or Addictive Flight? Helping fathers in recovery from addiction develop empathic relationships with their children.

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Dedication

This research is about fathers and families, and I would very much like to dedicate this work to my family. In particular, my father, who died just before I commenced this research, was indeed the greatest influence on my embarking on this research. And while I have spoken about what I didn't receive from him as a child, I am truly thankful for the many things I did receive from him. I also want to acknowledge my dear mother, whose love and endurance have been vital to my growth. To my sister Michelle and brothers Drew and Darien, you have been and are wonderful companions on my journey towards maturity and 'sanity'.

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or part, for a degree at this or any other institution.

Dion Khlentzos
September 2017

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List of Abbreviations

AAIDD..... American Association of Intellectual and Developmental Disabilities
ABS..... Australian Bureau of Statistics
ACER..... Australian Council for Educational Research
ACT ..... Australian Capital Territory
AFRC ..... Australian Family Relationships Clearinghouse
AFRN..... Australian Family Relationships Network
AIHW..... Australian Institute of Health and Welfare
ARACY ..... Australian Research Alliance for Children and Youth
ASSOC..... Association
Ca ..... California
CFA..... Confirmatory Factor Analysis
Co..... Company
DERS (DERS-26) ..... Difficulties in Emotion Regulation Scale (26-item version)
DOCS..... Department of Community Services
DOI ..... Digital Object Identifier
DSM..... Diagnostic and Statistical Manual
ed..... Edition
Ed./Eds. ..... Editor/s
EFA..... Exploratory Factor Analysis
EQ (EQ-16)..... Empathy Quotient (16-item version)
FACQ (FACQ-17) ..... Fathers' Attachment to Children Questionnaire (17-item version)
FACS ..... Family and Community Services
GHQ/GHQ-28..... General Health Questionnaire (28-item version)
Inc. ..... Incorporated
NC..... North Carolina
NJ..... New Jersey
NSW..... New South Wales
NY..... New York
PASPD ..... Project Air Strategy for Personality Disorders
RQ..... Research Question
SPSS..... Statistical Package for the Social Sciences
TIK..... Tuning in to Kids (parenting program)
UK..... United Kingdom
USA ..... United States of America
Vic..... Victoria

Abstract

This thesis explores the relationship between empathy and parenting in a sample of fathers recovering from addiction. It considers whether and how the development of empathic parenting skills can facilitate changes in emotion regulation and positive attachment to their children, and considers the implications of focusing on supporting men as fathers for their recovery.

Previous research has identified reduced capacities for empathy and emotion regulation in people experiencing addictions compared to those without addictions. The present study investigated firstly whether differences in attachment, empathy and emotion regulation would correlate with the presence or absence of addiction in a sample of fathers. Having established this to be the case, particularly with respect to empathy and emotion regulation, phase 2 of this study explored whether training in empathic parenting skills could help fathers undergoing treatment for addictions to improve their relationships with their children, their perceptions of themselves as fathers, and their sense of wellbeing.

While the link between addictions in fathers and diminished health outcomes in their children is well established, there has been little research to date that has studied the perspectives of fathers themselves during the recovery process. Accordingly, this research also sought to explore the parenting experiences of a sample of fathers as they recovered from addictions in two residential rehabilitation centres in Sydney, Australia, in 2013. The focus on the men's experiences encompassed two key questions: How do fathers recovering from addictions experience changing relationships with their children? What other changes take place for these recovering fathers throughout the parenting program?

The two phases of this research were designed as a mixed-method study, consisting of an initial quantitative survey of 169 fathers who responded to questionnaires that assessed their attachment to their children, their difficulties with emotion regulation, their mental and physical health symptoms, and their social, cognitive and affective empathy. This permitted a range of comparisons between those fathers recovering from

addictions and those not reporting addictions on these measures, as well as informing some of the content of the parenting program, which was adapted from the Australian program, *Tuning in to Kids* (Havighurst, Harley & Prior, 2004).

The following second phase was designed as an in-depth multiple case study that involved seven fathers in the two residential rehabilitation centres. Qualitative data, consisting of the fathers' stories as expressed in their individual interviews and parenting group sessions, were analysed using narrative analysis, and supplemented by the researcher's field notes. The narrative data were also coded for the four key variables outlined above, and were compared with quantitative survey data collected at pre-program, post-program and follow-up sessions to complement the qualitative data and help determine the presence and extent of change in these fathers.

The results were encouraging, as each of the seven fathers told of positive change in their lives. Through the recovery process the men described themselves and their children differently, as their children became more important to them and their confidence grew in those relationships. It was clear that fatherhood was a significant concern for these men, and their relationships with their children a central motivator for them. The men were thus able to develop greater emotion regulation themselves through learning about how their children learn to manage emotions and how they as fathers can help, in addition to emotion regulation exercises focusing on their own wellbeing as fathers. The change in the fathers' comments and questionnaire responses between the beginning and end of the parenting program also showed evidence of closer empathy-related attachment ('empathic connection') to their children, which is thought to underlie both the recovery process and their relationships with their children.

The implications of these results are profound. Firstly, this study has found that men with major histories of addiction still have the ability, with positive support and improved emotional awareness, to form an empathic connection with their children. Secondly, providing a means for these men to focus on fatherhood within their recovery program has also helped facilitate a greater awareness of being positive role models for their children. This in turn led some of the fathers to report that their children showed not only more respect towards them, but perhaps most importantly, improved wellbeing.

Personal Context

I never expected to have a child – I had already turned forty before I finally met the woman I was to marry, but two years later we became parents for the first time – later than most, but very excited and thankful to be parents at all.

For those fathers reading this who were present at the birth of their child, I am sure they will understand when I say that this was the most profoundly moving experience I have had. Tears streamed uncontrollably down my face as I watched my wife's body opened up and saw our new son enter our world from the comfort of his mother's womb.

That was barely 12 months before I embarked on this research, which is inspired by my experiences as a father, but also my experience of my own father, whose love I always felt was present but compromised by addiction. For me, being a parent has been full of joy, but tempered by anxiety.

My father was an enigma: he was a very talented man, particularly as a singer; he had a keen wit; and he loved his family, especially his grandchildren and great-grandchildren. But he never seemed to enjoy being a father. He lost his own father when he was just 13 and had to leave school the next year to support his mother and siblings. And while I always knew he loved me, I never felt that he tried to understand me until right near the very end of his life.

My dad's life always seemed to be about doing something to try to make himself feel better, and this included gambling for much of his adult life. It seemed like his children were in the way of his path to becoming happy. And yet, despite the underlying distress that I believe fuelled his gambling, I suspected that if he had got to really know us as children he would have given himself a better chance of achieving the happiness he longed for. In any event, I am sure that if he had reached a certain level of contentment prior to becoming a father he could have been a much more caring father.

I consider myself very fortunate: I have received plenty of support and advice from family and mentors, and although it has been quite difficult much of the time, I have felt able to be the parent I want to be to our son. But I feel that struggle, probably every day, between really attending to our child and just wanting to do my own thing, and I know that my dad struggled with this as well.

I have been deeply moved by the experiences and reflections I have had as a father. In particular, as I held our baby son one night, trying to rock him back to sleep, I considered that he would very likely carry part of me beyond the end of my life – and I hoped that he would be able to do so without making the same mistakes I (or my father) had made.

This study is about fathers, emotions, addictions and empathy. Being a son of a father with an addiction was difficult for many reasons, including not sensing my father's empathy for me growing up. Even so, I have been fortunate enough to receive training as a psychologist and counsellor in becoming more empathic myself, and so I can understand better what it is that our child needs from me. But under the stress of being woken up many times at night over our child's first two years especially, my typical response to stress usually more closely resembled exasperation than empathy. I also recognise my own instincts, despite my training and my love for my son, which have often been not to connect with him. So in writing this thesis I am wanting to understand fathers better, and particularly, but not exclusively, those with addictions. I also wish to gain a greater understanding of what it means to become a more contented father.

CHAPTER 1. LITERATURE REVIEW

Introduction

This thesis explores the relationship between fathers' experience of addiction and their capacity to develop empathic connections with their children. Informed by my own experience of growing up with a father whose addiction left him emotionally unavailable to his son, this doctoral research firstly investigates the effects of addiction on fathers' capacities for attachment, empathy and emotion regulation. It goes on to initiate an emotion-focused parenting program with fathers in recovery from addiction at two Sydney-based residential rehabilitation facilities.

Central to this inquiry is the question of whether and how the development of empathic parenting skills can facilitate changes in emotion regulation and positive parental attachment in fathers recovering from addiction. Of particular interest in this study is its emphasis on enabling the men's exploration of fatherhood and its meaning for them. Their stories are given voice in the thesis as part of a multiple case study design, which brings to the fore the men's narratives and provides rich accounts of their attempts to re-connect with their children as they come to terms with the effects of addiction on their children and on themselves as fathers.

A close connection between a father and his child is considered to involve more than shared activities and the imparting of wisdom; the father's ability to show empathy to his child is assumed to be a key component of the relationship. While it has not traditionally been considered as an essential part of a father's way of relating to his family, there is growing evidence that empathy from both parents contributes greatly to a child's healthy self-esteem (Havighurst, Harley & Prior, 2004). There may also be benefits for the father himself in learning this deeper form of connecting with his children (Plasse, 1995; Siegel & Hartzell, 2004).

The premises for this investigation are three-fold. Firstly, the enormous life change that is required in becoming a father can increase anxiety, particularly if he has a poor relationship with his partner, thus increasing the chance that he will not want to be emotionally and physically available to his family, which is often the case for people

with addictions (Soderstrom & Skarderud, 2013; Wedekind et al, 2013). Secondly, as has been demonstrated through research into attachment (Bowlby, 1969), parent-child bonding is inherently comforting and meaningful for both parties. If such a bond is not created, the ongoing relationship between father and child is likely to be negatively affected. Thirdly, the ability to bond with one's children requires the capacity for empathic connection, and for this skill the father must possess emotional maturity, including the capacity for both emotion regulation and self-reflection, which may attenuate the need to engage in addictive behaviours.

Fatherhood: History and Evolution

A History of Fathering in the Western World

Fathers have carried special significance to societies throughout history. The major religions have used the word *Father* to name their God, who is also seen as the creator and the moral authority of the world. In Carl Jung's archetypes, *The Father* is also depicted as the lawgiver and originator, the king, the judge and the protector (Stevens, 1999). There has traditionally been tension between the perception of fathers as the loving man and the powerful, harsh ruler. The word *Father* is derived from the same origin as *patriot* – the loyal supporter of one's country or tribe. Historically, a man is supposed to become a father – he gains more wealth, power, respect and prestige from doing so. Men have become fathers through passion or love, arrangement, convenience, or by accident.

The concept of the father in the Western world has evolved steadily over the last few centuries (Rohner & Veneziano, 2001; Lamb, 2010), and globally more rapidly over recent decades in particular (Barker & Pawlak, 2011). In USA, for example, fathers were traditionally seen as the stern patriarchs and moral teachers in the 1600s and 1700s, and later – after industrialisation in the latter part of the 18th century – as the distant breadwinner and provider until the early 1920s, during which Freud's influence inspired a sexual revolution in the West, as well as new mores in developmental psychology (Lamb, 2010). Fathers also began to take on the role of playmate, as it was seen as a masculine way of responsibly raising one's children. Nevertheless, at that stage the

father's role in the family was still seen as incidental (Rohner & Veneziano, 2001). Even today, a common meaning of the verb *to father* is to conceive a child; it does not necessarily imply any caretaking at all, and likewise the word *paternity* refers only to biology, not to an ongoing experience of being a father.

From the 1930s, the model of the male breadwinner had been severely challenged as a result of the Great Depression, and from that time the ideal father was considered in academic literature to be the traditional male gender role model (Rohner & Veneziano, 2001). Since then, fathering has been heavily influenced by two major types of global events: the World Wars and feminism. After World War II, fathers' presence in the home became more the norm, and a new era of affluence began: the traditional nuclear family was being celebrated in America and other parts of The West (Lamb, 2010).

Then, following the feminist revolution of the 1960s and 1970s, a woman's traditional role in the home – and (for many) not the workplace – was being challenged, and consequently, so was that of the man. Thus, fathers were increasingly starting to take on the role of co-parent (Rohner & Veneziano, 2001). Even so, while an increasing number of women were entering the workforce, working mothers still tended to see themselves essentially as mothers, while most fathers continued to conceptualise their identity primarily in terms of their career (James, 2009). Until around the end of the twentieth century, men in Western cultures commonly saw themselves as 'un-masculine' if they became involved in the more caring household activities previously only carried out by mothers (Rohner & Veneziano, 2001).

It was really only since the beginning of the 21st century that research has consistently been demonstrating the positive effects that warm, nurturing fathers can have (and have had) on their children, and conversely the adverse effects of not only abusive or neglectful fathering, but detached fathering (Lamb, 2010). Influenced by postmodernism, the barriers between the masculine and the feminine have continued to be broken down. Consequently, in countries such as USA and Australia, it is now considered quite normal for fathers to take on various roles, including carers and companions, as well as the more traditional protectors, teachers, role models and

providers, whether they are in families that are considered traditional or not, for example those with two fathers (Lamb, 2010).

Globally, the picture has been a little different. In a recent United Nations report (Barker & Pawlak, 2011), several changing trends in family demographics were identified. These included declining fertility rates leading to smaller families, some increases in the time fathers have spent on household work, and increasing rates of separation and divorce, among others. The report also referred to a study showing that there are now more relatively young fathers than ever before living apart from their children: over 20% of fathers aged 25-39 across 43 countries in the study were not living with their children, and more than 25% of children in single-mother families had not seen their father in the previous year. More women than ever are now leading their families solo, and in many households in which the father uses alcohol or perpetrates violence, the mother is often the sole effective parent for their children (Barker & Pawlak, 2011).

Perspectives from Evolutionary Theory

What do we know about fathers and parenting from other species? From the perspective of evolutionary psychology, the drive to protect and care for one's offspring can be considered an adaptive strategy that affords an increased sense of security in the parents as well as the offspring. Citing as evidence the irresistible drive within the animal kingdom to propagate one’s species, evolutionary psychologists have proposed that humans are motivated to find a partner and reproduce so as to reduce their fear of evolutionary 'failure' (Buss, 2003).

Evolutionary psychology has also examined studies of parenting behaviours in various animals, which has led to paternal investment theory (Geary, 2000). This theory states that the likelihood that a male animal will invest his time and energy into caring for his offspring is increased if (i) he can be relatively certain that he is the biological father; (ii) such investment will increase his offspring’s chance of survival, or at least improve the quality of his offspring; and (iii) there are increased mating opportunities available through such investment or, in species where this is relevant, the benefit of the

investment is not outweighed by the cost of the reduced mating opportunities that result. Geary (2000) deduced that a human father is more likely to invest in – and connect with – his children if these three conditions are present. The reduced likelihood that a step-father will invest in his partner's children (through his time as well as his money), for example, can be explained through this theory since condition (i) above is not met.

Geary (2005) further argued that, although the vast majority of primate and other mammalian fathers do not invest in their offspring – preferring the increased mating opportunities outside the family unit – this theory can be used to explain why most human fathers are motivated to engage in such investment. In this context Geary (2005) examined studies that gave support to the theory that men are more likely to invest time and other resources in their children if: such resources are available; the father believes that he can improve the social competitiveness of his children through such investment; and the attitudes of available women in his social group to casual sexual encounters are negative. Geary (2005) also noted that a highly significant factor in determining the likelihood of increased human paternal investment is the quality of the relationship between the father and the mother of their young child.

Men, Masculinity and Fatherhood

Sociological perspectives on masculinity

Men have traditionally gone into battle – whether it was against wild animals, opposing tribes of other men, or the elements. They still do, and if they are not literally fighting, they are doing so figuratively in other competitive pursuits. And to prepare for battle, men have needed to be trained to keep their emotions in check. This is especially true in the case of soldiers today (Green, Emslie, O'Neill, Hunt & Walker, 2010), but the phenomenon of harnessed emotion has long been part of the male psyche.

Therefore, popular opinion declared that a man should be strong, both physically and mentally. And a father, above all else, needs to provide for and protect his family. In common public Western discourse, these two beliefs stood relatively uncontested through to the 1960s (Levant, 1997), and were supported by biological and

psychoanalytic studies in particular. A father had his role to play, and it was very different from that of the mother. For example, in a study on outcomes in child development, Johnson (1963) concluded "the internalization of appropriate sex role orientations in both sexes depends upon identification with the father" (p. 331).

Some 14 years later, Quadagno, Briscoe & Quadagno (1977) reviewed the biological literature on gender at the time, and found that exposure to prenatal androgens in females in both monkeys and humans increased the prevalence of traditionally masculine behaviours, including high "energy expenditure" in the monkeys, and parent-reported "tomboyish" behaviour in their young daughters (p. 69). Such exposure also reduced maternal play behaviour, including playing with dolls. However, even in that article, cracks were beginning to appear in these long-held beliefs about gender differences, as the authors suggested that other interpretations may have been just as valid as the explanation that introduced male hormones were changing the young girls' behaviour. Could it be, they asked, that such changes in behaviour were more due to changed expectations of the parents and other family members and the subsequent effect on the girls, rather than biology, following such interventions? Challenging the notion of innate (or even biologically engineered) psychological sex differences had now become fair game.

Australian sociologist R. W. Connell added a compelling voice to the debate, with the ground-breaking works, *Gender and Power* (Connell, 1987) and *Masculinities* (Connell, 1995), in which the author convincingly argued that masculinity was not only socially constructed, but this construction had the purpose of oppressing women and the feminine. The message that the masculine was the ideal had been perpetrated in the popular press, through which the values of strength, independence and sporting prowess were lauded, while emotional and, to varying extents, academic intelligence, were all but ignored. The message was that the most masculine men in our society were role models to which men should aspire and to whom women would naturally be drawn. Such values have consistently been bred in all-male contexts such as single-sex boys' schools. He

labelled this oppression of other ways of being as “hegemonic masculinity” (Connell, 1995, p. 77).

Connell (1995) continued that societal beliefs about natural male dominance have implicitly condoned crimes mostly committed by men, including assault and rape. This theory had already gained leverage in a presentation given at the Australian Institute of Criminology by Douglas (1993), representing the group *Men against Sexual Assault.* This presentation emphasised that all men are responsible for the violent behaviour of a subset of men, regardless of their own behaviour, if they maintained their own traditional beliefs (or did not challenge others’ beliefs) about masculinity. Australian academics had begun to seriously question even the moral value of masculinity.

Connell (2005) later revised the theory of hegemonic masculinity in response to certain criticisms, including that it did not sufficiently account for the spectrum and dynamics of various masculinities in society. However, even after the theory was revised, there were criticisms that it either did not explain emotional responses of groups of men to actual or potential loss (Moller, 2007), or it failed to account for the power dynamics in social contexts in which there was a minority of men (Malmi, 2009).

Nevertheless, Connell’s (2005) theory remains highly influential, and academic scholars have increasingly acknowledged the social determinants of masculinity in favour of its physiological and previously accepted unchangeable nature (Shapiro, 2012). Levant (2011), for example, reviewed the developmental psychology literature and concluded that the evidence suggested that men’s lesser tendency to express emotions (particularly fear and sadness) was due to socialisation rather than innate sex differences. Levant (2011) also reported that in a previous literature review he had found that a man’s “endorsement of traditional masculinity ideology [predicted] more negative beliefs about the father’s role” (p. 771).

One aspect of masculinity has more recently been tested in a well-designed social psychological experiment. Taylor (2014) randomly divided young men and women into groups of varying gender formation and gave them a task to solve. The author found that

if the young men were told that they were wrong in their responses when they were in front of other men – hence losing social influence or perceived status in that group – they showed a significant increase in their stress responses, which were measured by increases in cortisol levels. Under the same circumstances, such responses were neither found in the women, nor in those young men who were in front of women rather than other men. The author concluded that men were invested in not losing their social influence or social esteem in male groups in particular; this is one of the "threats to masculinity" indicated in the title of the paper (Taylor, 2014, p. 51).

Masculinity and fatherhood

Fuelled by the issues raised by Connell (1987) and others concerning power imbalances between males and females in the workplace and family, social expectations of fathers were shifting, and fathers had to reconsider their traditional role as the 'good provider' in favour of a 'good family man' (Oren & Oren, 2010). The notion that fathers should be concerned about the quality of their relationships with their children was gaining impetus. An increased level of consciousness in Western society led to the recognition that children needed better fathers than they had often had in the past, although many men were yet to embrace this change.

The man's position as the financial and psychological 'head of the household' and sole breadwinner was thus no longer accepted as the norm. Consequently, as explained by Levant (1997), men were considerably more confused as to what their role in society should be, or what indeed it meant to 'be a man'. He referred to this phenomenon as the "Masculinity Crisis", and he observed that this created a tendency in marriages to "revert to stereotyped roles" (Levant, 1997, p. 221) under pressure, which were more frequently ending in separation and divorce. Further, men were often neither motivated to change, as their powerful position within the family was at stake, nor were they emotionally equipped to change, as their ability to discuss and negotiate task-sharing was often impaired due to the traditional socialisation process of males within Western culture (Levant, 1997).

Examining men's self-perceptions from a self-psychology perspective, psychotherapist Gary Dick (2011) found in the clinical literature and his own practice that men's self-esteem was strongly influenced by the warmth of their relationships with their fathers. He emphasised children's need to identify with their fathers in order for healthy psychological growth to occur. In particular, boys' capacity to develop healthy masculine characteristics depended on their ability to internalise their relationship with their fathers. However, Dick (2011) also found that fathers' masculinity was not the determining factor in their sons' healthy growth. This finding was supported by Lamb's (2010) review of the developmental psychology literature, from which he concluded that boys' capacity to develop conventional, masculine characteristics was maximised if they were raised by warm, nurturing fathers, rather than by stereotypically masculine fathers.

One clear theme in the client stories in Dick's (2011) study was the debilitating psychological effect on adult sons of fathers who had abused or neglected them physically or emotionally when they were growing up. This was the case for those adult sons whose fathers weren't overtly abusive or critical, but were nonetheless emotionally unresponsive to their sons, even if they had engaged in shared activities with them. This also supported to some extent the findings of Johnson (1963), although Dick (2011) emphasised psychological health rather than appropriate sex-role development.

Pleck (2010), however, came to a slightly different conclusion, after conducting a thorough critical review of the studies on parenting and fathers. He found that there was a common misconception in the developmental literature as well as the popular press that fathers are unique in their masculine parenting style, and that this unique fathering quality is essential to the healthy growth of their children. This misconception was exposed as the definition of the family was becoming broader, including an increasing number of gay parents, adoptive parents, step-parents, and non-residential parents, the latter group being mainly fathers (Sullivan, 2003; Weston & Qu, 2014). Pleck (2010) found that the studies that he reviewed either only weakly supported the value to children of masculine qualities in fathers, or did not support it at all.

In relation to these findings, Lamb (2010) reported, “Pleck shows convincingly that not only the identification of the father with masculinity is ill-conceived, but also that the two constructs are effectively orthogonal” (p. 10). Expressed otherwise, these findings suggested that outcomes for children were just as likely to be negative as they were to be positive if their fathers consistently behaved in traditionally masculine ways towards them.

In parallel, Levant (2011) found that while some ‘masculine’ qualities, such as assertiveness and confidence, have been associated with positive health outcomes for the men themselves, others, such as difficulty expressing emotions and reluctance to seek help, have not. Whether the positive male health outcomes identified by Levant (2011) are associated with similarly positive outcomes for a man’s children, however, may depend on whether he also displays warmth, which would be consistent with the profile of an authoritative parent (Baumrind, 1989). Otherwise, a father’s confidence and assertiveness may translate into male dominance more than effective parenting (Peters, Peterson, Steinmetz & Day, 2014).

On this point, Enderstein & Boonzaier (2013) conducted research into young South African men’s experiences of early fatherhood, and found that many of these young fathers were able to articulate a ‘change’ narrative, in which they were able to challenge their own assumptions about masculinity in order to see themselves as caring and responsible fathers. And from a physiological perspective, Oren & Oren (2010) described a fascinating phenomenon in which there is a decline in testosterone (corroborated in a Philippine study by Gettler, McDade, Agustin, Feranil & Kuzawa, 2015) as well as an increase in oestrogen levels in new fathers. This may have a highly adaptive effect for men who begin to take a nurturing role for perhaps the first time in their life, but it may also contribute to depression from a physiological perspective, since oestrogen has been implicated as a hormonal factor in the greater incidence of depression in women (Oren & Oren, 2010). In any event, could it be that the onset of fatherhood may lead to reduced masculinity in men?

Fletcher (2008, 2011) reviewed the literature on gender differences, which suggested that the male brain is essentially different from the female brain from birth: baby boys attend to different stimuli compared to baby girls. He argued that fathers therefore generally parent differently from mothers, at least in some respects, including the manner in which they play with their children. A father's influence on his children has also been found to be significant and independent of that of the mother (Fletcher, 2011).

Similar findings were published in two reviews of the fathering literature in North America, with respect to fathers' influence on their adolescent and adult sons and daughters (Rohner & Veneziano, 2001; Allen & Daly, 2007). While these findings appear to be at odds with those of Pleck (2010), it should be noted that, although these studies found differences in parenting styles between fathers and mothers, Fletcher (2011) and the other authors did not claim that it was the fathers' masculinity per se that was the key factor in their parenting that helped their children to thrive.

Macdonald (2011) observed that men's health has often been conceptualised purely in sociological terms, through which men have been seen as the disproportionately favoured gender. Masculinity has thus been viewed increasingly in negative terms, and key external factors that may adversely affect men's health, such as illness, unemployment and separation from their children, have often been ignored. Macdonald (2011) thus rejected a predominantly negative assessment of masculinity and its effects on men and their families, just as Levant (2011) rejected a mostly positive assessment. Thus there are competing images of what makes a good father today. The ideal of the strong, masculine father remains, and many men still aspire to that goal. However, while evidence grows concerning the value of the nurturing father (Lamb, 2010), this ideal may feel out of reach to many men. And where does emotion fit into these different styles of fathering?

Certainly it would appear that, on the one hand, hegemonic masculinity can inhibit emotional expression in men via social means, but expression of 'power' emotions such as anger has not traditionally been discouraged (Connell, 2005). There is also evidence

for biological bases of differential expression of emotion between men and women (Vigil, 2009). Whatever the basis for this difference, emotionality is part of the stress that occurs in the change to parenthood, with evidence that young men in particular show reduced emotional awareness (Gratz & Roemer, 2004; Gardener, Carr, MacGregor & Felmingham, 2013), and that mood disorders are not uncommon in fathers of young children, with rates of depression for Australian fathers up to 10%, and higher rates still for fathers who do not live with their children (Price-Robertson, 2015). Men have also been shown to be more reluctant than women to seek help if they are distressed (Mahalik, Good & Englar-Carlson, 2003; Macdonald, 2011), so this problem can become compounded for young fathers, especially if they have a fairly narrow male role orientation (Levant, 2011).

Becoming a Father: from Attachment in Infancy to Paternal Attachment

Attachment and male development

Bowlby's (1969) attachment theory, influenced by evolutionary biology, stated that a child's successful attachment to at least one significant adult in infancy is vital to its survival. Depending on the stability of the attachment, it may also be vital to their chances of maintaining sound mental health during their development from childhood to adulthood. According to Bowlby's (1969) theory, later developed by Hazan and Shaver (1987), attachment deficits in childhood pervade people's intimate relationships for the rest of their lives. And as parents, insecure adult attachment to one's partner has been shown to predict an increased likelihood of suffering from depression during the first two years after the birth of their child for both mothers and fathers (Rholes et al, 2011).

A man's journey from singleness, through to an intimate relationship, and then to becoming a father, may be the most significant developmental period in his life. The impact on his physical and emotional wellbeing, his economic resources, his time, and his relationship with his partner, can be profound (Fletcher, 2011). Whether this becomes a predominantly positive and rewarding experience or a negative and mainly stressful one depends on a number of factors, including economic and social resources (Furstenberg, 2011), his attitude to fatherhood, particularly if he is young (Devault et al,

2008), and his relationship with his partner (Carlson & McLanahan, 2010). Another influential factor, according to Siegel & Hartzell (2004), is how fathers (and mothers) can make sense of the effect of their own childhood attachment experiences on their ability to form warm and fulfilling relationships with their children.

Adjustment and delinquency in adolescent boys and young men

The roots of the problem of intimacy for many men stem from their early childhood, when a boy first learns – usually from his father, who was treated in the same way – that he should not cry or show fear. This rigid masculine social rule is then reinforced by other boys and, by the time he reaches puberty, due to such suppression of his feelings and hence his personality, he may be quite confused about who he is, even if he is performing well in his external world (Pollack, 1999).

After the socio-emotional upheaval (for some) of starting school, puberty will be his next normative developmental milestone. The advent of puberty is celebrated in a number of cultures, and often includes a symbolic and powerful ritual to welcome the child into adulthood. The male ritual often includes some form of a display of strength and courage, designed to give the young man a strong sense of identity and confidence. The positive male psyche is founded on these qualities, as well as adventure and autonomy (Meade, 1993; Eldredge, 2001).

Western patriarchal society has traditionally upheld the ideal of the independent and invincible man, and boys have often been raised to be not only physically active and powerful, but also emotionally invulnerable (Pollack, 1999; Grille, 2005), thus preparing them to meet the demands of the tough, external world, but not necessarily their own internal, emotional world. Empathy has not usually been highly valued in the competitive, male-dominated world of sport, politics and big business. Therefore, young men who have been raised this way are often ill-prepared for the self-awareness that may be required of them in an intimate relationship (Barker & Galasinski, 2003).

Australian authors, such as academic David Tacey (1995) and family therapist Steve Biddulph (2010), have continued this theme in their writings about adolescent male development in Australia. It is at this time that many young people – males in particular – instead of commencing an enthusiastic journey of self-discovery and supported independence, remain trapped in unsupported dependence, which typically manifests itself in addictions to alcohol, drugs, compulsive sexual behaviour, or other harmful habits. Alcoholism, for example, for young Australians has continued to occur at a high rate: the Australian Institute of Health and Welfare reported that 33% of young people aged 18-24 were drinking alcohol at levels of "very high risk" over the year 2013 (AIHW, 2016, p. 12). And although the rates of alcoholism in Australia have declined since 2004 (AIHW, 2016), the rates of other drugs such as methamphetamines have increased over the same time period, with the most recent data indicating that 1.5% of Australians in the 25-34-year age group reported dependency on such substances (Degenhardt et el, 2016), which includes the use of the dangerous drug, ice.

Crime statistics for young Australian males have also remained high. The Australian Bureau of Statistics reported that the rates of offending for young people aged 10-19 years was considerably higher for males than for females: the male offender rate in 2009-2010 was 3029 per 100,000 compared to 862 per 100,000 for females (ABS, 2011). The peak male offending age was 18, with almost 10% of all Australian 18-year-old male youths being convicted of a crime (ABS, 2011). Youth crime has been commonly associated with membership of 'gangs'. Bjorgo (1998) described a number of factors that were found to lead to the formation of violent Australian gangs, comprising mainly of young males. These included anger, promise of weapons and protection, and a search for a substitute family or community, which could be described as desperate, attachment-seeking behaviour.

Barriers to becoming effective fathers

The next expected developmental milestone is an intimate relationship, which might later be followed by parenthood. Erikson (1950) proposed that a young person's positive sense of identity required first and foremost an acceptance of who he is, in terms of both

his social and his personal sense of self. Without the satisfactory resolution of the task of identity formation in adolescence, it would be particularly difficult to connect meaningfully with his partner and children (Erikson, 1950). This theory has received support from a more recent longitudinal study on the relationship between healthy adolescent identity and adult capacity for intimacy (Beaumont & Pratt, 2011).

The excitement that may be involved in the transition to fatherhood can mask feelings of uncertainty for many men, especially sons of addicted parents and those who have not attained a clear sense of identity prior to becoming fathers (Price-Robertson, 2015). The external difficulties of a lack of support in many families and workplaces, a loss of freedom, a likely decrease in sexual activity and a lack of sleep, serve to compound any internal issues, such as those relating to attachment, identity and intimacy (Price-Robertson, 2015). Oren & Oren (2010) explained that new fathers frequently miss out on what they most need at this time, which is someone to listen to their pain around what they may have lost – their partner's energy is almost completely taken up with the new baby – before they can start to learn skills to help raise their new family. For those men who have suffered the effects of childhood and adolescent attachment deficits, there is potentially the double loss of feeling rejected by their wife or partner at this time due to her required change in focus.

The standard of parenting experienced by a man during his childhood has proved to be highly influential in giving him the confidence to be a good father. For example, Krampe (2003) explained that the clinical evidence from psychodynamic theories has pointed to the conclusion that men were much more likely to describe themselves as good parents if they had a positive sense of an "inner father" (p. 131). A similar result was found in a large study conducted by Mallers, Charles, Neupert & Almeida (2010), in which the adult participants were asked about their relationships with both parents growing up, and their current levels of stress over an eight-day period. The results showed that men who recounted a poor childhood relationship with their fathers reported the highest levels of emotional reactivity in response to daily stressful events. These results support Dick's (2011) findings, described previously.

In previous studies, Anderson's (1994) research suggested that men's connection to their infant children depended on the quality of their relationships with both their fathers and their wives. And Forste, Bartkowski & Jackson (2009) found that men who were not close to their fathers were less likely to report that they had a nurturing role as parents. Failure to form a secure attachment to his father can leave a man vulnerable, as a father himself, to insecure attachment to the family that he is involved in raising.

Pollack (1999) reported that many fathers whom he interviewed complained of the difficulty of being warm, loving parents because the modelling that they had received from their own fathers was so often remote, unpredictable or harsh. Indeed, Putnam (2006) has claimed that it is the father's neglect of instilling love and self-confidence in his son that is at the core of many developing men's sense of longing and despair. Conversely, Devault et al (2008) found that, in a sample of Canadian separated fathers, their stated ability to raise their children depended heavily on their attachment to their mother (as a child and as an adult), echoing Bowlby's (1969) theory.

Fathering and attachment

Naturally, a healthy attachment to both parents (where possible) is predictive of optimal outcomes. In a community sample of educationally successful young men and women, Hagerty, Williams & Oe (2002) found that self-reported secure attachment to their mothers predicted academic success, while secure attachment to their fathers predicted decreased likelihood of suffering from depression. In addition, Trumpeter, Watson, O'Leary & Weathington, (2008) found that, for the (adult) respondents in their study, the perceived presence of empathy from their own parents was a significant discriminator between a healthy self-esteem on the one hand, and depression and narcissism on the other.

The concept of childhood attachment has been expanded since the definition of infant attachment was articulated by Bowlby (1969) and later tested in the 'strange situation' by Ainsworth, Blehar, Waters & Wall (1978). Fletcher (2011) explained that attachment

of young children to their fathers has been considered to be better predicted by the fathers' capacity for engaging in safe 'rough-and-tumble play'. Evidence has shown that fathers who have been able to form healthy attachments to their children have helped to produce substantial benefits in their children's growth, particularly through such play (Grossmann et al, 2002; Fletcher, Matthey & Marley, 2006). Similarly, Brown, McBride, Shin & Bost (2007) reported in a study of fathers' interactions with their two-year old children that the *amount* of involvement only predicted secure attachment in their children when paired with the *quality* of that involvement. In that study, fathering quality was measured in a play situation by such factors as respect for the child's autonomy, limit-setting, sense of fun, and emotional support. Indeed, there is increasing evidence that the quality rather than the quantity of father-child interactions is the major determinant of positive child outcomes related to fathers' parenting (Lamb, 2010).

In a meta-analysis of the literature concerning non-resident fathers and their effect on their children's well-being, Amato & Gilbreth (1999) found across 63 studies that "feelings of closeness" (p. 557) from the fathers (and the children) predicted a reduced frequency of internalising and externalising behaviours in their children. In the discourse of the present study, these findings can be reframed as a secure attachment of these fathers towards their children being a protective factor against potential mental health problems in their children.

More recently, in a large Australian study, fathers of young children aged two to seven years completed questionnaires that assessed the degree to which they helped their children with personal care activities such as bathing, cleaning teeth, and getting dressed (Baxter, 2011). Results showed that, while the amount of father involvement was generally well below that of the mothers, greater paternal involvement predicted both a warmer parenting style towards their children and a better chance that their partners would describe them as supportive.

What benefits have been found for the fathers themselves in connecting more closely with their families? Positive outcomes have been demonstrated through increased social

connectedness and confidence achieved through participation in Australian antenatal groups (Fletcher et al, 2006); and increased sociability through becoming parents was demonstrated in fathers who already had a baseline level of sociability (Jokela, Kivimaki, Elovainio & Keltikangas-Jarvinen, 2009). Also, Ford, Nalbone, Wetchler & Sutton (2008) found that those fathers who were committed to their relationships with their children were likely to form a strong attachment to them, while Oren & Oren (2010) highlighted qualitative studies that showed that committed fathers also commonly reported increased meaning in their lives through being parents, consistent with Buss's (2003) theory.

In addition, Pollack (1999) reported on studies that showed that fathers benefited from a closer connection with their children if they were able to overcome many of their perceived childhood deficits through developing a higher self-esteem as a result of their parenting ability. Richardson (1995) examined the benefits to fathers who had a difficult upbringing themselves. While finding similar results to those reported by Pollack (1999), Richardson (1995) also emphasised the importance that the men in his study needed to develop empathy for their own fathers, themselves and their children, if real healing from their past were to take place.

Of particular interest to the present study are the psychological resources required of men entering and navigating their way through parenthood, since becoming a man is not sufficient preparation for becoming a father (Levant, 2011). Moreover, for men who enter fatherhood psychologically under-resourced, in particular those with addictions, the stress of parenthood can be overwhelming, as the selfless behaviour required so much of the time as a parent is generally not possible for them if their own basic developmental needs have been so severely impaired by addiction (Arenas & Greif, 2000) and possibly earlier trauma. The relationship between addiction, attachment and the capacity for empathy is the focus of the next section.

Empathic Connection, Addiction and Gender

Empathy, attachment and emotion regulation

The word 'empathy' is derived from the German word "*Einfuhlung"*, which means "to project yourself into what you observe" (Martinotti, Di Nicola, Tedeschi, Cundari & Janiri, 2009, p. 157). The word has come to mean the way in which one perceives what others feel, and the ability to take another's perspectives while keeping the self separate (Martinotti et al, 2009). Both Michalska (2009) and Decety (2010) assert that all definitions of empathy include three (explicit or implicit) components: emotional engagement (affective empathy), perspective-taking (cognitive empathy), and emotion regulation (since the ability to regulate one's emotions allows the person to perceive another's feelings without becoming lost in one's own emotional experience).

Empathic connection involves a relationship between two people that is characterised by the presence of empathy and a closeness that is typical of the therapeutic relationship in counselling (Rogers, 1967), but also other close friendships or loving relationships. The empathic involvement may be two-sided, but not necessarily (for example in therapeutic or parent-infant relationships). Attachment involves physical and emotional connection, and secure attachment in an infant is fostered by consistency, safety and predictability of the caregiver's involvement (Bowlby, 1969), as well as "empathic attunement", in which the parent aligns his or her "internal state with that of the child" (Siegel & Hartzell, 2004, p. 117). Thus, since a parent is more capable of showing empathy than his or her child, particularly in the child's infancy, it follows that attachment without empathy is closer to interpersonal dependence, while empathic connection can be considered as attachment with empathy.

Gratz & Roemer (2004) defined emotion regulation as "modulation of emotional arousal, [as well as] awareness, understanding, and acceptance of emotions, and the ability to act in desired ways regardless of emotional state" (p. 41). Diverse forms of research have demonstrated links between attachment style and the capacity for empathy and emotion regulation. For example, Weinfield, Sroufe, Egeland & Carlson (2008) reviewed experimental findings and school-based studies that showed securely attached

school-age children more capable of giving empathy than their insecurely attached counterparts. A similar result was obtained by Panfile & Laible (2012), who found that for securely attached children, their relatively high empathy levels were mediated by their capacity for emotion regulation. Schore (2003) used clinical and neurological evidence to demonstrate that adults with insecure attachment histories were more likely to have problems with both emotion regulation and empathy. In a sample of British children and adolescents (aged 11-18) McEwen & Flouri (2009) found a link between self-reported emotion regulation difficulties and their fathers' use of psychologically controlling behaviour.

Amongst American adolescents the level of self-reported attachment to their parents was found to correlate positively with the affective (though not cognitive) component of their levels of empathy (Gelb, 2002). In a Canadian study on a similar theme involving school-age children (6 to 13 years), questionnaire responses were collected from parents, best friends and the teachers themselves. The results showed a strong, positive relationship between the children's empathy levels and their capacity for both emotional and behavioural self-regulation (Roberts, Strayer & Denham, 2014); while in lab-based studies, 18-month-old children who had been classified as securely attached showed the greatest skills in emotion regulation in response to stress (Thompson, 2008). Indeed Sroufe (1997) defined attachment as the 'dyadic regulation of emotion' between mother and infant. This concept can be extended to the regulation of emotion between partners: Bowlby (1969) emphasised the enduring nature of attachment, stating that one's own childhood attachment security would reliably pervade one's later relationships, which would thus involve positive or negative emotional experiences between partners.

Neurology and assessment of empathy

Differences among people's empathy levels have also been demonstrated with respect to gender. For example, Tania Singer and colleagues (2004) conducted an experiment to examine the neurological basis of pain sensation when a person received a small electric shock compared to seeing one's partner receiving such a shock. The results showed that two parts of the brain, the Anterior Cingulate Cortex (ACC) and the Anterior Insular

Cortex (AIC), were involved in both the somatosensory perception of one's own pain and the emotional response to another's pain. However, another section of the brain, the amygdala, recorded activity when participants felt physical pain but not the emotional – that is, empathic – pain of seeing one's partner in physical distress. This study was one of the first to isolate different areas of the brain according to different types of pain perception, but in their first study Singer et al (2004) only tested female subjects' experience of empathic pain.

Singer et al (2008) then carried out another experiment four years later, this time including men's neurological responses to seeing others receiving small electric shocks. This study again showed elevated AIC and ACC activity, but it was significantly greater for female than for male witnesses. In addition, Hampton (2006) reviewed studies that showed more connections between the left part of the amygdala and the ACC in females. These results were consistent with others that have indicated that men not only score lower on average than women on empathy questionnaires (Baron-Cohen & Wheelwright, 2004; Martinotti et al, 2009), but also display differential activation of relevant brain areas (Ginger, 2003), particularly when responding to others' pain (Rueckert & Naybar, 2008).

In related work, Baron-Cohen & Wheelwright (2004) developed a 120-item questionnaire that consisted of two scales, which they labelled the Empathy Quotient (EQ) and the Systematizing Quotient (SQ). These scales were developed to assess respondents' respective capacities to understand others' perspectives and to systematically organise information. The results of this research showed that on average, males across various cultures scored higher on their SQ scores than their EQ scores, while the reverse was true for females. The authors concluded that these results suggested reliable psychological differences between males and females, particularly in relation to empathy.

This study has support in other research that has focused on neurological gender differences in empathy. For example, British researchers Christov-Moore et al (2014) conducted an extensive review of the literature examining the social and neurological

determinants of empathy, and found that the majority of studies found a greater capacity for both affective and cognitive empathy in females. In addition to gender, age differences were found, suggesting that younger males showed the lowest empathy levels. And in another UK study, Muncer & Ling (2005) found the empathy levels of young men (average age 26) to be lower than in Baron-Cohen & Wheelwright's (2004) study. It should be noted that no distinction was made in this study between those participants with and without children; parental status as well as age could have contributed to this difference in empathy levels.

Addiction and gender

There is also evidence that men typically show not only less empathy on average than women, but also a greater tendency towards addiction. For example, Hampton (2006) summarised studies that showed that the release of dopamine, a brain chemical involved in the experience of internal reward, is up to three times as great in adult male brains as in female brains, in response to the injection of low doses of amphetamines.

The word 'addiction' comes from the Latin word *addictus*, meaning to be devoted to someone or something. In drug addiction, the addict searches for comfort and pleasure but, unable to find it in his drug of choice, attempts to satisfy his desire by seeking ever greater quantities and often different types of it (Grant, 2012). However, the more the body becomes sensitised to the substance, the more it opposes its initially pleasant effects (Solomon, 1980). In this process the brain shifts from the sensation of drug reward, which is intensely pleasurable, to drug craving or dependence, which becomes overwhelmingly painful (Adinoff, 2004).

Aetiology of addiction

Aetiological theories of addiction fall broadly into four categories: cognitive-behavioural, familial/genetic, social constructionist and psychodynamic. Cognitive-behavioural theories have emphasised the role of reinforcement in forming and prolonging the addictive behaviour, and negative self-talk in maintaining it (Bandura, 1997; Marlatt & Gordon, 1985). Familial/genetic theories assert that in addition to the

family environment, children's vulnerability to later substance misuse results from genetic or personality traits from one or both parents (Tarter, Schultz, Kirisci & Dunn, 2001; Chassin, Flora & King, 2004; McMahon, 2013b). While these two theories have been and are very important to the discussion about the causes of addiction, neither will be the focus of the present research, which is principally concerned with the interplay between attachment and addiction. Cognitive-behavioural theories remain useful for supporting recovery; however, their focus is more concerned with individual behaviour and self-talk then with father-child attachment. Similarly, while familial/genetic theories are obtaining an increasingly strong evidence base, they focus more on individual physiology than on those aspects of the parent-child relationship that are relevant to the later development of the young person's addiction.

Social constructionist theories of the development and maintenance of addiction emphasise instead the surrounding environment. Sattmann-Frese & Hill (2007) proposed that addiction is endemic in our corporate, consumerist culture. Products and services have increasingly been marketed as essential to one's sense of happiness and self-esteem, while many products contain excessive amounts of caffeine, fats, sugar or salt, each of which can provide the body with a type of 'high', the effect of which (intentionally or not) is to create consumer dependence on such products.

Another perspective on the social construction of addiction came from Hari (2015), who reported on studies that involved experiments with caged rats who were given the choice of drinking either pure or cocaine-flavoured water. Some of the rats were given stimulating environments with plenty of 'rat toys' and other rats to play with, while the others were kept in austere conditions with none of these extras. Hari (2015) reported that while all the rats showed initial interest in the cocaine-laced water, those in the stimulating conditions that included continual social contact with other rats lost interest in the spiked water, but those in solitary confinement did indeed become addicted to it. Hari (2015) drew the parallel with the causes of human addiction and concluded, consistent with the thesis of the present study, "The opposite of addiction … is human connection".

O'Connor (2015) disputed Hari's (2015) conclusion which, she stated, claimed that the social environment is the sole cause of the addiction. However, the claim that social factors are crucial (if not always sufficient) in the recovery from various forms of addiction has been supported by numerous studies that have identified family (Rowe, 2012) and other social components (DiClemente, 2007) as being critical to recovery from various addictions.

Psychodynamic theories assert that the addict's pursuit of the feelings of contentment and connection, which so many drugs are able to mirror, represents a deep longing for the same safety and connection that would normally have been provided by the mother or other caregiver during infancy (Winnicott, 1986). These theories propose that there may have been neglect or abuse, or some other form of traumatic event that prevented these normal childhood experiences from occurring (Walker, 2007). Previous studies have shown a significant relationship between the number of adverse childhood experiences and the risk of later developing alcoholism, drug abuse or depression ((Anda et al, 2002; Dube, Anda, Felitti & Croft, 2002; Dube et al, 2003).

The neurological basis for this theory is our internal experience of attachment, which is provided by the brain's opioid receptors, which are 'switched on' during affiliative bonding (Depue & Morrone-Strupinsky, 2005; Tucker, Luu & Derryberry, 2005), providing the sensation of social reward as well as reducing anxiety. Their effect can be mimicked by substances such as cocaine, heroin and morphine (Cozolino, 2006), which also suppress anxiety and provide short-term euphoric sensations. One prevalent psychodynamic theory of addiction is the 'self-medication hypothesis' (SMH: Khantzian, 1985), which states that using addictive substances not only provides short-term relief from the painful feelings associated with past or present trauma, but the sufferer also chooses specific substances according to the nature of the psychiatric disorder from which they are suffering. This theory shares concepts with other compensatory theories of addiction (e.g. Padykula & Conklin. 2010).

Given, however, that the rate of substance abuse has been shown to be higher in men (at least in Australia and USA: Barlow, 2002; ABS, 2008) but not the number of traumatic events, particularly sexual trauma (Kezelman & Stavropoulos, 2012), a one-to-one relationship between traumatic background and the use of substances to medicate the suffering associated with the responses to those events is unlikely to exist. In addition, the specificity aspect of the SMH (using particular substances to self-treat specific mental health problems) has limited supporting evidence (Lembke, 2012). However, the relationship between trauma and addictions, particularly conceived as disorders of self-regulation, has proved useful as a paradigm in the treatment of various forms of addiction (Gelkopf, Shabtai & Bleich, 2002; Tronnier, 2015).

Similarly, although a background of trauma has not always been part of the narrative of recovering addicts (Grant, 2012), there is evidence that such backgrounds can increase the risk of developing severe addictions not restricted to substance use. For example, in a recent Australian study, gambling addicts were interviewed about their recollections of early gambling and other family experiences in their childhood. The researchers found that while most of the interviewees reported experiencing early success at gambling but not necessarily any trauma, those who were described as the high-risk gamblers also recalled early adverse family interactions, which in some cases included abuse. This was thought to have increased the risk due to the 'high' from winning (or anticipating winning) serving to soothe their psychological distress (Thomas, Saugeres, & Moore, 2014). While gambling – even at a pathological level – has not always been viewed as an addiction, it has recently been re-classified as 'Gambling Disorder' in the DSM-5 under the category 'substance-related and addictive disorders' (APA, 2013), as there is evidence that its associated mental processes share common neurological pathways with substance abuse (Romanczuk-Seiferth, van den Brink & Goudriaan, 2014). A significant relationship between drug dependency and insecure attachment was also found in a sample of German adolescents (Schindler et al, 2005).

Addictions and empathy

The experience of empathy/attachment and addictions is common to a number of regions in the brain. In particular, the amygdala, which contains the opioid receptors, responds to both attachment cues and to drug cues, while most of the other regions implicated in the experience of empathy are involved in some form of regulatory function (Davidson, Putnam & Larson, 2000; Tucker et al, 2005; Cozolino, 2006). This is important, since emotion regulation is described as both a necessary component of empathy (Michalska, 2009) and a protective mechanism against addictions (Cozolino, 2006). In another study referred to by Cozolino (2006), the ACC and AIC regions in the brains of cocaine addicts were found to be smaller than those of a group of control subjects. These were the two regions that Singer et al (2004, 2008) found to be central to the experience of empathy. Addictions to various substances have also been found to be associated with emotion regulation difficulties (Cooper, Frone, Russell & Mudar, 1995; Fox, Axelrod, Paliwal, Sleeper & Sinha, 2007; Fox, Hong & Sinha, 2008).

Evidence suggests that infants' opioid receptors (and those of other mammals) have similar properties to the positive effects of opioid drugs when connection is made between mothers and their young (Tucker et al, 2005; Cozolino, 2006); likewise, when mothers (or fathers) are reunited with their offspring, the opiates in their brains 'turn off' the distress signals. In addition, brain regions that contribute to emotional self-regulation (and hence to empathy) are "thought to be central to the organization and reinforcement of both attachment and addiction" (Cozolino, 2006, p. 120). Thus, the presence of empathy and secure attachment – empathic connection – may suppress addictive behaviour, and vice versa.

Two contexts in which this negative relationship between empathic connection and addictions may be noticed are in psychotherapy and families. Treatment for people recovering from addictions may involve CBT, twelve-step programs, motivational interviewing or other forms of psychotherapy, but invariably includes the presence of an empathic therapist who can also help the client to work on attaining firmer boundaries and greater self-awareness (Prochaska & Norcross, 1994). For example, Ford & Russo

(2006) outlined a program for working with clients suffering from substance abuse and other problems, including mental illness or criminal convictions. The therapy involved psycho-education about addiction and faulty beliefs, personal journalling around stress triggers, and relaxation and emotion regulation exercises. The empathic connection with the therapist frequently provided clients with the leverage to be able to connect in a new way with loved ones. The authors described a case in which a man recovering from substance abuse and a history of violence initiated contact through this therapeutic process with his 19-year-old son whom he had not seen for 16 years.

Regarding families, Barker (2007) described research that found that a strong sense of emotional security was predicted by the existence of loving adult relationships, while Grille (2005) noted that "empathy arises out of emotional security" (p34). Conversely, a lack of emotional security has been found to "manifest as disturbances in the balance of giving and taking" (Grille, 2005), which characterises addictions. In a sample of young men and women (aged 21-35), Giancola (2003) found that alcohol consumption increased aggressive behaviour most significantly in men who scored low on empathy.

Abstinence from substance abuse does not always lead to greater empathy. Martinotti et al (2009) found that a sample of abstinent alcohol-dependent subjects scored lower on empathy questionnaires than a healthy control group, and while McCown (1989) found that the level of empathy in a group of respondents to an empathy questionnaire was higher for those who did not report having a current addiction, when he conducted a follow-up survey (1990) he found that abstinence from using the same substances did not predict higher empathy scores. A positive relationship between empathy and abstinence was detected in the stories of recovering alcoholics by Dunlop & Tracy (2013), however: those who described themselves as having changed throughout their rehabilitation were more likely to show evidence of empathy while reporting their attitudes about other people, whereas those who described themselves as having remained stable in their stories generally failed to show evidence of empathy towards others in those conversations.

Fathers, Stress and Addiction

Addictions and fatherhood

For men whose developmental needs have not been met as discussed previously, addictions may develop as a coping mechanism in response to a crisis. For example, studies have shown increased rates of alcoholism or drug abuse in men following the loss of a child, divorce, job loss, or after returning from war service (Jorm, 1996; Arenas & Greif, 2000; Ford & Russo, 2006; Maloney, Hutchinson, Burns. & Mattick, 2010). In Western society, becoming a father is for many men, particularly those with a pre-existing addiction, a developmental crisis. A man's reaction to such a crisis may involve a change in mood or avoidant behaviour, including increased substance abuse, during new (Fletcher, 2008) or impending (Everett, Bullock, Longo, Gage & Madsen, 2007) fatherhood.

The majority of men are capable of being very effective fathers (Fletcher, 2011). However, since parenthood requires great external and internal demands, if a man enters this role under-resourced or with a substance dependency, it will be difficult to adequately fulfil the role to the benefit of his children. For example, McMahon, Winkel & Rounsaville (2008) compared fathers with a history of drug abuse with those with no history of substance abuse, and found that the former fathers showed poorer outcomes on several dimensions, including poorer relationships with their children's mothers, less satisfaction and less involvement in parenting, and poorer self-ratings as fathers. Further, while parenthood has been shown in some studies to be a protective factor against parental addictions (e.g. Maloney et al, 2010), certain factors have been shown to increase the likelihood of addictive behaviour: for example, if they are young fathers (Fletcher, 2008), or if they are experiencing psychological distress (Maloney et al, 2010).

Research has consistently shown a greater propensity in men towards addiction, including major Australian studies that found incidence of alcohol and drug addiction in males to be between two and three times the incidence in females (Jorm, 1996; ABS, 2008; Maloney et al, 2010), with up to 10% of men under 35 being diagnosed with a

substance use disorder (Hall, Teesson, Lynskey & Degenhart, 1999; ABS, 2008). In fact, men with anxiety disorders or depression have been found to be more likely to 'self-medicate' through substance abuse than women with the same disorders (Barlow, 2002; Fletcher, 2008).

Addictions, along with overwork and controlling or abusive behaviour, represent some of the strategies that many men have used to avoid the pain of their emotional insecurity. According to Barker (2007), "The rise of individualism is a key factor accounting for increased depression in the Western world, where we measure worth through money, public visibility and winning" (p.110). This point has also been emphasised by Stavropoulos (2007) and de Botton (2004). Barker (2007) also explained that, due to the customs of the corporate world, advertising and our lifestyle choices, addiction, at least to alcohol, can be considered a relatively normal phenomenon, more so for men, especially if they don't feel that they often 'win' (financially, relationally or otherwise) in life, and particularly during crises (Devault et al, 2008).

Addiction recovery for fathers

It usually takes people to reach 'rock bottom' before they take action to deal with their addiction. The process of recovering from addictions generally enables the person to develop a closer connection with himself, and thereby a greater capacity for connection with others (Strobbe & Kurtz, 2012), including an ability to accept and understand their feelings in more depth. To choose the latter course of action may involve painful reflection on their own childhood or other difficult emotional experiences, but it can also enable them to gain insight into the causes of their own behaviour; it will also require emotional strength and insight (Siegel & Hartzell, 2004). In the case of parents, such insight will allow a greater understanding of, and hence relationship with, their children, and therefore a possible reduction in their own stress levels.

Evidence from a longitudinal study has found that an addiction rehabilitation program can be very beneficial for the children of alcoholic fathers. Andreas, O'Farrell & Fals-Stewart (2006) assessed 125 children of alcoholic fathers for psychosocial adjustment

against a control group of an equal number of children before, immediately after, and at follow-up sessions up to 12 months after treatment. The results showed poor levels of adjustment for the children of alcoholic fathers before treatment, but for those fathers who continued the program and did not relapse, their children's adjustment showed consistent improvement beyond completion of the rehabilitation program to levels at least as high as those of the control group. Positive outcomes for school-age children of alcoholic fathers were also found in a study by Kelley & Fals-Stewart (2007), who used an intervention that combined individual counselling with couple therapy for the children's fathers and mothers.

Fathers and Vulnerable Families

Divorce and fathers' separation from their children

Vulnerable families are often associated with fathers who possess few resources. For example, Furstenberg (2011) examined the evidence on differences between fathers with low incomes and those with medium or high incomes, and found several differences between these groups. These studies found that the fathers with lower income: were more likely to become fathers earlier and by accident; had less social support; were less aware of current social expectations of them as fathers; were more likely to have a pre-existing mental disorder and/or an addiction; and were more likely to come from broken homes themselves. Fathers with low incomes were also less likely to stay married than other fathers (Amato and Dorius, 2010).

In relation to men and marriage, Amato and Dorius (2010) also reported that married men had better physical and mental health and lower rates of alcoholism than divorced men. Divorced and other fathers who do not live with their children also "face chronic strains due to…difficulties of maintaining close father-child relationships under conditions of limited access" (Amato & Dorius, 2010, p. 181). Fathers can become particularly vulnerable to mental illness and alcohol abuse following divorce (Amato and Dorius, 2010). If becoming a father can be a stressful time for a man, the process of separation and divorce can be considerably more stressful, especially if it involves

separation from his children (Owen, 2003; Zanoni, Warburton, Bussey & McMaugh, 2014).

Indeed, the marital status of fathers has been a significant predictor of various major outcomes found in the landmark American (U.S.) study, *Fragile Families* (Carlson & McLanahan, 2010). In this study the authors found that unmarried fathers, compared to married fathers, were much more likely to: have a child with another partner (32% of unmarried versus 14% of married fathers); have been incarcerated at some stage in their lives (40% versus 8%); have ever seriously hurt the mother of their children (8% versus 3%); and to have left their child's mother within five years after the child's birth (45% of unmarried versus 23% of married fathers).

Moreover, the number of relationship transitions experienced by unmarried couples over that five-year period was significantly greater (average 2.55 transitions) than the corresponding number for married couples, who experienced on average less than one such transition (0.67) over the same time period. In relation to the father-child relationship, the authors concluded that a majority of "children born outside of marriage will be living apart from their biological father by age 5" (Carlson & McLanahan, 2010, p. 256). This has been shown to be particularly the case for children of fathers with substance abuse problems or those who have perpetrated domestic and family violence (Waller & Swisher, 2006).

The impacts of fathers' addictions and mental health problems on families

The effects of a father's alcoholism or other addictions on his children have been shown to be consistently harmful. As previously indicated, a large proportion of fathers who abuse alcohol suffer from an underlying depression, and in a meta-analysis of the research, Kane & Garber (2004) found consistent evidence that a father's depression predicted emotional and behavioural disturbances in his children. This finding was corroborated by El-Sheikh and Buckhalt (2003) for children of alcoholic fathers and mothers, and by Fals-Stewart, Kelley, Fincham, Golden & Logsdan (2004) for drug-abusing fathers.

Jacob, Kahn & Leonard (1991) found that the adolescent children of alcoholic and depressed fathers in their sample were less “congenial” and less proficient at problem-solving than those of the “non-distressed” fathers (p. 176). Adolescent children of alcoholic fathers have also been found to be more likely to engage in problem drinking themselves (Waller & Swisher, 2006), partly through modelling, and partly to suppress their own pain as a result of their fathers’ emotional abuse or unavailability (Phares, 1996; Grant, 2012). In fact, the relationship between addictive or other unhealthy behaviours and poor-quality relationships is likely to be circular: according to Barker & Galasinski (2003), addictions are a form of self-medication against the depression that is caused by the shame arising from "toxic family relationships" (p89). Notably, fathers’ substance abuse has been shown to often lead to insecure attachment in their infants and older children (Eiden, Edwards & Leonard, 2002; Mikulincer & Shaver, 2008; Peleg-Oren, Rahav & Teichman, 2008).

Not only do these family situations increase the likelihood of a young person developing an addiction, but they also decrease the incidence of empathy in the developing child, according to the views of some experienced clinicians. Robin Grille, an Australian psychotherapist, noted, “individuals who are more prone to [toxic] shame are less capable of empathy, and are more self-preoccupied” (Grille, 2005, p. 200). And when young children miss out on their basic attachment needs, Grille (2005) observed, they frequently remain like children in adulthood, living in dependency, and hoping that their needs will be addressed by others.

Quantitative studies concerning men and fathers have lent support to this kind of analysis. For example, Gallant, Gorey, Gallant, Perry & Ryan (1998) found that alcoholic fathers of adolescent children rated their ability to show empathy significantly lower than did the non-alcoholic fathers; Watkins, O'Farrell, Suvak, Murphy & Taft (2009) found that increased alcohol consumption by fathers was associated with decreased parenting satisfaction; and Collins, Grella & Hser (2003) found that fathers

who were less involved with their children showed higher levels of addiction than those who were more involved.

Mental health problems in fathers can also have lasting adverse effects on their children's emotional development. In a very large longitudinal Australian study, Giallo, Cooklin, Wade, D'Esposito & Nicholson (2014) obtained a sample of over 2000 fathers, and they found that fathers' postnatal depression predicted emotional and behavioural problems in their children up to five years later if the fathers had expressed strong negative emotions (such as anger and frustration) towards their young children over that time. And in research with important social implications, Millon, Grossman, Millon, Meagher & Ramnath (2004) summarised the research that showed that the majority of men diagnosed with antisocial personality disorder in adulthood reported having been raised by alcoholic fathers.

Finally, single-parent families provide a clear case of vulnerability. There is usually less support for these parents and of course less income. And if single parents want to engage in any activities without taking their children with them it is clearly more difficult to rely on another responsible adult to look after them, which is particularly important in the case of young children. Also, the parents often report more difficulty setting boundaries with their children. Some researchers have found that single fathers are particularly at risk in this area, and that they have reported on average less closeness with their children than have single mothers (Nielsen, 2012).

Research into Parenting Styles

Features of effective parenting

Research has shown that effective parenting is most likely to consist of some or all of the following parental attributes: warmth, boundaries, empathy, flexibility, and secure attachment. Baumrind (1989) identified four distinct parenting styles: *authoritarian* (low on warmth, high on 'demandingness'); *authoritative* (high on warmth, high on demandingness); *permissive* (high on warmth, low on demandingness); and *disengaged*

(low on warmth, low on demandingness). Only one of these styles – authoritative parenting – has consistently demonstrated positive developmental outcomes in children, since children are most likely to thrive under conditions of feeling safe (as safety and firm boundaries are achieved through demandingness) and loved (through warmth).

In relation to fatherhood, Guzzo (2011) found that those fathers who were neither raised by their own biological fathers nor experienced involved father figures were less likely to see themselves as authority figures and hence had less confidence in disciplining their own children. Amato & Gilbreth (1999) conducted a meta-analysis of non-resident fathers and found that, compared to other parenting styles, a father's authoritative parenting was associated with fewer psychological problems in his children. Paternal warmth and limit-setting has been shown to be highly beneficial for both sons (Dick, 2011) and daughters (Nielsen, 2012).

Other studies have demonstrated the value of parents' ability to be flexible in the methods that they use to guide their children's development through relationship-focused approaches. For example, a gentle, encouraging style has been shown to be most effective with shy and sensitive children, while a more assertive and firm, yet patient and warm approach, has proved most beneficial for raising more volatile children (Smart, 2007).

Behavioural and emotion-focused parenting programs

The best-researched parenting programs have traditionally been those that employ behavioural approaches, which emphasise limit-setting and boundaries; these types of parenting programs are often the most popular as they tend to be more easily adopted by parents. Techniques in such programs have commonly included reinforcement of desirable behaviours and ignoring of problematic behaviours. These approaches have included *Toddler Taming* (Green, 1984) and an international program developed in Australia, known as the *Triple P Positive Parenting Program* (Sanders, 1999). The Triple P program aims to provide for potentially exasperated parents accessible multi-level strategies that work across a variety of ages and cultures.

A parenting approach that has been specifically targeted at the children's needs is emotion coaching. John Gottman was a pioneer of this approach, which aimed to teach parents to respond empathically instead of punitively or dismissively to strong emotions exhibited by their children (Gottman, Katz & Hooven, 1997). The benefits of parental empathy have been demonstrated through positive developmental outcomes in children (Siegel & Hartzell, 2004; Grille, 2005; Trumpeter et al, 2008). Such outcomes include improved mental and physical health, a greater capacity for intimacy, and better problem-solving skills (Gottman & de Claire, 1998). Gottman et al (1997) found that parents' ability to emotion-coach their children predicted better relationships both with their children and with each other. This led to the development of an attachment-focused Australian parenting program known as *Tuning in to Kids* (TIK). Research into the results of this program has shown that such training for parents can be helpful for young children who have difficulty controlling their emotions (Havighurst et al, 2004; Havighurst, Wilson, Harley & Prior, 2009). More recent studies by Havighurst and her colleagues have found improvements in parenting emotion-coaching skills and improved behaviour in pre-school (Havighurst et al, 2013) and primary school-age children (Havighurst et al, 2015). This approach has been shown to be more prevalent among mothers (Gottman. 1998), but other studies have supported the value of fathers' emotion coaching of their children (e.g. Baker, Fenning & Crnic, 2010).

Empathy: help or harm to the parents?

One recent study has questioned the benefit of parental empathy for the parents themselves. Manczak, De Longis & Chen (2016) found that, although the parents in their study (24% fathers) who were higher in empathy were more likely to report healthy self-esteem and more purpose in their lives, they also showed evidence of more internal physical inflammation in their bodies, indicating that there was a physiological cost to the empathy that they were providing to their children. The authors inferred that there may be long-term medical risks for parents in continually providing empathy to their children.

It is not clear, however, what such empathy meant in practice. Did the parents often empathise with their children's behaviour (as distinct from their feelings, as recommended in the parenting program in the present study), and to what extent did they become over-involved in their adolescent children's struggles and conflicts? In addition, while the authors of that study controlled for variables such as quality of the parent-child relationship, time spent together, and parental stress and depression, certain other potentially relevant variables were not controlled for, including gender and socio-economic measures, as well as parental emotion regulation and attachment patterns. It may have been, for example, that parents with insecure attachment histories and poor emotion regulation may have been less inclined to provide boundaries for their children with their empathy, which may have had implications for those parents' levels of stress and ongoing health.

Attachment-related disturbances in parenting

In addition to these factors, parents' attachment styles during their own childhood have been shown to be highly influential on their parenting method and therefore the effects on their children's development (Siegel & Hartzell, 2004). Bowlby's (1969) attachment theory proposed that, barring unusually significant circumstances in the interim, an adult's pattern of secure or insecure attachment to his or her partner and/or children would mirror their attachment experiences (mostly to their mother) as an infant. Therefore, if a parent had suffered trauma or abuse as a child, their ability to successfully attach to a 'love object' (Winnicott, 1986) would be so severely impaired that they would generally be unable to form a meaningful attachment to their child without intensive psychotherapy to allow them to begin to resolve these attachment issues (Walker, 2007).

Parents who may have suffered from an insecurely attached childhood are thus less likely to be able to form meaningful attachments to their partner as well as their children (van Ijzendoorn, 1995), and are also at greater risk of having substance addictions (Flores, 2001; Golder, Gillmore, Spieker & Morrison, 2005; Mikulincer & Shaver, 2008; Thorberg & Lyvers, 2010). Such parents are less capable of soothing their child's

distress and hence helping their child to develop the very important skill of emotion regulation (Thompson, 2008). Research has shown that both parents have a significant role to play in helping their children to handle strong emotions (Fletcher, 2008).

Siegel & Hartzell (2004) explained that, when a child's behaviour elicits a strong emotional response from a parent, that parent has a choice between reactive behaviour towards the child and seeking to identify the source of the trigger that has led to such an emotional response. Significantly (in relation to the aims of the present study), Gratz & Roemer (2004), Ford & Russo (2006), and Tronnier (2015) each noted the importance of training in emotion regulation skills in the treatment for substance abuse.

Developments in Australian and International Programs for Men and Fathers

Overview

Based on the review so far, three issues have been shown to impact the wellbeing of fatherhood. Firstly, attachment security and psychological development of young men are important in laying the foundation for later fatherhood. Secondly, addiction greatly affects human relationships in general, and compromises a father's parenting ability in particular, and so recovery programs are vital in giving these men a chance to become healthy fathers who can properly care for their families. Thirdly, fathering groups are needed as the missing link that gives voice to fathers when they encounter stress and difficulties in their parenting. What programs and services are available for each of these groups, particularly in Australia?

Programs for Boys and Young Men

While men's groups focus on support and, for addictions, treatment, programs for youth focus mostly on prevention. Generally, two separate issues need to be addressed in helping boys safely and healthily mature into men. The first is the treatment of marginalised groups (regardless of gender). Programs and services provided by state and federal governments in Australia are increasingly targeting these issues. In each of the

following groups the rates of self-harm and suicide have been shown to be greater than that of the general population of young people (aged 15-24) in Australia. These include youths with diverse sexuality and gendered identities, Aboriginal youth, young asylum seekers and refugees, incarcerated youth, and young people with substance abuse issues, psychosis or other mental disorders (ABS, 2015; www.beyondblue.org.au).

The second issue involves the normative development of children and young people in our society; this is within the broader context of providing support for children's mental health and development of empathy (Eisenberg & Strayer, 1990). Recent Australian initiatives include anti-bullying programs (www.bullyingnoway.gov.au; http://www.safeschoolscoalition.org.au), which contribute to empathy development in school-age children, as well as internet safety programs (www.esafety.gov.au). There are also non-government programs that seek to address some of the issues discussed in this research, such as problems with male identity in Australian boys and young men, and preparation for adulthood and parenting.

Two of the programs that aim to help youth navigate the difficult journey from childhood to adulthood include the Youth Mentoring Program (www.aymn.org.au), which offers individual support for young people, and the Pathways Foundation (www.pathwaysfoundation.com.au), which is an outdoor group-based program that includes fathers with their sons or mothers with their daughters. These programs are not part of the curriculum for most schools, and as discussed, commentators on young men's development have observed that there is much more as a society that can be done to facilitate the healthy psycho-social growth of Australian boys and young men (Biddulph, 2010).

Addiction Rehabilitation Programs

Residential programs that provide detoxification and rehabilitation for men and women with substance abuse and behavioural addictions have been running since the formation of the original twelve-step model (Anonymous, 1939). Such programs are usually run by organisations such as the faith-based Salvation Army or the non-denominational

Odyssey House on an abstinence model, in contrast to the harm minimisation model adopted by other organisations, such as Uniting Care (www.regen.org.au). Detoxification services are attached to public hospitals or the organisations that provide rehabilitation. While addiction recovery programs are often run for men and women together, many of the small group sessions cater separately for the two genders, recognising many issues that are specific to men and women in recovery from addictions.

For clients with less severe addictions and sufficient means, outpatient services attached to private hospitals or clinics have also been popular for some time. Both inpatient and outpatient treatment programs may employ various models of group therapy (Yalom & Leszcz, 2005) and/or psycho-education, but generally also involve exploration of and help with emotion regulation skills (Mennin, 2006). An example of an inpatient program with a specific intervention for emotion regulation is Odyssey House in Melbourne, which employs the Motivating Affect Self-Control (MASC) program developed in Australia and designed for adults in recovery from addictions (Armstrong, 2008). That program consists of psycho-education, including explanation of how people's moods affect their capacity for self-control, as well as training in emotion management skills. Other programs include anger management, dealing with cravings, assertiveness and employment skills, as well as personal therapy related to family-of-origin issues: for example, South Pacific Private Hospital in Sydney (http://www.southpacificprivate.com.au/day-and-evening-programs). However, parenting groups are not usually part of the daily schedule of residential or outpatient addiction recovery programs.

There has also been a recent trend in USA towards a more medical model of addiction treatment, in which the residential period is reduced from at least six months to just one month (Roy & Miller, 2012). This would of course have major implications for funding and program content if that model were to be adopted in Australia.

Parenting Programs: General parenting skills and father-specific programs

While parenting programs have become more popular in many countries in the 21st century, there remains in Australia and other Western countries the belief that parenting is done mostly by mothers. Therefore, to date, parenting services and programs have largely attracted – and to an extent been tailored for – mothers (Zanoni, Warburton, Bussey & McMaugh, 2013); the inclusion of father-specific programs is much more recent (Panter-Brick et al, 2014).

There are now an increasing number of men's and fathers' programs promoted by community groups in Australia (and other Western countries), including The Australian Fatherhood Research Network (www.aracy.org.au), the Australian Men's Shed Association (www.mensshed.org), and Dads in Distress (www.dadsindistress.asn.au). Two examples of recently piloted Australian fathering programs include *Dads on Board*, targeting fathers who have perpetrated family violence, and *Healthy Dads, Healthy Kids*, targeting overweight and obese fathers (Fletcher, May, St George, Stoker & Oshan, 2014). There still remains to some extent a stigma attached to men's seeking counselling and other types of support outside their family (Oren & Oren, 2010), and some men's groups have been criticised for reinforcing negative attitudes towards women (Flood, 2012). However, many men have described in their testimonials the invaluable benefits of such support, sometimes in dramatic terms (www.mensline.org.au).

There is some debate surrounding the value of therapeutic versus support groups, the former assuming that the clients have 'deficits', with the latter adopting a strengths-based stance, which men frequently find less judgemental and less threatening (King, 2005). This latter rationale is behind a program that aims to leverage potentially violent fathers' relationships with their children as a means of preventing them from engaging in family violence (Bernard van Leer Foundation, 2014).

For parents with mental health issues, Newman (2011) has developed a parenting program specifically targeted at parents with attachment disturbances and other mental health conditions including borderline personality disorder. This program, known as

Parenting with Feeling, helps parents of infants to mirror their children's feelings more successfully, a skill required to help these parents make more benign attributions about their children's intentions and behaviour.

Research on parenting programs for parents with addictions is scant, but in a promising and significant finding for the present study, Plasse (1995) reported that parenting groups for parents with a substance addiction had success in helping the participants recover from their addiction as well as becoming more confident as parents. Later, Suchman, Mayes, Conti, Slade & Rounsaville (2004) reported that substance-abusing mothers who completed an attachment-based parenting program were found to be "more compliant in following clinical advice" (p. 184) than those in the non-parenting group. A family-based program, *Parents Under Pressure*, that showed evidence of improvements in parent-child relationships and reduction of substance use in all families that completed the program (Dawe, Harnett, Rendalls, & Staiger, 2003). More recently, two parenting programs designed specifically for substance-abusing fathers have been developed that include psychological interventions targeting both the substance abuse and the men's relationships with their children (McMahon, 2013a; Torres, Sng & Deane, 2015).

The *Tuning in to Kids* parenting programs (Havighurst et al, 2009) have been designed on the principles of emotion coaching (Gottman et al, 1997), with the goal of assisting parents to connect better with their children by responding empathically and helping them to solve problems that they have found frustrating or upsetting. While there has been some evidence that providing empathy can create more stress for parents of adolescents (Manczak et al, 2016), research by Havighurst et al (2004) has been consistent with studies reported by Siegel & Hartzell (2004) in finding benefits for the parents (as well as for their children) in being able to form an empathic connection with their children.

Implications for the Present Study

Summary of Previous Findings

The evidence in the literature has pointed to positive outcomes for fathers and their children associated with the following qualities (among others) in the fathers who are:

- either securely attached to their children, or have the emotional strength to work through their insecurities and past hurts to be able to form such an attachment to them;
- mentally healthy, including having no addiction or being in the late stages of recovery from their addiction;
- involved with and committed to their relationship with their children (and ideally to a wider social circle);
- in a loving, stable relationship with another adult who also supports the child's wellbeing;
- able to respond empathically to their children;
- able to regulate their own emotions and thus have the capacity to help their children regulate their emotions.

Importance of the Present Study

Newman, Ridenour, Newman & DeMarco (2003) emphasised the importance of providing a research purpose to lay the groundwork for the research questions and methodology. There are several purposes of this study that underline its important social implications. The purposes of this research are to:

(i) Analyse the psychological (including behavioural) factors that may influence a father's empathic connection to his children.

(ii) Determine whether there is a relationship between a father's empathic connection with his children and the presence of an addiction.

(iii) Understand better the perspectives of fathers, including the plights that many of these men face as parents, particularly those with addictions.

(iv) Explore the social context of the fathers in this study; add to the theory base in this area; and increase public awareness of the importance and value of helping these fathers with their parenting.

(v) Help make life better for fathers, particularly this population of fathers, and their families, if possible.

(vi) Examine the notion that if a father can (re-)connect with his child, he can find more of a sense of purpose himself and perhaps even a reduction in his own anxiety and addictive behaviour if there is any.

Research Questions

Thus, the research questions for the present study are as follows:

1. [From (i) & (ii) above]: What factors relate to fathers' attachment to their children, and are these factors different for fathers recovering from addictions compared to those who report no addiction?
2. [From (iii) & (iv)]: How do fathers in recovery from addictions experience fatherhood?
3. [From (v) & (vi)]: How might training in empathic parenting provide these men with an opportunity to reassess their capacities as fathers as well as encouraging the development of empathy and an enhanced sense of wellbeing?

Preview of the Coming Chapters

In this first chapter, we have had a brief look at what fathers do and how they develop – and where things can go wrong, especially when addictions enter their lives, and consequently their families' lives as well. Of particular interest has been how addictions affect fathers in four key areas: attachment to their children, their general health, and their capacity for both emotion regulation and empathy.

In *Chapter 2* we examine the methodology used in this study, which employs a two-phase approach: the first one enabling comparisons between fathers with and without addictions, while the second employs a multiple case study to illuminate the lives of seven fathers in recovery from addictions, and how each one responds to a parenting program. *Chapter 3* provides the results of the first phase of the study, including a path model, which aims to unearth how the fathers' mental health, emotion regulation and empathy may be influencing their attachment to their children.

In *Chapter 4* the major characters are introduced; we learn about their background – their crises and their losses, their addictions – but also their hopes for a better life through their recovery. In *Chapter 5* we learn how these men respond to each session of

the parenting program, again focusing on their empathy and emotional skills as well as their relationships with their children.

We then hear how it turns out for each father in *Chapter 6*, following these fathers through to their final interviews – how they describe themselves through their words and the questionnaire responses. Finally, in Chapter *7*, the pieces are put together, and we ask the 'so what?' questions and why this research matters.

CHAPTER 2. METHODOLOGY

Methodological Foundation

Research in the behavioural sciences has traditionally adhered to a positivist paradigm, and hence largely restricted itself to quantitative methodologies (Lopez-Fernandez & Molina-Azorin, 2011). Qualitative research, on the other hand, which is underpinned by a naturalistic and interpretive framework, exploring participants' individual perspectives and employing much smaller sample sizes, has frequently been discouraged, with many quantitative researchers arguing that such research lacks objectivity and validity (Applebaum, 2012). Little wonder, then, that research that has employed a combination of these methodologies has often been strongly critiqued based on the apparent incompatibility of the two philosophies (Bazeley, 2004; Toomela, 2011). However, despite the theoretical differences, a number of researchers have found that qualitative and quantitative analytic methods can function effectively together; this is known as mixed methods research. The two methods have increasingly been used in social research since the late 1980s, both side-by-side and in succession in the same studies, respectively termed complementarity and development (Barnes, 2012). The use of these two principles in the design of the present study will be discussed below.

Mixed Methods Approach

The research design of the present study was multiphasic, with a quantitative first phase followed by a mixed-method second phase. The data obtained in the second phase were principally qualitative, with an embedded quantitative component (Creswell, 2014). For the first phase of the study, a sample of fathers (with and without addictions) large enough to conduct quantitative analyses was chosen so that (i) comparisons could be made between the two groups on the variables of interest; (ii) the questionnaire scales could be validated on the larger group and then used in the second phase to assess possible changes in each participant on these variables; and (iii) an item analysis could be conducted to determine which questions most clearly distinguished between the two groups, so that this information could be used as part of the content of the parenting program in the second phase of the study. The second and third points provided the means by which the principle of development was employed in this study.

The predominant part of the analysis in the second phase was qualitative, in order to permit the researcher (and the reader) to appreciate the men's own perspectives of their experiences of fatherhood. This was supplemented by quantitative data obtained from the men's questionnaire responses across three particular time points throughout the program. Further, the men's narratives were coded according to the same variables that were measured quantitatively, so that these two forms of data could be synthesised to provide strengthened evidence for (or against) individual change throughout the parenting program. Complementarity was thus achieved by the analysis of the combination of the two types of data. In this way, some of the shortcomings of each approach were offset by the use of the other method (Bartholomew & Brown, 2012; Lutz & Knox, 2014). This research methodology could further be described as integrative mixed methods (Bazeley, 2011), in which qualitative and quantitative analyses are integrated to help provide a fuller interpretation of the results.

The integrative approach involves more than conducting separate quantitative and qualitative analyses; rather, the relationship between the two sets of results is examined and interpreted to deepen and strengthen the overall analysis (Castro, Kellison, Boyd & Kopak, 2010). In the present study this approach involved the quantitative comparison between fathers with and without addictions on the variables of interest, followed by a mixed second phase in which a closer investigation of seven participants was conducted, involving the comparison of their individual quantitative profiles with those of the larger group from the first phase, enriched by the analysis of the qualitative data of each of these participants. Further, the quantitative change measures of these participants were examined side-by-side with their changing descriptions of themselves to provide the fuller integration of the two types of results.

Research Design

This study employed a sequential mixed methods design, with a quantitative first phase followed by a qualitative second phase with an embedded quantitative component (Hanson, Creswell, Plano Clark, Petska & Creswell, 2005), Figures 2.1-2.3 show successive representations of the design and analytic method of this study. Figure 2.1 shows the overall design of the present study. Phase 1 of the study was entirely quantitative, aiming to gather baseline data from Australian fathers concerning their attachment to their children and other relevant information. Phase 2 was conducted after a detailed analysis was carried out on the Phase 1 data to determine some of the areas on which to focus the parenting program during that phase of the study.

Figures 2.2 and 2.3 indicate the levels of specificity with which the second phase of the study was analysed. Figure 2.2 depicts the phase 2 design as a multiple case study (Yin, 2009), as it provided a detailed comparison of the stories of the men who participated in the second phase of the study. This phase could further be described as a concurrent nested design (Hanson et al, 2005), in which the major component was qualitative (shown in capital letters) and the supporting component quantitative (shown in lower case). Finally, figure 2.3 shows the two types of analysis of the data from phase 2. Firstly, the quantitative component included analysis of the men's questionnaire scores over the duration of the study, for those who completed the parenting sessions and interviews. The participants' results were then compared with the mean scores obtained for all questionnaires. As explained above, the qualitative component of this phase was analysed using a narrative method in order to amplify the men's stories of fatherhood, relationships and ongoing recovery from addiction.

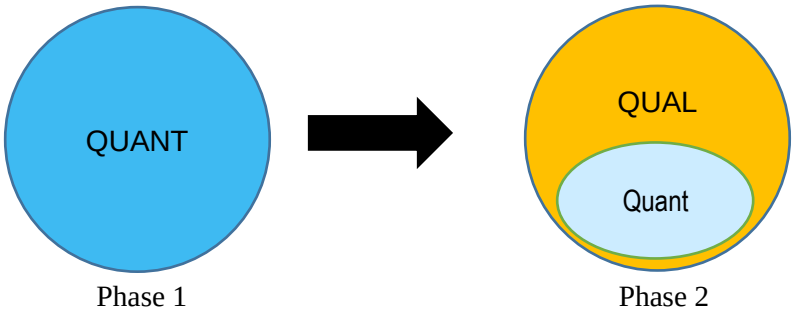

Figure 2.1: Overall Study: Mixed Methods Design

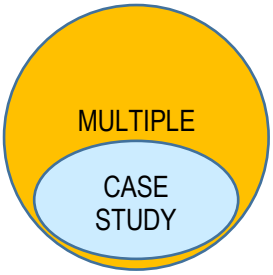

Figure 2.2: Phase 2 design – Multiple Case Study (qualitative with nested quantitative component)

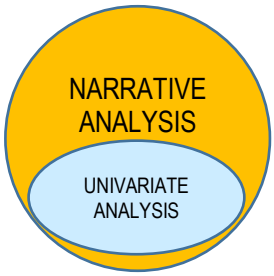

Figure 2.3: Phase 2 data analysis methods

Validity and Reliability

These constructs are most commonly discussed in the context of quantitative research, and are indeed examined for each of the questionnaires used in this study. However, they are defined slightly differently in qualitative research. For example, whereas reliability in quantitative research refers to consistency of measurement and repeatability of the findings, qualitative reliability refers to the transparency of each of the researcher's methodological decisions (Noble & Smith, 2015). Similarly, while validity

in quantitative research refers to the capacity of an instrument to measure what it claims to be measuring, in qualitative research validity is concerned with the accuracy of the findings with respect to the actual data. Thus, the perspectives of the participants should be faithfully portrayed in the reporting of the results, with any relevant personal experiences or perspectives of the researcher clearly articulated (Noble & Smith, 2015).

Qualitative reliability and validity also involve researcher reflexivity, which Guba & Lincoln (2005) defined as the (self-) critical subjectivity of the researcher with respect to their choice of research topic, their relationships with their participants, and the personal history that they bring to their research. In the case of the present study, as has previously been discussed, this researcher brought a personal history as, among other identities, the son of a gambling addict, to the research. By both reflecting individually on this and discussing its possible effect on the research with appropriately trained others, the researcher was able to maintain an awareness of this potential bias and focus instead on the individual experiences of the participants, regardless of whether their responses were consistent with his assumptions and expectations. Indeed, the researcher's reflexivity mirrored the therapeutic skill and requirement of modelling empathy for the participants during the interviews and parenting program.

Program phases and Participants

Phase 1

Research Design

Phase 1 of this research was designed to respond to the first Research Question (RQ 1): *What factors relate to fathers' attachment to their children, and are these factors different for fathers recovering from addictions compared to those who report no addiction*? The aim of this question was to test the assumption that men with addictions in particular might have difficulties with emotion regulation and empathy, in addition to other mental health issues, and hence a reduced capacity for attachment. In order to do this, questionnaires were given to a sample of fathers in drug and alcohol rehabilitation centres, and these results were compared with those of other fathers reporting no addiction. Within RQ 1, the following hypotheses were tested:

a) The fathers' self-reported attachment to their children, empathy levels, general mental health, and their ability to constructively handle their emotions, will each be better or 'healthier' for fathers reporting no addictions than those in rehabilitation centres or otherwise reporting an addiction;

b) The psychological predictors (as mentioned in (a) above) of these men's attachment to their children will be different for those fathers with and without addictions;

c) Notwithstanding the results of (b) above, a path analysis can be generated to determine the relationship between these psychological variables for the combined sample of fathers, that is, those with and without addictions.

Participants

Altogether, 217 respondents commenced the questionnaires either face-to-face or online. Of these, 169 responded to the questionnaires throughout the study. This included 95 respondents who completed the paper version in a single sitting in rehabilitation centres or outpatient clinics, and 74 who responded online. The questionnaires were counted as 'complete' if the respondents completed the demographic questions and at least started the questions assessing their attachment to their children (this was the first of the four questionnaires within the entire survey). By this definition, 95 out of 97 men completed the paper surveys (97.9%), while the completion rate for the online respondents was much lower at 61.7% (74 out of 120 respondents), making an overall response rate of 77.9%. Applying the stricter criterion of completing all four questionnaires, however, reduced the completion rates to 86/97 for the paper surveys (88.7%) and just 48/120 (40%) for the online surveys, making a total of 134 out of 217 for the first phase of the study, or approximately 61.8%.

Of the overall sample of 169 fathers, the 95 respondents who completed the questionnaires in person came from rehabilitation or outpatient centres where they undertook the survey in small groups, gathered in rooms with other fathers with either the researcher or a clinical staff member overseeing the process. The remaining 74 responses were obtained from anonymous online respondents who were invited to

participate if they were fathers. The respondents who completed the hard-copy questionnaires were all recruited from inpatient or outpatient centres and therefore were automatically classified as being in recovery from addictions, while the online respondents did not have to have an addiction in order to be eligible to respond to the surveys. Therefore, those respondents were specifically asked if they had been struggling with substance or behavioural addictions in order to determine the group into which they would be classified.

Surveys were initially administered in person by the researcher or clinic staff in the rehabilitation centres. Of the 97 surveys administered in these centres, there were 72 in Sydney, 14 in Melbourne and 11 in Brisbane. Of all the paper versions, 69 were administered in rehabilitation centres and 28 in outpatient clinics. The online survey responses all displayed IP addresses from within Australia.

The age groups of the respondents in the study ranged from the youngest at 18-24, up to 65 and over. The median age group was 35-44. The children of the questionnaire respondents ranged from birth to 46 years, with 80% of the children aged 13 or under. The number of children per father in the study ranged from 1 to 8, with a median number of 2 children per respondent. Of the entire group of fathers, 43% were married, 21% described themselves as single, 13% were divorced, just over 12% separated, 8% cohabiting, and 2% widowed.

The education level of the group was fairly evenly spread, with 29% of the sample (49 respondents) indicating that they had completed the School Certificate or some schooling, a further 11% reporting completion of the HSC (NSW Higher School Certificate) or Year 12 leaving certificate, 22% a Trade or Diploma, 19% a Bachelor degree or Graduate Diploma at a university, 17% a Master's degree or PhD, and the remaining 2% other qualifications. Just over half of the respondents described themselves as professionals, with 18% describing themselves as a Professional manager, and 34% describing themselves as 'Professional (other)'. Labourers accounted for 18% of the sample, while junior managers comprised around 4%. A relatively large number

of the fathers identified as unemployed (20%) due to the number of participants recruited from rehabilitation centres. Just under 2% described themselves as retired, with 4% stating that they had 'Other' employment.

Quantitative Measures

For the quantitative component of the research, the full survey, which consisted of 158 questionnaire items in addition to the initial demographic questions, was administered to all participants. The survey contained four separate questionnaires. This instrument was used in both phases of the program. Based on the research questions, the main constructs of interest were empathic connection (with their children) and psychological wellbeing. Empathic connection was assessed via questionnaires on empathy and attachment, while wellbeing was assessed via questionnaires on emotion regulation and general health (which was in fact mainly mental health). The full questionnaire can be found in Appendix B.

Empathy Quotient

Empathy was measured using the *Empathy Quotient* (EQ: Baron-Cohen & Wheelwright, 2004). This questionnaire has been widely used to test people's capacity to give empathy and has been shown to discriminate between empathy levels of males and females. In addition, the EQ has shown evidence of being able to discriminate between respondents with and without developmental delays (Baron-Cohen & Wheelwright, 2004) or mental health problems (Lawrence, Shaw, Baker, Baron-Cohen & David, 2004), as well as between those with and without addictions (Martinotti et al, 2009).

The Empathy Quotient (EQ) consists of 60 questions, with 20 of the questions not assessing empathy. These questions were included in order to keep the respondents from guessing that they were being assessed on their level of empathy and thus responding accordingly (Lawrence et al, 2004). Responses to all items on the EQ are based on a four-point Likert scale (Strongly agree, Slightly agree, Slightly disagree, Strongly disagree). Consistent with the recommendations of the authors of that scale, the scores were coded 0, 1 or 2 for each item, in which both of the 'disagree' or both of the 'agree'

options scored zero, with the latter case representing reverse-scoring. Thus the final score for the EQ was between 0 and 80, where higher scores indicated greater empathy.

Through their factor analysis of the 40 target items on the EQ, Lawrence et al (2004) found three distinct factors, which they named *Cognitive Empathy*, *Emotional Reactivity* and *Social Skills*, although not all questions loaded onto any of these three factors. The second subscale could equally well have been named *Affective Empathy* or *Emotional Responsiveness*, as higher scores on this subscale (as part of the whole questionnaire) also indicated greater empathy, rather than over-reactivity. The authors obtained a high result for internal consistency as measured by Cronbach's alpha for the full 40-item instrument, with a value of $\alpha = 0.92$ (Baron-Cohen & Wheelwright, 2004). A summary of the scales on the EQ is shown in Table 2.1.

Table 2.1: Scales and sample items on the EQ

Scale	Description	Sample Item
Cognitive Empathy	Capacity to take another's perspective and/or perceive what s/he might be feeling	Other people tell me I am good at understanding how they are feeling and what they are thinking
Emotional Reactivity	Tendency to react or respond emotionally to someone else's pain	I get upset if I see people suffering on news programmes
Social Skills	Capacity to gauge the effect of one's own behaviour on others	I often find it difficult to judge if something is rude or polite

Fathers' Attachment to Children Questionnaire

There is no commonly used self-report measure of fathers' attachment to children aged 2-12 years. Therefore, in order to develop this instrument, a number of adult/parental attachment instruments were considered. From this preliminary analysis it was found that the five most common component scales in these instruments were: *Anxiety/competence* (Condon & Corkindale, 1998; Sibley, Fischer & Liu, 2005); *Avoidance/trust* (Johnson, Ketring & Abshire, 2003; Sibley et al. 2005); *Pleasure in Relationship/Detachment* (Condon & Corkindale, 1998; Brown et al, 2007; Sibley et al

2005); *Feeling of burden/patience* (Furman & Buhrmester, 2001; Brown et al, 2007); and *Communication* (Johnson et al, 2003; Brown et al, 2007).

The most relevant self-report measures of attachment for fathers were the *Revised Parent Attachment Inventory* (r-IPA: Johnson et al, 2003) and the *Paternal Post-natal Attachment Scale* (PPAS: Condon, Corkindale & Boyce, 2008), although neither of these specifically measured fathers' attachment to pre-school or primary school-age children. The r-IPA was first adapted from the Inventory of Parent and Peer Attachment (IPPA: Armsden & Greenberg, 1983), an adolescent self-report questionnaire, which was subsequently developed to measure parents' attachment to their adolescent children, but has been used with parents of children as young as nine (Johnson et al, 2003), while the PPAS was adapted from a parent-to-infant attachment questionnaire previously developed by Condon & Corkindale (1998) and then standardised on a sample of fathers (Condon, Corkindale & Boyce, 2008).

Two scales comprise the r-IPA: *Trust/avoidance* and *Communication* (Johnson et al, 2003). The *Communication* scale was considered to be less relevant to relationships between fathers and younger children, since it includes a number of items concerning parents' tendency to confide in their children, so it was dropped for the present study, leaving the items from the *Trust/avoidance* scale. Johnson et al (2003) found the internal consistency for the *Trust/avoidance* scale to be $\alpha = 0.91$. Those questions in their study that were found to have an item-total scale correlation of at least 0.50 were then maintained for the current instrument, leaving 14 items.

The remaining 20 items of the attachment questionnaire in the present study comprised a revision of 15 items from the original version of the PPAS, which was subsequently updated (Condon, 2015); three from the revised *Experiences in Close Relationships questionnaire* (ECR-R: Sibley et al, 2005); and two from the *Parent-Child Relationship Questionnaire* (PCRQ: Furman & Buhrmester, 2001). Internal consistency measures for the relatively short PPAS scales were $\alpha = 0.75$ for the 'Tolerance' (or *Burden/patience*) scale, and $\alpha = 0.71$ for the 'Pleasure' (*Pleasure in relationship/detachment*) scale.

Unlike the questions from the r-IPA, which were adopted word-for-word, these items were re-written in order to be suitable for fathers of pre-school and primary school-age children, which were the target age group of the children of fathers in the present study. This age group was chosen to be consistent with the age group of children of parents in previous *Tuning in to Kids* programs (Havighurst et al, 2004, 2009).

The resulting 34 items were then combined to form the Fathers' Attachment to (pre-school and primary school-age) Children Questionnaire (FACQ). Thus, questions 1-14 were taken from the r-IPA, while questions 15-34 were adapted from other scales. Questions 15-28 of the FACQ were adapted from items of the PPAS: questions 15-22 from the *Burden(/patience)* scale, and questions 23-28 from the *Pleasure in relationship(/detachment)* scale. Finally, questions 29-34 were assembled to notionally form an *Anxiety(/competence)* scale. Question 29 was adapted from an item on the PPAS, questions 30 and 31 from the PCRQ, and questions 32-34 from the ECR-R. Responses to all items are based on a five-point Likert scale (Strongly agree, Agree, Not sure, Disagree, Strongly disagree). Scores range from 1-5 on each item, making the final score for the FACQ between 34 and 170, where higher scores indicate greater attachment to one's child. A summary of the scales on the FACQ is shown in Table 2.2, and a list of items 15-34, which were derived from previous instruments, is shown in Appendix C.

Table 2.2: Scales and sample items on the Fathers' Attachment to Children Questionnaire (FACQ)

Scale	Description	Sample Item
Trust-Avoidance	The extent to which the father trusts or wants to avoid his child	I trust my child
Burden-Patience	The extent to which the father is able to feel patient with his child or feels that his child is more of a burden to him	I often feel resentful that I don't have enough time for myself
Pleasure-Detachment	The extent to which the father derives pleasure from his relationship with his child or experiences himself as detached when with his child	I feel a great deal of affection for my child
Anxiety-Competence	The extent to which the father is confident or is anxious about his parenting and relationship with his child	My child only pays attention to me when I'm angry.

Difficulties in Emotion Regulation Scale

The Difficulties in Emotion Regulation Scale (DERS: Gratz & Roemer, 2004) was included in order to assess the men's capacity to respond productively to their own emotions since, as previously explained, this capacity has been shown to be central to the experience of empathy, attachment, and recovery from addictions. The Difficulties in Emotion Regulation Scale (DERS) contains 36 items. Gratz & Roemer (2004) found that these items loaded onto six scales: *Lack of emotional awareness, Difficulty engaging in goal-directed behaviour when distressed, Lack of emotional Clarity, Difficulty resisting impulsive behaviour when distressed, Emotional non-acceptance,* and *Limited access to emotion regulation strategies perceived as effective*.

Responses to all items are based on a five-point Likert scale (Almost never, Sometimes, About half the time, Most of the time, Almost always). Scores range from 1-5 on each item, making the final score for the DERS between 36 and 180, where higher scores indicate greater difficulties with emotion regulation. The DERS has been shown to have strong internal consistency for the entire instrument, with the authors reporting the original value of Cronbach's alpha for the DERS as $\alpha = 0.93$ (Gratz & Roemer, 2004). A summary of the scales on the DERS is shown in Table 2.3.

Table 2.3: Scales and sample items on the DERS

Scale	Description	Sample Item
Lack of emotional clarity	Capacity to be clear about one's feelings	I am confused about how I feel
Lack of emotional awareness	Capacity to monitor one's feelings	I am attentive to my feelings
Impulse control difficulties	Tendency to lose control over feelings, thoughts or behaviour when emotional	When I'm upset, I become out of control
Non-acceptance of emotional reactions	Tendency to adopt a negative attitude to one's own emotional expression	When I'm upset, I become embarrassed for feeling that way
Difficulties with goal-directed behaviour	Capacity to behave in desired manner regardless of emotional state	When I'm upset, I have difficulty getting work done.
Limited access to emotional strategies	Capacity to find a means to help oneself recover from negative emotional experiences	When I'm upset, I know that I can find a way to eventually feel better.

General Health Questionnaire

The instrument used to measure general health symptoms, and mental health in particular, was the 28-item version of the *General Health Questionnaire* (GHQ:

Goldberg, 1978). It includes subscales on *Somatic Complaints, Anxiety & Insomnia, Social Dysfunction,* and *Severe Depression* (Goldberg, 1978). Responses to all items are based on a four-point Likert scale, with response choices varying according to the question. Scores for the GHQ-28 range from 1-4 on each item, making the final score between 28 and 112, where higher scores indicate greater recent difficulties with general and mental health symptoms.

Numerous studies have reported on the internal consistency of this instrument, with values for Cronbach's alpha for the GHQ-28 ranging from α = .90 (Goldberg & Williams, 1988) to α = .95 (Failde & Ramos, 2000). The GHQ and the DERS were also chosen for the present study because they were used with parents involved in the TIK program in the previous studies by Havighurst et al (2004, 2009). A summary of the scales on the GHQ-28 is shown in Table 2.4.

Table 2.4: Scales and sample items on the GHQ

Scale	Description	Sample Item
Somatisation	Recent experience of bodily symptoms in response to stress	* been getting a feeling of tightness or pressure in your head?
Anxiety/Insomnia	Recent experience of anxiety and/or difficulty sleeping	* lost much sleep over worry?
Social Dysfunction	Recent experience of difficulty with daily functioning	* felt that you are playing a useful part in things?
Severe Depression	Recent experience of depressed mood and/or suicidal thoughts	* felt that life is entirely hopeless?

*Note: All items commence with the question *Have you recently (in the last four weeks or so)* –

Demographic Questions

Six items assessed basic demographic information (see Appendix B). These questions included the respondent's age group, how many children he had, the ages of his children, his marital status, his education level, and his occupation. Another question asked the respondent to nominate the age of the child about whom he had chosen to respond in the attachment questionnaire. The only other instruction given in this question was that the child should be in the target age group (2-12 years) or as close to that age group as

possible. The term ‘father’ was assumed to be defined in either the traditional, biological sense or as the principal male care-giver or step-father. The data were coded as follows:

- Father’s age group (AGE): 1-6 (corresponding to the categories 18-24, 25-34, 35-44, 45-54, 55-64, or 65+)
- Target child’s age group (CHAGE): 0-4 (0 if child was less than 2 years old, then 1-4 respectively for the age groups 2-5, 6-12, 13-19, and 20 or above)
- Number of children: 1-3 (1, 2, or 3 or more children)
- Marital Status: 1 (married or cohabiting) or 0 (single, separated, divorced or widowed)
- Education: 1 (completed secondary or tertiary education) or 0 (some schooling or trade/diploma)
- Occupation: 1 (currently in a paid occupation) or 0 (unemployed or retired)

The variables Father’s age group (AGE) and Child’s age group (CHAGE) were recoded to maintain reasonable cell sizes; these recoded variables remained numeric and continuous.

Paper and Online Questionnaires

The paper copies of the questionnaires were distributed to the clinic managers and residents/consumers of the rehabilitation centres chosen for this study. The rehabilitation centres used in this study employed programs that focused first on the physical manifestations of the addictions, such as craving, through a detoxification process, and then on the psychological, social and spiritual aspects of their addictions, which were mostly alcohol and other drugs, as well as behavioural addictions, including gambling.

An online questionnaire was also developed in order to capture responses from a wider group of fathers, including those not reporting addictions, and to permit comparison between the groups on the various measures. Since this instrument was not exclusively available to men in drug and alcohol rehabilitation centres, two further questions were included on this version of the instrument. These questions asked the respondents whether they had experienced any difficulties (i) controlling their use of substances, and (ii) managing any behavioural addictions. Data representing respondents’ addiction

status were coded 1 (indicating the presence of an addiction) if they responded face-to-face in a rehabilitation centre or, for online respondents, they answered yes to either question (i) or (ii) described in the previous sentence. Data were coded 0 if the online respondents answered no to either question. Thus the final survey instruments contained either 165 items for the hard-copy version or 167 items for the online version.

Research Procedures

Directors of inpatient and rehabilitation centres and outpatient clinics were initially contacted to invite residents/consumers in their centres to participate in the study. If interest was shown by the directors and program managers, the following materials were sent by post or given in person:

- an advertisement, inviting any fathers in the centre to attend a 30-to-40-minute session where they would complete the questionnaires;
- information sheets outlining the details of the study;
- consent forms; and
- questionnaires, if requested (for some centres, the researcher administered the questionnaires, while in others these were administered by the director or a member of clinic staff after consultation with the researcher).

No payment or other inducement was offered to any potential survey respondents.

Data Analysis

The analysis of the data from phase 1 was performed using purely quantitative methods, involving data obtained from the questionnaire items and scales. Scale reliabilities were carried out on each of the four questionnaires, in addition to factor analyses on three of the instruments (FACQ, EQ and DERS), in order to validate the results of the present sample on previous studies. Comparisons were also made between the two main groups of interest: Addiction/Recovery and Non-Addiction. These groups were determined as follows: firstly, since all hard-copy questionnaires were given to respondents in rehabilitation centres, these respondents were automatically classified into the Addiction-Recovery group or, more simply, the ‘Addiction’ group. Then for the online questionnaires, respondents were included in that group if they answered yes to either of

the questions asking about addictions, or they were included in the Non-Addiction or 'No Addiction' group if they answered no to both questions.

Initial data investigation was carried out, including univariate, bivariate and item analysis. Following the tests of internal consistency and factor analyses, multiple regressions were performed on the four outcome measures and the demographic variables, both including and then excluding the Addiction factor, in order to determine the best equations predicting the four variables assessed through the questionnaires: Attachment, Emotion Regulation, General Health, and Empathy. From these results, path analyses were conducted on the four variables of interest in order to investigate possible directions of influence among these variables for this population. These results are given in Chapter 3.

Phase 2

Research Design

Mixed methods were employed in the second phase of this study. A smaller number of fathers participated in this phase, which was designed as a multiple case study. This design was chosen so that the perspectives of the participants could be examined in more depth, permitting an investigation into both the common themes and the unique aspects of their stories (Stake, 2006).

The second research question (RQ 2) asked: *How do fathers in recovery from addictions experience fatherhood?* This question required an in-depth investigation into the participants' stated experiences of fatherhood, including what being a father meant to them, their joys and struggles as fathers, and their relationships with their children and other family members. A qualitative investigation of this domain enabled the collection of rich data that highlighted the men's own voices and subjective viewpoints of fatherhood. While questionnaire responses provided information on these men's self-ratings on various dimensions, verbal feedback from individual interviews and in the group sessions provided a fuller description for this question of the men's conceptions of their experiences as both fathers and as recovering addicts.

Finally, the third research question (RQ 3) asked: *How might training in empathic parenting provide these men with an opportunity to reassess their capacities as fathers as well as encouraging the development of empathy and an enhanced sense of wellbeing?* This question asked to what extent the men changed their descriptions of themselves as fathers during and after the parenting program, and whether they were aware of any such changes. Specifically: how, if at all, did their assessments about being a father and their relationships with their children (and perhaps other significant family members) change? Did they display evidence of greater levels of empathy – both in their questionnaire responses and in their conversations – towards their children, but also more generally? And did they show any evidence of an improved sense of wellbeing through their responses to the questionnaires on emotion regulation and general and mental health, in their later interviews, and in their general demeanour? These questions were therefore best addressed using a mixed approach, since the answers required material from the interviews and parenting group sessions, as well as from the comparison of these men's questionnaire responses from those of the large group in the first phase.

Rationale for employing a multiple case study

According to Yin (2009), case studies are most appropriate for social research if the study is (at least in part) qualitative, the researcher has little control over the behaviour of the participants, the focus of the study is contemporary, and the study requires some depth of observation. These conditions were largely met in the present study: as discussed, the second phase data were mostly qualitative, the focus was contemporary, and the men's stories about their lives and their parenting were explored in some depth. The men's behaviour was also largely out of control of the researcher – even though the parenting program material and individual interview questions were pre-arranged – since the questions were for the most part phenomenological in nature, permitting the men the freedom to respond according to their own experience and not the researcher's agenda. This issue will be discussed further in Chapter 5.

The parenting program for the present study was designed ideally for 6-10 participants in both groups, consistent with the recommendations of the creators of the *Tuning in to Kids* program (Havighurst et al, 2004). In this sense, the analysis of the individual stories and group processes in this program also lent itself to a multiple case study, due to its scope and size (Stake, 2006). Spotlighting these individual cases permitted the researcher to gain more insight into the degree of these fathers' psychosocial issues, and to attempt a more informed explanation of their particular patterns of behaviour, including any changes in their reported attachment to their children, their capacity for emotion regulation, their level of mental health, and their capacity for empathy.

Yin (2009) added that case studies are most useful when "the boundaries between phenomenon and context are not clearly evident" (p. 18). As the background for all participants in the second phase of the present study was their participation in a residential rehabilitation program, the context was not only constant, but was expected to be highly influential on the men's verbal responses and behaviour during the parenting program. In addition, a case study approach suited questions that explored the extent to which these men's clinical and social issues affected their sense of self and their parenting, and how the men's individual descriptions of their relationships with their own fathers might influence their potentially changing descriptions of themselves as fathers.

Rationale for narrative analysis

The analytic method chosen for the qualitative component of phase 2 was narrative analysis, which permitted the researcher to explore in some depth the participants' stories and their construction of meaning in their experiences (Esin, 2011), including defining moments, identification of significant characters in their lives, and how the men positioned themselves in their stories. This style of analysis, which has been used increasingly in qualitative research in psychology (Kirkman, 2002; Camic, Rhodes & Yardley, 2003; Stephens, 2011), served to amplify the main themes present in the men's descriptions of their lives as fathers and their relationships with their children.

While alternative stories were sought to describe these men's lives, including those from partners where possible, most of the information about their lives was obtained through their own stories rather than observation or analytic generalisation (Yin, 2013), making a narrative methodology most appropriate for this research. In addition, a number of relatively recent studies on recovery from addictions and other health-related conditions have used this analytic approach (e.g. Bottorff, Radsma, Kelly & Oliffe, 2009; Dunlop & Tracy, 2013; Frank, 2013; Gilbert, Ussher & Perz, 2014).

Setting

The second phase of the study was conducted in two rehabilitation centres. The same parenting program was conducted in these two centres in turn. The program that was used was the *Tuning in to Kids* (TIK) program (Havighurst et al, 2004).. This program has demonstrated success in training parents to be empathic and respectful of their children's emotions (Havighurst et al, 2004). Although the vast majority of the participants had previously been mothers (only 13 fathers out of 264 parents across the two studies: Havighurst et al, 2004, 2009), a pilot program specifically aimed at fathers, known as Dads TIK, has more recently been developed and run (Wilson, Havighurst & Harley, 2014). The parenting program in the present study did not use the revised content based on their study, however, as the present program was developed before the final Wilson et al (2014) results were published.

The TIK program consists of six two-hour sessions, with an option for an extra two 'booster' sessions, consistent with one of the recommendations of the authors of the program (Havighurst et al, 2004). Due to the particular issues experienced by the population in the present study, it was considered important to allow more time to focus on the fathers' own sense of emotional competence, particularly the skill of emotion regulation, which would also supplement the work done in the substance abuse recovery groups. However, due to the time constraints involved in running a parenting program within a residential rehabilitation program as well as advice from the program managers of the rehabilitation centre concerning the men's concentration levels, seven sessions averaging one hour and a quarter in length were given to both groups.

Participants

The criteria for participation in this phase of the research were: (i) being a father aged 18 or over; (ii) desire and consent to participate in the program, including the interviews and questionnaires, both during and after the parenting program; (iii) preferably having at least one child between 2 and 12 years living with them at home (for residents of rehabilitation centres this would mean living with this child on a part-time basis); (iv) not having a severe mental illness, personality disorder or brain injury; (v) not having any (disclosed) legal issues concerning access to or custody of their children; and (vi) for those participating in the parenting program, nominating their 'trace contact', who could potentially be followed up for an interview after the participant's completion of the parenting program. Any screening of participants prior to the commencement of the parenting program would be based on the recommendations of the clinical staff of the rehabilitation centres.

A total of 20 fathers in the two rehabilitation centres, which comprised the research centres for phase 2 of the study, volunteered to complete the full surveys (information given under Phase 1). Of these fathers, 18 agreed to participate in the initial interviews (but two of these men were not present at the initial interviews). The number of children per father for these 18 men according to the survey data ranged from 1 to 5, with a median number of 2 children per respondent. It was considered that there was a small range of error in these responses, depending on the men's interpretation of the question. For example, one of the men stated that he indicated he had five (biological) children, but later revealed that in fact he had seven: five who lived with him, and two who lived with his ex-partner.

The age groups of these 18 fathers ranged from 18-24 to 55-64, with the median age group 35-44. The ages of their children ranged from 1 to 19 years, with a median child age of 7. Most of these men described themselves as single (10 out of 18, or 56%). Four indicated that they were married, two were divorced, one was cohabiting, and one was separated. The majority of the interviewees did not complete year 12 at school (14 out of

18, or 78%); three stated that they had completed a trade or diploma; and just one stated that his highest education level was completion of year 12. Responses to occupation status were quite diverse, with five stating that they were skilled labourers, four being professionally employed (including one 'professional manager'), three indicating unskilled/semi-skilled labour, three unemployed seeking work, two unemployed not seeking work, and one junior manager.

Qualitative and Quantitative Measures

In the second phase of the study, qualitative interviews were conducted with participants both before and after the parenting program. The initial interviews explored the men's relationships with their nuclear family and their family of origin (particularly the experience of being fathered), their sense of identity, their perception of their parenting ability and capacity for coping with stress, and their sense of meaning in being fathers (see questions in Appendix A).

Those fathers who completed the parenting program were asked to participate in final interviews. The questions in these interviews covered such topics as the men's perceptions of any changes in their lives or self-concepts since completing the parenting program, renewed conceptions of fatherhood, their progress with their original goals for the program, and their beliefs concerning their partner's current perception of them as fathers, if relevant. If they had given the researcher permission to contact their partners or other close contacts, those people were also invited to be interviewed about any changes that they may have noticed in their partners (the fathers in the program). The post-program questions can be found in Appendix A.

Table 2.5: Testing sequence of participants in phase 2 of the combined substance abuse recovery group

Assessment Time (AT)	Group 1	Group 2
AT1: Start of first group sessions	Pre-program questionnaires & Interviews	
AT2: 3-4 weeks after T1	Parenting Program	Pre-program questionnaires 1
AT3: Start of second group: 6-7 weeks after T2	Post-program questionnaires	Pre-program questionnaires 2 & Interviews plus Parenting Program
AT4: 6-7 weeks after T3		Post-program questionnaires
AT5: 2-3 weeks after T4 (4-5 months after Group 1 Pre-program Interviews)	Follow-up questionnaires & Post-program Interviews	Post-program Interviews

In both cases the fathers in the present study were tested on four occasions as shown in Table 2.5. The fathers in Group 1 were given pre-program questionnaires as described in Phase 1, as well as individual interviews (time AT1); those in Group 2 were then given their first pre-program questionnaires while Group 1 commenced the group parenting program (time AT2). Group 1 completed post-program questionnaires at the conclusion of their parenting program while Group 2 completed the second pre-program questionnaires and interviews and commenced their parenting program (time AT3). Group 2 were then given their post-program questionnaires (time AT4).

Finally, the fathers in Group 1 were given their follow-up questionnaires to complete, as well as participating in post-program interviews. At this time, any interviews with partners or other close contacts of the men were also conducted by phone (time AT5). The final interviews were given four to five months after the initial (Group 1) interviews, which were conducted before the start of the whole parenting program.

Research Procedures

For the second phase of the study, an organisation was contacted to request their participation in the research via parenting groups for fathers in two of their rehabilitation centres, so that the parenting program could be delivered to two similar groups of fathers who were involved in the same rehabilitation program, but in separate centres to prevent conversations between the men participating in the parenting program the first time and those participating in the second group. The purpose of this decision was to keep the groups independent so that assessment of the psychological progress of the second group of men could be made without possible influence from the members of the first group. Quantitative assessment was carried out three times for each group: both before and after the parenting program, and either post-program follow-up (first group) or pre-program assessment (second group), in order to align the times of testing for the two groups (see Table 2.5). The above materials, with updated information reflecting the requirements for this phase of the study, were sent to the participating centres.

The fathers in the rehabilitation centres were asked if they would like to participate in the study, which involved an initial interview about their experience of fatherhood, followed by participation in a seven-session parenting program aimed at helping them to develop closer connections with their children and to become more confident as fathers. The men were also asked to participate in an interview at the conclusion of the parenting program, complete questionnaires before and after the program, and nominate a 'trace contact': someone such as a partner or close family member who knew the participant well, and who may have been prepared to participate in an interview to discuss the participant's parenting and any other relevant issues. As per the ethics requirements of this study, the participants were given an information sheet describing the details and purpose of the study as well as a consent form to sign, which included a statement that the interviews and group sessions would be recorded.

A modified version of the *Tuning in to Kids* (TIK) program was chosen as the parenting program for this study. See Chapter 5 for more details about this program. While the original *Tuning in to Kids* program was principally designed for parents of children aged

four to five years (Havighurst et al, 2004, 2009), it has been used with parents of children up to 11 years of age. The present study, in its focus on parental outcomes, broadened the range to fathers of children from early to late childhood, advertising to fathers of children from approximately two to twelve years of age. The actual ages of the children of the fathers in the parenting program ranged from 18 months to 15 years.

The residential rehabilitation program typically runs for 6-9 months, depending on the individuals' rate of recovery from their addictions. The program is based on the 12-step recovery model (Anonymous, 1939), and complete abstinence is required for continuation in the program. All men would have already experienced the detoxification process before commencing their rehabilitation program. Thus the parenting program was offered to fathers simultaneously at various stages of their recovery process. Table 2.5 shows the schedule of individual and group sessions for the participants in phase 2 of the parenting program.

Data Analysis

For phase 2, which involved the fathers who undertook the parenting program, both quantitative and qualitative methods of analysis were applied. Survey data collected from these participants in phase 1 served as baseline data to enable measurement of self-reported change after participation in the parenting program in phase 2. Pre-program, post-program and follow-up questionnaire results were compared for each individual who completed the program including the questionnaires. Pre-program (and some peri-program) data are presented individually and within the phase 2 sample as part of a profile for each participant in Chapter 4; individual responses to group sessions and group dynamics during the parenting program are provided in Chapter 5; while individual narrative analyses and further quantitative analyses were also conducted, and these results are presented in Chapter 6.

The data for this analysis was initially obtained by listening to the individual interview recordings for each of the seven principal participants as well as each of the group

sessions. Following this, the transcripts of the individual interviews and group sessions were read a number of times each, as well as the field notes for each group session. Next, a full verbatim narrative was created for each of the seven men, which included their individual responses in each group session, bounded by the text of the interview transcripts. These full transcripts were then read several times for content, structure, plot and themes (Esin, 2011). Following this, each theme was classified into one of the main constructs that formed the theoretical basis of the present study, namely fatherhood, attachment to one's children and families, empathy, emotion regulation, mental health, masculinity, or addiction and recovery.

The themes, which varied across participants, were further classified into pre-program/peri-program themes if they arose during the initial interviews or the first six sessions of the parenting program, or post-program themes if they were related to the last session or post-program interview. This decision was made on the basis that the last group session and the final interview specifically asked each man for any changes that he had noticed in himself during the parenting program. In some cases, themes were classified as post-program if any of the men referred to their progress in earlier sessions. The themes were then listed at the bottom of each full transcript, and selected quotes (up to a paragraph in length) were highlighted according to each theme.

Pre-program themes for each man were then linked to their related post-program themes, which created sub-narratives within each over-arching change narrative. These sub-narratives were connected to the over-arching narrative by the researcher's understanding of the deeper story that he believed each man was attempting to convey. Following each thematic narrative analysis, the pre-program and post-program questionnaire scores were compared, and any differences were interpreted. Finally, all of the information was presented as case profiles for each participant, and each change narrative was compared with the pre- and post-questionnaire data to comprise the final mixed-method analysis within the multiple case study.

CHAPTER 3. QUANTITATIVE RESULTS FROM QUESTIONNAIRE RESPONSES

Introduction

In this chapter, detailed analysis is carried out on the questionnaire responses of the sample of 169 fathers in Phase 1 of the present study; this will allow a comparison between fathers identifying with addictions and those with no disclosed addiction, particularly on the variables of interest in this study: attachment to child, emotion regulation, empathy, and general (mental) health. The psychometric properties of each of the instruments used in the study will be given. In addition, the results relating to research question 1 (RQ 1), as described in the previous chapter, will be presented: namely to identify and give meaning to the factors that underlie the respondents' quantitative descriptions of their relationships with their children, and to locate any differences between those respondents who did and did not identify as having (or being in recovery from) an addiction. This research question was further subdivided into three quantitative hypotheses (see Chapter 2).

Overview of analysis

The quantitative analysis of the questionnaire responses in this section has been carried out with the purpose of addressing RQ 1. To this end, tests of internal consistency of scales were carried out to determine the reliability of the instruments, followed by a series of confirmatory and exploratory factor analyses of the Fathers' Attachment to Children Questionnaire (FACQ) instrument, which was used for the first time in the present study. The purpose of these analyses was to determine the validity of the factor structure of the instrument. Factor analyses were also carried out on the Empathy Quotient (EQ) and Difficulties in Emotion Regulation Scale (DERS) to determine whether the previously determined factor structures also applied to the sample of respondents in the present study.

Following the above procedures, multiple regression analyses were performed to determine the best predictors, firstly of the men's attachment scores, and then their scores on empathy, emotion regulation and mental health. Structural equation modelling was then carried out to identify the direction of the influence of these factors as well as

the effect due to the addiction group on the levels of attachment for the present sample of fathers. Finally, an analysis of the individual questionnaire items by addiction group was carried out. The purpose of this analysis was to identify specific areas of difference in the self-reported functioning between the two groups of fathers, in order to help build some of the content of the parenting program to be delivered to the men in recovery from addictions.

Participants

As indicated in the previous chapter, the full sample of respondents in Phase 1 consisted of 169 fathers: 95 who responded to the questionnaires in rehabilitation and outpatient centres, and 74 who responded online. Those respondents were specifically asked if they had been struggling with substance or behavioural addictions in order to determine the group into which they would be classified. Of the 74 online respondents, 8 (10.8%) confirmed that they were having difficulties with either or both forms of addiction, while 66 responded that they were not. The 'Addiction' variable was created by combining the responses of the 95 fathers who responded in person with those of the 8 respondents who indicated in their online questionnaire that they were having difficulty managing an addiction. The resulting 103 respondents were thus classified as being in the Addiction group, with the remaining 66 classified in the No Addiction group. This information is displayed in Table 3.1 below.

Table 3.1: Composition of Addiction and No Addiction groups

Respondent Type	Addiction disclosed or in recovery centre	No addiction disclosed	Total
Online	8	66	74
Face-to-face	95	0	95
Totals	103	66	169

Scale reliabilities

In analysing the results of the responses on the questionnaires, the first requirement was to ensure an acceptable level of reliability of each scale before any conclusions could be made about their validity or any possible connections between the variables that they were purporting to measure. Given the nature of addictions, including a substantial prevalence of comorbid mood and personality disorders (Seligman & Reichenberg, 2007), respondents may have given unpredictable or inaccurate responses to questionnaires, making this an important issue to test.

For the present study, instrument reliability was tested using Cronbach's alpha (α). This measure has been widely used in psychology and other fields as a robust measure of internal consistency of scale items (Coolican, 2014). Internal consistency refers to the capacity of all the items on a scale to measure the same construct. The general consensus is that scores between .70 and .95 indicate that an instrument is likely to have strong internal consistency, although lower scores may be acceptable on short subscales (Tavakol & Dennick, 2011). The four questionnaires showed alpha values for the present study as indicated in Appendix O. All four questionnaire full scales displayed high internal consistency, ranging from .88 to .95. These values suggested that these questionnaires each measured a single construct for this sample. This includes the Fathers' Attachment to Children Questionnaire (FACQ), which was used for the first time for the present study.

Revision of Questionnaires

Examining the Factor Structure of each Instrument

The purpose of this analysis was firstly to test whether the hypothesised structure of each questionnaire was the best fit for the data. Confirmatory Factor Analysis (CFA) was used for this purpose. CFA compares the factor loadings (correlations) of the observed values of the item variables with those of the predicted values onto each factor (Kahn, 2006). This would then either confirm the existing factor structure (subscales) as displayed in Appendix O, or it would permit alternative models to be considered using Exploratory Factor Analysis (EFA), in order to obtain reduced numbers of questions on each questionnaire with as much explained variance of the original versions as possible, but with more accurate and efficient factor structures (Henson & Roberts, 2006). This would help determine a revised set of underlying factors that could best fit the responses of the fathers in the current study, also establishing a measure of construct validity for each questionnaire (Reio & Shuck, 2015), and hence permitting a more focused and confident examination of how addictions might impact these and possibly other fathers' relationships with their children.

Validation of the underlying factor structure of the FACQ instrument through CFA was considered essential, as this was the first time that this questionnaire had been used. This procedure was also carried out on the DERS and EQ, based on the results from this sample, in order to determine whether their factor structure mirrored those found in previous studies. However, no factor analyses were carried out on the GHQ in this study because, unlike the DERS and EQ, the original GHQ-28 was content-developed after determining the four subscales: *Somatic Complaints, Anxiety/Insomnia, Social Dysfunction,* and *Severe Depression* (Werneke Goldberg, Yalcin & Ustun, 2000).

Assumptions underlying the use of both CFA and EFA include (i) multivariate normality of the variables, (ii) linear relationships between each pair of variables, (iii) factorability of the sample, and (iv) minimum sample size (Fabrigar, MacCallum, Wegener & Strahan, 1999). The assumption of multivariate normality is particularly necessary for CFA, since it requires inferences to be made about the population underlying the sample

(Kahn, 2006). This was tested by examining the magnitude of the skew and the kurtosis for each variable, as well as the percentage of outliers (scores more than two standard deviations from the mean), which should normally be less than 5% (Fabrigar et al, 1999).

The results, which can be found in Appendix K, showed no serious departures from normality for the vast majority of the individual items on the FACQ, DERS and EQ (Tables K1, K2, K3) or on any of the full scales (Table K5). Bivariate linearity was tested by examining selected correlations (see Appendix K). These relationships also showed few significant violations of bivariate linearity among the variables. Data factorability was tested using the *Kaiser-Meyer-Olkin measure of sampling adequacy (KMO test)* and *Bartlett's test of sphericity*. Samples are determined to be factorable if KMO > .5 and Bartlett's test is significant, say at the .05 level (Mvududu & Sink, 2013). Using these tests, each of the three full-scale questionnaires were found to be factorable (see Tables K51, K52 & K53).

Recommendations for minimum sample sizes for adequate factor analysis of data have ranged from 100 to 1000 or more (Fabrigar et al, 1999; Kahn, 2006). Alternative guidelines have emphasised the participant-to-variable ratio (in the present study the variables are the questionnaire items) or the size of the communalities, which are the proportions of variance in each item explained by the factors. The minimum recommended size of the participant-to-variable ratio has generally been 5:1 (Henson & Roberts, 2006; Reio & Shuck, 2015), although ratios as low as 3:1 have been justified by some researchers "in the presence of strong, reliable correlations and few distinct factors" (Reio & Shuck, 2015, p. 15). The number of items in the FACQ, DERS and EQ were 34, 36 and 40 respectively, and since the sample size was 169, the participant-to-variable ratio for each scale was between 4:1 and 5:1.

Concerning communalities, Kahn (2006) advised that if they were of moderate size – "in the range of .50" – then EFA "required a sample size of 100 to 200" (p. 700). For the present study, the communalities for the majority of the items on each of the FACQ, DERS and EQ were above .50 (see Appendix M). Based on the above recommendations,

the sample size of 169 in the present study, while on the low side, was considered sufficient for meaningful factor analysis.

There are several statistics for testing hypotheses in CFA. These include the Root Mean Square Error of Approximation (RMSEA), the Non-normed Fit Index (NFI), the Comparative Fit Index (CFI), and the Standardised Root Mean-squared Residual (SRMR). The present study has employed the first three indices as measures of goodness of fit for the various factor models. The RMSEA compares the covariance matrices of the actual and hypothesised factor models, for which purpose it has been found to have good reliability (Kahn, 2006). Values closest to zero indicate best fit, with values less than .06 considered to be good, while values between .06 and .08 have been described by some researchers as acceptable (Mvududu & Sink, 2013; Milfont & Fischer, 2010).

The CFI and NFI statistics, on the other hand, indicate good fit if they are close to one, with values of .90 and .95 in each case respectively considered adequate and good fits (Mvududu & Sink, 2013). For each questionnaire, the RMSEA, CFI and NFI were calculated for the original models and then, if they did not show evidence of a good fit, EFAs were conducted to determine alternative models by successively extracting factors and (if appropriate) deleting items from each new model. Following these analyses, a CFA was again conducted to test the adequacy of the new model. This was carried out until a model with the most parsimonious fit to the data was found.

Based on previous research (see Fabrigar et al, 1999; Kano & Harada, 2000; Kahn, 2006; Mvududu & Sink, 2013; Reio & Shuck, 2015), dimension reduction (reducing the number of factors and items) of EFAs was carried out for each model, first by using two criteria for retaining factors: Kaiser's criterion and the 'scree plot'. These criteria concern the 'eigenvalue' of a factor, which is the ratio of the variance explained by that factor to that of a single variable (Kahn, 2006). Kaiser's criterion states that only those eigenvalues greater than 1 (factors explaining more variance than single variables) should be retained. A scree plot is a graph of eigenvalues against the number of factors. At some point the graph usually changes gradient quite sharply; this is the point to the left of which the researcher would normally retain the factors. The combination of these

two methods is commonly used in EFA to determine the number of factors to retain that best describe the model's factor structure (Kahn, 2006).

The following criteria were also used to determine which variables and factors should be retained or eliminated (Kahn, 2006; Mvududu & Sink, 2013): (i) The size of the communalities (h^2) of each variable (those with the lowest values were considered for removal, particularly if $h^2 < .20$); (ii) The size of the factor loadings of each variable on the various factors (variables with less than $r = .32$ were considered for removal, since they explained less than about $r^2 = .10$ or 10% of the variance on any factor); (iii) The total proportion of variance of the sample scores explained by the given number of factors; (iv) The parsimony of the model (determined by retention of as few factors explaining as much variance as possible); (v) The internal consistency of both the full scale and each factor (using the value of Cronbach's alpha); and (vi) The interpretability of the factors, which was determined by the extent to which they contained variables that 'cross-loaded', or scored at least moderately (greater than .32) across more than one factor – such factors were considered not to be clearly interpretable. In addition, the factors were named based on the wording of the question items that loaded onto those factors. The name of the factor was chosen to best represent the theme of the questions that comprised it.

Further, in order to determine the simplest model with the most interpretable set of factors, the factor matrix for each questionnaire (the set of scores arranged in rows of items and columns of factors) was 'rotated'. Rotation in factor analysis is a mathematical procedure whereby the axes of the instrument that is being analysed are shifted in order to obtain a different perspective on the data. This redistributes the variance among the variables and factors, with the aim of increasing large factor loadings (close to ±1) and decreasing small loadings (close to 0), thereby helping to clearly distinguish relevant items from others and hence remove superfluous questions (Kahn, 2006). In this way, items that add relatively little explained variance to a particular factor are deleted from the model.

There are a number of possible rotation methods; the choice of method should be determined by the independence or otherwise of the factors (Williams, Brown & Onsman, 2012). If the factors are assessed to be independent, an orthogonal rotation is used, whereas if the factors are correlated with each other, an oblique method is used. Since the original factors were generally found to be correlated on each of the questionnaires (see Tables M24-M26), the oblique method 'Direct Oblimin' (IBM SPSS, 2015) was used in most cases for the factor rotations in the present study.

Following the rotation, EFA calculates factor loadings through both structure coefficients and pattern coefficients. The structure coefficients show the loading of each variable onto each factor, while the pattern coefficients show the factor loading of each variable after controlling for the effects of the other factors (Kahn, 2006). Factor extraction was conducted on the items of each questionnaire, in most cases using Principal Axis Factoring (PAF). This method was employed instead of the more commonly used Principal Components Analysis (PCA), since PAF calculates the shared variation among each variable and the associated factors, rather than including the unique variance of each variable as PCA does. This permits an examination of the latent structure of the instrument, unlike PCA, which focuses solely on reducing the number of components, or factors (Reio & Shuck, 2015). PAF has also been found to be more reliable than PCA when communalities are low (Kahn, 2006) or if the normality assumption is violated (Mvududu & Sink, 2013).

Factor Structure of the Fathers' Attachment to Children Questionnaire (FACQ)

An initial factor analysis (EFA) of the original FACQ (34 items) was conducted using SPSS version 23 software (IBM SPSS 2015), in which seven factors were automatically extracted (using the PAF method), accounting for a total of approximately 62.5% of the variance in the item (variable) responses. Only four of the seven factors were retained, since only their eigenvalues each exceeded 1. Furthermore, the scree plot showed a very steep drop from the first to the third factors, a less steep drop from the third to fifth factors, and thereafter a very shallow gradient (see Figure M1). Therefore, because the last significant change in gradient occurred between the 4^{th} and 5^{th} factors, it was

decided that four factors should be retained, consistent with Kaiser's criterion. A CFA was then conducted using AMOS 23 software (IBM SPSS AMOS 23, 2015). The goodness of fit was tested for this model, with the resulting values of RMSEA = .097, NFI = .55 and CFI = .65, indicating a poor fit on each of the indices. Therefore, the next step involved again running an EFA as described above.

For the second EFA, the communalities of the original 34 items of the FACQ were computed, showing all except three of these values to be greater than .50. However, the communality for item 11 was $h^2 = .11$, lower than the minimum threshold of .20, and hence this item was eliminated from the revised questionnaire. A third EFA was then carried out on the revised 33-item questionnaire model, which now accounted for 52.6% of the variance in the model, due to the reduction from seven to four factors. On examination of the pattern matrix it was found that item 12 showed poor loadings of less than .32 on all four factors. Therefore this item was eliminated from the next analysis. Further EFAs were then carried out, eliminating one variable at a time as before, based on low communalities, low factor loadings or cross-loadings. This resulted in the following 11 items being deleted from the 11 respective models (in this order): 21, 28, 18, 26, 32, 15, 14, 22, 20, 7 and 33.

The revised model, which now contained 21 items, accounted for 59.7%, a reduction of only 2.8% of explained variance from the original model. There were no particularly low communalities (see Table M4), and the pattern matrix for this model revealed no individual loadings less than .32 and no cross-loadings (see Table M6). Therefore this model was subjected to a second CFA. The results showed RMSEA = .073, NFI = .78 and CFI = .88. While these results showed a better fit than the full model, the CFI and NFI statistics were still below the threshold of adequate fit, so the EFA process was continued.

Following the data reduction principles outlined above, items 17, 3, 34 and 10 were successively eliminated from the model, leaving 17 items. However, since item 4 displayed approximately the same communality as item 10, and the former item also

loaded a little lower onto its factor, a second 17-item model was tested (see Tables M7-M9), which yielded better fit results of RMSEA = .061, NFI = .84 and CFI = .93, so this model was adopted instead (even though the NFI value was still a little low) as the best model that fitted the data. This information is shown in Appendix I (Table I1).

Table 3.2: Factor loadings for individual items on final rotated version of Fathers' Attachment to Children Questionnaire (FACQ-17)*

Factor 1: Pleasure in relationship (α = .85)	Factor Loading
27. I feel a great deal of affection for my child.	.895
24. I feel close to my child.	.668
25. I often talk about my child's achievements to friends or others outside the family.	.651
23. I often feel proud of my child.	.641
19. I usually enjoy time spent with my child.	.631
13. I feel my child is good.	.573
10. I don't like being around my child.	.524
Factor 2: Anxiety about relationship (α = .76)	
30. I often worry that I will lose my child's admiration.	.861
29. I am concerned that I do not spend enough quality time with my child.	.684
31. It hurts me that my child may be closer to other family members than to me.	.668
Factor 3: Conflict (α = .78)	
6. I feel angry with my child.	.819
1. I get frustrated with my child.	.672
16. I often feel annoyed or irritable when I am with my child.	.608
2. I am constantly yelling and fighting with my child.	.544
Factor 4: Mutual Trust (α = .83)	
5. My child respects my feelings.	1.017**
9. My child cares about my point of view.	.702
8. My child understands me.	.536

*Scale reliabilities using Cronbach's alpha also shown for each of the four subscales (factors). Full-scale α = .83.
**Rotation inflated loading to a magnitude over 1 (maximum possible loading). Un-rotated loading was .686.

The four factors were renamed, based on the changed question structure of the new version of the questionnaire. The internal consistency values of the revised subscales were also generally superior to that of the original subscales. For example, the three-item revised *Anxiety about Relationship* subscale obtained an alpha value of $\alpha = .76$, compared to $\alpha = .72$ for the previous six-item version; and the seven-item *Pleasure* subscale produced $\alpha = .85$ compared to the previous six-item version with $\alpha = .78$. The relevant information for the revised FACQ-17 measure is shown in Table 3.2 above.

Factor Structure of Empathy Quotient (EQ)

As with the FACQ, confirmatory factor analysis was carried out on the EQ instrument. As shown in Table 2.1, there were three factors on the original EQ. A CFA was conducted on the full 40-item EQ; this was considered important, as Lawrence et al (2004) found that 12 of the 40 items did not adequately load onto any of the previously named factors. An EFA was then conducted on the present sample, with 11 factors being automatically extracted, accounting for a total of approximately 63.6% of the variance in the item (variable) responses, but on further examination of the eigenvalues using Kaiser's criterion, it was apparent that only five of those factors should be retained. While the scree plot (see Figure M3) showed the last steep drop between the 4^{th} and 5^{th} factors, suggesting four factors, five were retained due to the larger R^2 value (44% compared to 40%) and relatively large number of items. To test the goodness of fit of this model, a CFA was conducted as before. The results were RMSEA = .051, NFI = .56 and CFI = .79, with the latter two results indicating that this model did not adequately fit the data for this sample. Therefore, successive EFAs were applied to the data, as per the process for the FACQ.

For the first EFA, the communalities of the original 40 items of the EQ were computed using PAF extraction; this information is displayed in Table M10, which shows the communality for item 49 at $h^2 = .18$, lower than the minimum threshold of .20, and hence this item was eliminated from the first revision of this questionnaire. Ensuing EFAs were then carried out on the EQ models, eliminating one item at a time as before.

The same criteria that were used to delete items from successive FACQ models were used to reduce the EQ models: low communalities, low item-factor loadings, and moderate to high cross-loadings. Using these criteria, the following items were eliminated from successive models: 18, 59, 29, 14, 28, 57, 21, 19, 6, 15 and 4; this left 28 items, as per Lawrence et al's (2004) 28-item, three-factor reduced model.
In addition, the three-factor model, as shown in Table 3.1, was tested for its fit to the present sample. While it was superior to the full 40-item model, however, the EFA process in the present sample revealed that four factors better explained the variance in this model, with fit statistics for that model of RMSEA = .063, NFI = .64 and CFI = .81, slightly better than the results for the three-factor model. However, these results were still weak, so this model was further reduced.

From the 28-item model, items 50, 27, 42, 36, 34, 39, 11, 32, 37, 43, 52 and 26 were successively deleted, leaving 16 items, with the model again suggesting four factors. This model accounted for 60.0% of the variance in the four factors. No communality was less than .25, and there were no item-factor loadings below .46 (see Tables M12-M14). The results of the CFA were RMSEA = .054, NFI = .80 and CFI = .92. Two of these results described an adequate or good fit, with the third still quite low, but a better fit than any of the other models nonetheless: see Table I2.

The revised EQ-16 is shown in Table 3.3 below, including the four factors with the new names and revised set of items and their loadings. Although the values measuring the internal consistency of the subscale factors were still only moderate, scoring alpha values between .61 and .79, this does not necessarily indicate low internal consistency of these subscales, as they each had only a few (three to five) items (Tavakol & Dennick, 2011). In addition, the items now demonstrated strong face validity on each subscale.

Table 3.3: Factor loadings for individual items on final rotated version of The Empathy Quotient (EQ-16)*

Factor 1: Cognitive empathy (α =.79)	Factor Loading
54. I can easily work out what another person might want to talk about.	.775
58. I am good at predicting what someone will do.	.671
55. I can tell if someone is masking their true emotion.	.565
25. I am good at predicting how someone will feel.	.555
22. I find it easy to put myself in somebody else's shoes.	.523
Factor 2: Insensitivity (α = .72)	
46. People sometimes tell me that I have gone too far with teasing.	.734
10. People often tell me that I went too far driving my point home in a discussion.	.655
48. Other people often say that I am insensitive, though I don't always see why.	.620
Factor 3: Perception of Social Cues (α = .79)	
41. I can easily tell if someone else is interested or bored with what I am saying.	-.672
1. I can easily tell if someone else wants to enter a conversation.	-.666
38. It upsets me to see an animal in pain.	-.625
44. I can sense if I am intruding, even if the other person doesn't tell me.	-.574
60. I can usually appreciate the other person's viewpoint, even if I don't agree with it.	-.524
Factor 4: Social Discomfort (α = .61)	
8. I find it hard to know what to do in a social situation.	.735
35. I don't tend to find social situations confusing.	.577
12. Friendships and relationships are just too difficult; I tend not to bother with them.	.464

*Scale reliabilities using Cronbach's alpha also shown for each of the four subscales (factors). Alpha value for full-scale EQ-16 is α = .82.

Factor Structure of Difficulties in Emotion Regulation Scale (DERS)

A CFA was also carried out on the 36-item DERS, which the original authors found to have six factors (Gratz & Roemer, 2004) – see Appendix O. An EFA was then conducted; the first rotated analysis found, like the original instrument, six factors, onto

which all items loaded greater than .32, and there were no communalities below .20. The 36 items explained 68.0% of the variance in the factors, which was a high result compared to that of the previous two instruments (see Appendix I). However, the variable composition of the DERS in the present study was different from that of the original instrument. In addition, some items cross-loaded onto two factors. Moreover, the CFA statistics of RMSEA = .078, NFI = .73 and CFI = .84 were unsatisfactory, so EFA model reduction was again conducted as before.

Successive EFAs were carried out again using PAF extraction and oblimin rotation. The items that cross-loaded in this model were numbers 15, 23, 30 and 36 (see Table M20), with item 36 showing the poorest factor loading of any of these items, so it was deleted from this analysis. In the ensuing model revisions, the same criteria as those used for model reduction for the FACQ and EQ were used, resulting in the successive elimination of the seven items 16, 35, 23, 31, 28, 3 and 30. This left a 28-item model that explained a strong 66.3% of the variance of the five remaining factors.

A CFA was thus performed on the revised 28-item model. The results were RMSEA = .062, NFI = .81 and CFI = .91 – significantly improved from the results for the full model, but still only just adequate. Therefore the EFA process was continued, with item 22 displaying the lowest individual factor loading, so this item was eliminated from the model. The process was then repeated, with item 15 similarly displaying a relatively low loading onto its factor, so this item was also removed, leaving 26 items. This model was then tested using a CFA, revealing fit statistics of RMSEA = .055, NFI = .84 and CFI = .94, which were better results not only than the fuller models, but also better than further reduced models of 24 or 25 items (see Table I3). Therefore, this model was adopted as the revised DERS-26. The five factors were renamed, based on the composition of the new model. The new names, together with the revised set of items and their loadings, are shown in Table 3.4.

Table 3.4: Factor loadings for individual items on final rotated version of the Difficulties in Emotion Regulation Scale (DERS-26)*

Factor 1: Lack of control (α = .87)	Factor Loading
14. When I'm upset, I become out of control.	-.748
27. When I'm upset, I have difficulty controlling my behaviours.	-.734
19. When I'm upset, I feel out of control.	-.713
32. When I'm upset, I lose control over my behaviours.	-.659
24. When I'm upset, I feel like I can remain in control of my behaviours.	-.465
Factor 2: Emotional awareness (α = .87)	
8. I care about what I'm feeling	.792
10. When I'm upset, I acknowledge my emotions.	.763
2. I pay attention to how I feel.	.689
6. I am attentive to my feelings.	.684
7. I know exactly how I'm feeling.	.620
1. I am clear about my feelings.	.560
17. When I'm upset, I believe that my feelings are valid and important.	.538
34. When I'm upset, I take time to figure out what I'm really feeling.	.520
Factor 3: Negative attitude to own emotions (α = .90)	
11. When I'm upset, I become angry with myself for feeling that way.	.765
21. When I'm upset, I feel ashamed of myself for feeling that way.	.750
12. When I'm upset, I become embarrassed for feeling that way.	.734
25. When I'm upset, I feel guilty for feeling that way.	.699
29. When I'm upset, I become irritated with myself for feeling that way.	.630
Factor 4: Concentration difficulties (α = .87)	
18. When I'm upset, I have difficulty focusing on other things.	.847
26. When I'm upset, I have difficulty concentrating.	.790
13. When I'm upset, I have difficulty getting work done.	.702
33. When I'm upset, I have difficulty thinking about anything else.	.565
20. When I'm upset, I can still get things done.	.490
Factor 5: Emotional confusion (α = .84)	
9. I am confused about how I feel.	-.701
5. I have difficulty making sense of my feelings.	-.655
4. I have no idea how I'm feeling.	-.569

*Scale reliabilities using Cronbach's alpha also shown for each of the five factors.
Alpha value for full-scale DERS-26 is α = .93.

Having established revised questionnaires that showed evidence of a more internally valid and meaningful factor structure for the present sample of respondents, the revised questionnaires – the FACQ-17, DERS-26 and EQ-16 – were used in subsequent analyses to determine group differences in relation to addiction, as well as any other associations among variables. Firstly, however, it was important to examine any group differences related to the demographic variables.

Relations between variables

Sample Characteristics: Addiction and No Addiction groups

The Addiction and No Addiction groups were compared for differences in the demographic measures before considering the variables of interest (attachment, emotion regulation, mental health and empathy), in order to contextualise any possible effects of addiction on those variables. First, chi-square (χ^2) tests were carried out on the variables that assessed the respondents' marital status, education and occupation to determine whether the groups differed on those measures. Significant differences were found between the two groups according to their marital status, their education level, and their occupation, each at $p<.0005$ (see Table 3.5 below).

T-tests were also carried out to assess differences between the two groups of respondents according to the numeric variables that measured their target child's age, the median age of their children, the number of children, and their own age group. A significant difference was found between the groups according to the number of children ($p<.05$), with those in the Addiction group having more children on average (see Table 3.5). While the average age of the target child of the fathers in the Addiction group was a little higher than in the No Addiction group, this difference was not statistically significant. Similarly, the median age of the children of the men in the Addiction group was higher on average than in the No Addiction group, but was also statistically non-significant. The ages of the fathers in the two groups also did not differ significantly (see Table 3.5). Nevertheless, since the men in the Addiction group were slightly younger on average and their children a little older, it can be concluded that those in that group generally became fathers earlier than those in the No Addiction group.

Table 3.5: **Differences between Addiction and No Addiction groups on demographic variables**

Marital Status* **	**Single**	**Married**	**Cohabiting**	**Separated**	**Divorced**	**Widowed**
Addiction	31%	21%	11%	18%	16%	3%
No Addiction	6%	77%	5%	3%	9%	0%
Education* **	**Some schooling**	**Year 12**	**Trade/ Diploma**	**Bachelor/ Grad Dip**	**Masters/PhD**	**Other**
Addiction	46%	10%	24%	11%	7%	3%
No Addiction	3%	12%	18%	32%	33%	2%
Occupation* **	**Labourer**	**Junior Manager**	**Prof Manager**	**Prof other**	**Unemployed**	**Other**
Addiction	26%	5%	10%	29%	28%	2%
No Addiction	6%	3%	30%	41%	8%	12%
Father's Age group (n.s.)	Mean	s.d.		**Number of children***	Mean	s.d.
Addiction	3.10	1.07		Addiction	2.44	1.57
No Addiction	3.20	1.17		No Addiction	1.89	0.96
Target child's age group (n.s.)	Mean	s.d.		**Median age of children (n.s.)**	Mean	s.d.
Addiction	1.95	1.08		Addiction	10.32	8.23
No Addiction	1.68	1.13		No Addiction	8.78	9.34

*p < .05; ***p < .0005

Given that the two groups differed according to education, occupation and number of children, and that there was also evidence that those fathers identifying with addictions were more likely to have become fathers earlier but then describe themselves as single, separated or divorced, these results present a picture of those fathers generally struggling more with relationships, education, employment, and by implication, finances, than the fathers without addictions. This is consistent with the profile of the men in the *Fragile Families* study referred to by Amato & Dorius (2010), and is also reflective of the profile of men with various forms of addiction in several Australian studies.

For example, the Australian Cancer Council reported that regular cigarette smokers were likely to smoke more frequently if they: were unemployed (average 125 cigarettes per

week compared to 97 per week for those who were employed); did not possess a post-school qualification (112 compared to 95 per week for those who did possess such a qualification); or were divorced, separated or widowed (average 128 per week) compared to those who were married or in de facto relationships (average 99 per week). Moreover, single fathers reported smoking more cigarettes per week than married fathers (137 compared to 99: Scollo & Winstanley, 2015).

A profile of reduced resources has also been shown to characterise people with other addictions in Australian society, for example problem gambling and excessive alcohol use. Specifically, higher rates of problem gambling in poorer urban and rural areas of Australia have been found to be associated with a disproportionate availability of poker machines in those areas compared to wealthier areas (Young, Markham & Doran, 2012). And the Australian Institute of Health and Welfare (AIHW, 2011) reported higher risk of harm due to excessive alcohol misuse for Australians who were unemployed compared to those who were employed (25% compared to 22%), and those without post-school qualification compared to those with such a qualification (22% to 18%).

Similar results were found for cannabis use (AIHW, 2011), with recent users more likely to be unemployed (20%) compared to 11.5% who were employed, or single (20%) compared to those who were married or de facto (6.5%). Australians in the highest economic bracket (top 20% of the population) were more likely to have never used cannabis (69%) than those in the lowest 20% (61%). Those with post-school qualifications were also more likely to have never used this substance (72%, compared to 59% of those without post-school qualifications). It should be added that it is likely that some socio-economic effects on both alcohol and cannabis use in these studies were masked due to the inclusion of responses from young people aged under 18 in those surveys.

Sample Means – Questionnaire Variables

Before group differences in the results of the questionnaires could be compared and any conclusions reached, any possible effects of the mode of responding, or method effects (Maul, 2013) needed to be considered. Since all face-to-face respondents were classified into the Addiction group but most (89.2%) of the online respondents reported no addiction, any differences in the target variables between the groups might have been due to the mode of responding (as well as the demographic variables) in addition to, or even instead of, the effect of the presence or absence of an addiction.

Evidence that people's responses on questionnaires are influenced by the social context in which they respond has been well documented (Terry & Hogg, 2000; Hardré, Crowson & Xie, 2012). For example, different patterns of responding may occur according to whether survey participants have responded to a survey in the same room as the researcher, or online at home or in another private place. In the case of the present study, the face-to-face environment increased the likelihood that the respondent was the person he described: it could at least be confirmed that these respondents, if not actually fathers, were men, whereas, in theory at least, online respondents might not have fulfilled any of the criteria for being eligible to respond.

There is also evidence that respondents in face-to-face surveys are more likely to concentrate on the question at hand, since online surveys afford the respondent the opportunity to carry out other tasks simultaneously; and there is both a higher completion rate and a lower incidence of 'Not sure' responses for face-to-face surveys compared to online surveys (Heerwegh, 2009). For the present study, there was indeed a substantially higher survey completion rate for the men who responded face-to-face compared to those who responded online (88.7% to 40%: see Chapter 2). The difference in percentages of 'Not sure' responses (which were only possible in the FACQ) between the two groups was much smaller: 11.3% for the face-to-face respondents versus 11.8% for those who responded online. Even so, given that most of the online respondents did not identify as having an addiction and the majority of the face-to-face respondents would have had less contact with their children as they were largely in residential

rehabilitation centres, this result is notable for running against expectations on those bases.

On the other hand, online surveys provide the respondents with more confidence that their responses will indeed be anonymous (Heerwegh, 2009), so face-to-face respondents' self-report responses may be less accurate due to the "social desirability" effect (Henderson, Evans-Lacko, Flach & Thornicroft, 2012, p. 152), especially if the survey questions concern the intentions of the respondent. In addition, for the present study, since the Addiction and No Addiction groups were drawn almost entirely along mode-of-responding lines, it is possible that this modal effect could have become a confounding variable for this study. And indeed, among the online respondents, the fathers who disclosed having an addiction may have been more honest or self-aware in their responses than many of those who did not.

However, socially desirable responses concerning the respondent's attachment to his children, for example, would not have had an obvious effect on the accuracy of the responses of the men in the face-to-face context, as no form of reward (tangible or psychological) was promised according to their responses to the questions, including no reporting of the responses to their case managers. Indeed, the Information Sheet for respondents in both contexts indicated that the responses would be used to inform the content of the group sessions rather than any suggestion of selection of individuals for the parenting groups based on their responses to the questionnaires.

Nevertheless, since the composition of the Addiction and No Addiction groups differed according to the mode of responding, the questionnaire means for the target variables across the three groups Addiction-face-to-face respondents, Addiction-online respondents, and No Addiction-online respondents needed to be considered; these are shown in Table 3.6 below.

Table 3.6: Questionnaire total means across the 'Addiction' and 'No Addiction' groups according to mode of responding

Questionnaire	'No addiction' (N=66) online	n	'Addiction' (N=8) online	n	'Addiction' (N=95) face-to-face	n
FACQ-17 (Attachment) [1]	$\overline{x}$ = 69.0 s = 7.7	61	$\overline{x}$ = 66.3 s = 11.7	7	$\overline{x}$ = 66.1 s = 7.1	93
DERS-26 (Emotion Regulation) [2]	$\overline{x}$ = 54.3 s = 14.4	54	$\overline{x}$ = 64.0 s = 23.7	5	$\overline{x}$ = 61.4 s = 16.7	93
GHQ-28 (Mental Health) [3]	$\overline{x}$ = 45.7 s = 8.7	52	$\overline{x}$ = 59.2 s = 20.1	5	$\overline{x}$ = 45.9 s = 13.2	92
EQ-16 (Empathy) [4]	$\overline{x}$ = 20.0 s = 5.7	45	$\overline{x}$= 20.3 s = 4.9	4	$\overline{x}$= 15.2 s = 5.4	89

[1] Maximum score on FACQ-17 = 85 (highest attachment)
[2] Maximum score on DERS-26 = 130 (greatest emotional difficulties)
[3] Maximum score on GHQ-28 = 112 (most mental health problems)
[4] Maximum score on EQ-16 = 32 (highest empathy).
For each column, N represents the total number of respondents who commenced the questionnaires, while each individual n represents the numbers of respondents who completed each questionnaire. Means and standard deviations are shown as $\overline{x}$ and s.

It can be seen from Table 3.6 above that the means for the full-scale questionnaire scores for the online respondents who disclosed an addiction were, in three of the four cases, closer to the scores for the face-to-face respondents in the rehabilitation centres (that is, those in recovery from addictions). Even allowing for the very small number of respondents in the cells for the online respondents in the Addiction group, these showed a pattern of responses indicating poorer psychological functioning, with the scores for both addiction groups suggesting lower levels of attachment, more difficulties managing emotions, and more mental health concerns. And while the GHQ scores for the face-to-face (mainly rehabilitation) group were much closer to the scores for the No Addiction group than to those of the Addiction group, the scores were still lowest (indicating fewest symptoms) for the No Addiction group.

The exception was the Empathy (EQ-16) score for the groups above. The mean EQ-16 score for those (albeit just four) online respondents who disclosed an addiction was actually slightly higher (indicating greater empathy) than the score for the online respondents who did not. There are a number of possible reasons why this mean score more closely mirrored that of the online respondents not reporting an addiction than that of the fathers in the recovery centres. One possibility is that the demographic variables were more influential than the target variables: for example, as previously indicated, respondents with no (disclosed) addictions in this study were significantly more likely to have completed secondary school and a tertiary qualification than their counterparts with addictions.

Furthermore, using a chi-square test of independence, the education levels for the online respondents were found to differ significantly from those of the face-to-face respondents ($p<.0005$) as with the Addiction and No Addiction groups discussed earlier, with online respondents more likely to identify as having a tertiary degree. And a one-way ANOVA test showed that the respondents' education level was related to their empathy scores ($p<.005$), with those reporting having achieved a university education scoring significantly higher on the EQ-16 (19.4 for Bachelor/Graduate Diploma and 20.5 for Masters/PhD) compared to those who reported their highest education level as 'School Certificate/Some Schooling' (mean EQ-16 score 14.6).

Another factor may have been what could be described as survey completion bias, akin to volunteer bias (Heiman, 2002). As the empathy quotient (EQ) was the last (and longest, at 60 questions) of the questionnaires, it is possible that those respondents who completed all four questionnaires online, compared to those who abandoned the full questionnaire before completion, were more interested in the questions, or could have even been described as 'higher-functioning' than those online respondents who did not, thus being more likely to give more 'positive' or 'healthy' responses. In fact, that is exactly what happened: the mean scores of the online respondents who completed all questionnaires, including the Empathy Quotient, were higher in attachment, and lower in

emotional and mental health difficulties than the responses of those who did not complete all questionnaires. See Table 3.7 below.

Table 3.7: Questionnaire total means for those online respondents who completed all questionnaires

Questionnaire	'No addiction' (N=45) online	n	'Addiction' (N=4) online	n
FACQ-17 (Attachment)	$\bar{x}$= 70.0 s = 6.8	45	$\bar{x}$= 70.0 s = 14.5	4
DERS-26 (Emotion Regulation)	$\bar{x}$= 53.4 s = 14.7	44	$\bar{x}$= 55.3 s = 15.5	4
GHQ-28 (Mental Health)	$\bar{x}$= 45.6 s = 8.8	45	$\bar{x}$= 52.0 s = 14.0	4
EQ-16 (Empathy)	$\bar{x}$= 20.0 s = 5.7	45	$\bar{x}$= 20.3 s = 4.9	4

Table 3.7 shows the mean questionnaire scores calculated only for those online respondents who completed all questionnaires including the EQ (the last set of questions to complete within the whole questionnaire). Comparing Tables 3.6 and 3.7, it can be seen firstly that the mean EQ-16 scores are the same in both tables since both show the results for all 49 respondents who completed that particular questionnaire. For the other three questionnaires, it can be seen that the FACQ-17 scores are higher on average for respondents both with and without addictions who completed the EQ. And for the other two surveys for which higher scores indicate lower functioning – the DERS-26 and the GHQ-28 – the mean scores in Table 3.7 show lower values, again suggesting higher functioning for those respondents who went on to complete the whole questionnaire.

Moreover, notwithstanding the EQ-16 scores for the online respondents, the results from the other three questionnaires showed sufficient evidence that the attachment, emotion regulation and general health scores for those online and face-to-face respondents

classified as having an addiction were close enough to each other to justify combining those two groups. And while this merging of the two groups may have appeared less warranted in terms of the respective men's attachment and empathy scores, this could be done without falsely increasing the chance of claiming differences between the two new groups (Addiction and No Addiction). Hence, after the merging, any significant finding in relation to these men's empathy scores would be more likely to reflect a real difference. The possible influence of method effects on the results is discussed further in this chapter in the section on path analysis.

Sample Means – Current and previous research

Further to the review of the relevant literature in Chapter 1, previous research using the DERS, GHQ, EQ and related questionnaires has generally demonstrated impaired functioning in participants identifying with addictions. For example, Fox, Axelrod, Paliwal, Sleeper & Sinha (2007) found that, after adjusting for demographic group differences, the cocaine-addicted patients in their study reported more emotional difficulties before treatment – scoring higher on the DERS – than a healthy control group. And Buckholdt et al (2015) found the DERS scores of patients in a recovery centre with substance use disorder to be higher than those of a sample of healthy undergraduate students, but lower than other patients whose substance dependence co-occurred with self-harm and/or an eating disorder.

Indeed, mental disorders have been found to be present in a large proportion of people with substance abuse issues compared to those reporting no substance abuse (Barlow, 2002; DASSA, 2008). One example was a large study of U.S. war veterans with alcohol dependence, in which it was found that 56% of that population had comorbid psychological illnesses (Kleber, Weiss & George, 2007). Studies that have specifically employed the GHQ have also shown evidence of more self-reported mental health symptoms in patients with addictions. For example, in a study of university students in Ireland, Deasy et al (2014) found a significant positive correlation between high GHQ scores (indicating more mental health symptoms) and the students' use of "escape-avoidance" behaviours (p. 5), including substance use. And in an Australian study,

Feeney, Connor, Young, Tucker & McPherson (2004) reported that pre-treatment alcohol-dependent patients obtained significantly higher scores on the GHQ than the national norms for that questionnaire.

In relation to empathy scores, two previous studies have obtained lower mean scores for participants identifying with addictions than those without addictions. As discussed in Chapter 1, McCown's (1989) study compared the levels of empathy of a sample of addicted and non-addicted participants using a questionnaire assessing empathy and impulsivity, and found the empathy levels for those with addictions to be significantly lower than the comparison group. Employing the Empathy Quotient (EQ), Martinotti et al (2009) found the mean EQ scores for abstinent alcohol-dependent patients to be lower than the average general population EQ scores in Baron-Cohen & Wheelwright's (2004) study. And Ferrari, Smeraldi, Bottero & Politi (2014) found in their study lower scores on the affective (though not the cognitive or social skills) component of the EQ for drug-addicted patients compared to a healthy control group.

There have also been studies that examined the relationship between addictions in fathers and their attachment to their children. While the FACQ instrument was of course not available to be used in previous studies, there is solid evidence, as previously discussed, that fathers' addictions typically diminish the quality of their relationships with their children. Specifically, alcoholism and other addictions in fathers have been found to lead to less involvement (Collins et al, 2003) and worse relationships with their partners and children (Waller & Swisher, 2006; Mikulincer & Shaver, 2008), as well as decreased parenting satisfaction (Watkins et al, 2009), compared to non-addicted fathers.

Results for Hypothesis 1(a)

According to the first hypothesis at the start of this chapter, the group identifying with (or being in recovery from) addictions will have lower functioning in the areas of attachment, empathy, emotion regulation and mental health. For the present study, the mean scores of the two groups, Addiction and No Addiction, were compared on each of the four questionnaire total scores. Following on from Research Question 1 and the

results of previous studies, lower (self-reported) functioning was expected of those respondents who were in rehabilitation centres or identified online that they were struggling with an addiction. Specifically, poorer emotion regulation and mental health (equating to higher DERS-26 and GHQ-28 scores) and lower levels of empathy and attachment to their children (equating to lower EQ-16 and FACQ-17 scores) were expected of respondents in the Addiction group compared to those in the No Addiction group. The results are shown in Table 3.8 below.

Table 3.8: Questionnaire total means across the Addiction and No Addiction groups (Numbers of completed questionnaires in each cell shown in brackets)

Questionnaire total	'No addiction' (n=66)	n	'Addiction' (n=103)	n
FACQ-17 (Attachment)	$\bar{x}$ = 69.0 s = 7.7	61	$\bar{x}$ = 66.1* s = 7.5	102
DERS-26 (Emotion Regulation)	$\bar{x}$ = 54.3 s = 14.4	54	$\bar{x}$ = 61.6** s = 17.0	98
GHQ-28 (Mental Health)	$\bar{x}$ = 45.7 s = 8.7	52	$\bar{x}$ = 46.6 s = 13.8	97
EQ-16 (Empathy)	$\bar{x}$ = 20.0 s = 5.7	45	$\bar{x}$ = 15.4** s = 5.5	93

*p<.05; **p<.01

Table 3.8 shows the mean questionnaire scores for both groups. All four differences were in the expected direction, with significant differences (p<.01) found between the two groups on the variables that provided measures for emotion regulation and empathy (scores higher in difficulties in emotion regulation and lower in empathy were obtained for the 'Addiction' group). The group difference in Attachment as measured by the FACQ-17 was significant at p = .02, and although using a regular Bonferroni correction (Dunn, 1961) would require this difference to achieve significance at .05 ÷ 4 = .0125, a modified Bonferroni adjustment would permit this to be described as significant (see section titled Multiple Regression for more details). The group difference for mental

health, as measured by the GHQ, failed to achieve statistical significance. Thus it can be concluded at this point that the first hypothesis has been confirmed on three of the four measures.

Certain aspects of the sample and the responding process are relevant to these group differences. On the one hand, as noted in the previous section, most of the online sample who fully completed the questionnaires gave more 'functional' responses – showing more empathy, closer attachment, better emotion regulation, and fewer mental health symptoms – than those who did not complete all of the questionnaires. On the other hand, the respondents from the rehabilitation centres were mostly recovering from their addictions, having previously undergone the detoxification process, so most could not be said to be in the midst of their addiction, thus again most likely inflating their scores towards more positive responses.

Clearly, as predicted by previous research, the fathers in this study who did not identify as having some form of addiction showed much more evidence of feeling able to constructively handle their own emotions and consider other people's emotions and perspectives. The evidence from other studies had, however, also suggested that there would be significant differences between addicted and non-addicted respondents with respect to their mental health. The lack of statistically significant findings for this variable could be due to the masking of this effect by other variables – this will be examined further in the next section – or it could be due to the measuring instruments themselves. The GHQ aims to assess recent physical and mental health symptoms (Goldberg & Williams, 1988), which may or may not be more prevalent in residents in a rehabilitation centre, depending to some extent on how well that program serves their needs.

Regarding the scores obtained by the respondents in the present study on the DERS, GHQ and EQ, it could be observed that the men in the Addiction group, in particular, demonstrated substantially impaired functioning compared with participants in previous studies, particularly in the areas of emotion regulation and empathy. When comparing

emotion regulation difficulties for social alcohol drinkers with those of abstinent alcohol-dependent participants, for example, Fox Hong & Sinha (2008) found that social drinkers showed higher DERS scores than the abstinent alcoholic patients who responded to that questionnaire five weeks after receiving detoxification for their alcohol dependence: the mean scores were 72.7 and 62.2 respectively. These scores were lower than the original 36-item DERS scores for those men identifying with addictions in the present study (suggesting better emotional control: mean DERS scores were 84.7 for those in the Addiction group), even though all the participants in the rehabilitation centres in the present study would have already undergone the detoxification process at least one month before commencing their rehabilitation programs.

Surprisingly, perhaps, the mean total DERS-36 score of those in the No addiction group in the present study was closer to the higher of the two scores in the Fox et al (2008) study – the social drinkers – and well above the mean score for the abstinent alcoholic group. This could in part be a cultural effect, as the Fox et al (2008) study was conducted in Yale, USA, rather than Australia.

In a study examining pre- and post-program DERS scores for parents (mostly mothers) in their Australian *Tuning in to Kids* parenting program, Havighurst et al (2009) administered the DERS to parents of children with emotional and/or behavioural difficulties. In that study the authors used the questionnaire to assess the level of emotional functioning for the parents before and after the program, and found that the mean of the parents' DERS scores before the program did not change significantly after the program. The score (70.6) was comparable to the mean DERS-36 score for the No Addiction group in the present study.

Havighurst et al (2009) also used another instrument employed in the present study – the GHQ-28 – to assess the level of the same group of parents' self-reported recent mental (and general) health. The parents' mean GHQ pre-program score was 19.8 (again with no post-program change), with the researchers using the alternative measuring system of 0 to 3 for each response (making a total score of 0 to 84), rather than the scoring system used in the present study (total scores ranging from 28 to 112). When scaled to the

present scoring system, their value equated to a mean GHQ score of 47.8, slightly above the mean scores – perhaps surprisingly – of the men in both groups in the present study.

In another Australian study employing the GHQ, Feeney et al (2004) investigated the subjective health status of alcohol-dependent patients, and found the GHQ scores of those participants to be higher than those reported in both the present study and the Havighurst et al (2009) study. In this case the authors used a third scoring system for the GHQ (0 or 1 per item, making a total score range from 0-28). Feeney et al (2004) found the mean full-scale GHQ score to be 7.9, which equates to 55.7 (again higher than both groups in the present study), demonstrating a relatively high number of health problems reported by that population of alcohol-dependent patients. It should be noted that while the men in the present study were mostly at least four weeks into their addiction recovery process, those in Feeney et al's (2004) sample identified as having an addiction but not necessarily receiving any treatment for it.

Concerning empathy scores, as previously discussed, the mean EQ score in Martinotti et al's (2009) sample was 40.3, higher than the 40-item version obtained by the fathers in the Addiction group in the present study (mean EQ score 35.8), but lower than those in the No Addiction group (mean 44.0). The mean EQ score in Baron-Cohen & Wheelwright's (2004) study was 41.8 for men in general, which is, as could be expected, closer to the scores for the men in the present No Addiction group. In another study assessing empathy levels, Muncer & Ling (2005) found the EQ scores for a sample of relatively young men (average age 26) to be 37.9, reflecting the results in other studies that found lower rates of empathy among younger men.

Mental Health

In relation to assessment of mental health in the present study, although no significant difference was found between the GHQ scores for respondents in the Addiction and No Addiction groups, the prior research suggested a positive relationship between the presence of addiction and mental health symptoms. Therefore, more specific measures of mental health symptoms within the GHQ were considered by examining the four

subscales. Table 3.9 below shows the mean scores for the four subscales on the GHQ across the Addiction and No Addiction groups.

Table 3.9: GHQ subscale means across Addiction and No Addiction groups

Group Subscale	Addiction	No Addiction
Anxiety/Insomnia	$\bar{x}$ = 12.42 s = 4.63	$\bar{x}$ = 12.21 s = 4.45
Somatic Complaints	$\bar{x}$ = 11.32 s = 3.79	$\bar{x}$ = 12.02 s = 3.45
Severe Depression	$\bar{x}$ = 9.55 s = 3.82	$\bar{x}$ = 8.09** s = 2.20
Social Dysfunction	$\bar{x}$ = 13.26 s = 3.82	$\bar{x}$ = 13.88 s = 2.12

**p<.005

The table above shows the mean scores on each of the GHQ subscales for the Addiction and No Addiction groups. Each subscale on the GHQ-28 consists of seven questions, each on a Likert scale of 1-4, so the scores for each subscale range from 7 to 28. As can be seen from the table, three of the four differences in the group means were small (less than one unit); only the difference in the scores on the *Severe Depression* subscale achieved statistical significance. To be specific, of the seven items in the *Severe Depression* scale, only one was rated above the lowest possible score (1 on each item) on average for depressive symptoms by respondents in the No Addiction group (scoring a mean of around 8 instead of the minimum 7), compared to two to three of the seven items for the Addiction group.

Thus it can be concluded that there are likely to be differences in the prevalence of depressive symptoms between the two groups of fathers. This is to be expected, as there has been consistent evidence that people with various forms of addiction have higher rates of depression than the general population in Australia and other countries. For example, one study found the rates of depression in U.S. research participants who abused drugs to be three times the rate in society in general (Seligman & Reichenberg,

2007), and in a meta-analysis of research on the relationship between cannabis use and depression, Lev-Ran et al (2014) found cannabis users to be 1.17-1.62 times (or on average about 40%) more likely to develop depressive symptoms than the general population.

Studies relating alcohol abuse to depression show a similar pattern, even allowing for the fact that depression in both drug and alcohol-addicted patients may either precede or follow substance dependence (Foulds, Adamson, Boden, Williman, & Mulder 2015). For example, Currie et al (2005) found in their Canadian sample the 12-month prevalence of depression to be as high as 23% for patients diagnosed with substance abuse disorder. Regarding behavioural addictions, Hodgins, Peden & Cassidy (2005) found in their Dutch sample of pathological gamblers the prevalence of comorbid mood disorders – mostly depression – to be as high as 61%. By comparison, the general Australian rates of depression have been found to be close to 5% over a 12-month period (ABS, 2008), with lifetime prevalence estimates up to 25% in both Australia and The Netherlands (Kruijshaar et al, 2005).

Attachment

In relation to possible differences in attachment between the two groups, it should be acknowledged that the evidence presented previously connected addictions in fathers to poor relationships with their families. However, the assessment of the quality of relationships is not limited to the scores on attachment questionnaires; it generally includes information from both parties, and in the case of parents and children, also data on outcomes for the children.

Nevertheless, it was not the primary purpose of this research to examine these effects, as important as they are; rather, the fathers' perspectives were the main focus of this study. As such, since this research is in large part about 'empathic connection' – the combination of empathy and attachment in fathers – it was decided to examine the relationships between the respondents' empathy scores on the EQ-16 and the various revised subscales of the FACQ-17. As previously indicated, the concept of adult

attachment is generally restricted to the perspective of the respondent, whereas empathy questionnaires also aim to assess their capacity to consider another person's perspective. Therefore, correlations between the FACQ-17 subscales and the EQ-16 were calculated, as shown in Table 3.10 below.

Table 3.10: Correlations between EQ-16 full scale and FACQ-17 subscales across Addiction and No Addiction groups

FACQ-17 subscale	Correlation with EQ-16 Full scale
Mutual Trust	.32***
Conflict	.20*
Pleasure in Relationship	.29***
Anxiety about Relationship	.33***

*p<.05; ***p<.0005

Table 3.10 shows the correlations between each of the FACQ-17 subscale and EQ-16 scores. It can be seen that the men's scores on the *Mutual Trust, Pleasure in Relationship,* and *Anxiety about Relationship* subscales showed moderately high correlations, each between .29 and .33, with their empathy scores. However, since the *Pleasure in Relationship* subscale had the most items (7) it was expected that the individual items on that scale would be less likely to be related to the empathy scores than those on the shorter *Anxiety about Relationship* and *Mutual Trust* (three items each) subscales.

This turned out to be the case, as all six items on the *Anxiety about Relationship* and *Mutual Trust* subscales were found to be related to the respondents' EQ-16 scores at p<.01, compared to only four of the seven items on the *Pleasure in Relationship* subscale. Therefore, the first two subscales were considered as the best proxy measures for the quality of the fathers' relationships with their children. Fathers who scored high on empathy in the present study, then, were more likely to report more trust and less anxiety about their relationships with their children, as well as being more likely to indicate that they felt competent as parents than those who scored low on the EQ-16.

The means on each of the subscales were then calculated across the Addiction and No Addiction groups to test whether there was evidence that addiction had an independent effect on any of these measures of the respondents' attachment to their children. From Table 3.11 below it can be seen that the Addiction and No Addiction groups differed significantly only on the *Anxiety about Relationship* subscale. Noting that higher scores indicate greater feelings of attachment from the fathers, it can be deduced that the fathers who identified as having addictions were more likely to express anxiety about their relationships with their children than fathers in the No Addiction group.

However, paradoxically, the fathers in the Addiction group displayed slightly higher attachment scores than the other fathers in relation to conflict with, and trust in, their children. This may have been associated with contextual effects as discussed previously. Specifically, the fathers in the rehabilitation centres may have been less inclined to disclose conflict with their children than the online respondents for fear that they may have been further prevented from seeing their children if those responses were made available to the clinical staff, despite the assurance that this would not be done.

Table 3.11: FACQ-17 subscale means across the Addiction and No Addiction groups

FACQ-17 subscale	Addiction	No Addiction
Mutual Trust	$\bar{x}$ = 11.12 s = 1.93	$\bar{x}$ = 10.79 s = 2.47
Conflict	$\bar{x}$ = 15.99 s = 2.84	$\bar{x}$ = 15.66 s = 3.07
Pleasure in Relationship	$\bar{x}$ = 31.12 s = 3.83	$\bar{x}$ = 31.90 s = 3.08
Anxiety about Relationship	$\bar{x}$ = 7.91 s = 2.61	$\bar{x}$ = 10.52*** s = 2.55

***p<.0005

The information in Table 3.11 confirms that respondents identifying with an addiction were more likely to endorse the items on the FACQ-17 that aimed to assess their level of anxiety about their relationships with their children, scoring lower on attachment than those without addictions. Therefore, from Tables 3.08, 3.09 and 3.11, it can be seen that, for the present sample of fathers, respondents identifying as having addictions showed evidence of significantly poorer functioning compared to those without addictions in each of the areas of empathy (full-scale EQ-16 scores) and emotion regulation (full-scale DERS-26 scores), one aspect of mental health (*Severe Depression* subscale on the GHQ), and one aspect of attachment in particular (*Anxiety about Relationship* subscale on the FACQ-17). However, the *Anxiety about Relationship* subscale was not used in place of the full-scale FACQ-17 in ensuing analyses, since it contained only three items, and it presented too narrow a focus for the purposes of the present study, as that subscale examined just one component of attachment.

Correlations between variables

Relationships among the variables were calculated in order to determine the best predictors for this sample of the fathers' attachment to their children (FACQ-17 scores) by ultimately carrying out multiple regressions on the variables of interest. Correlations were first calculated between each pair of variables in order to test the strength, precision and direction of these relationships, and also to test for any possible multicollinearity, which can compromise the validity of any findings from multiple regression analyses (Zainodin & Yap, 2013).

In the correlation matrix in Table 3.12, the categorical variables corresponding to the men's addiction group (ADDICTION), marital status (MSTAT), education level (EDUC) and occupation level (OCCUP) were defined dichotomously in order to be treated numerically in the correlations and subsequent multiple regressions. The demographic variables were coded (as described in Chapter 2) and defined as follows:

- Father's age group (AGE): 1-6
- Target child's age group (CHAGE): 0-4

- Number of children (NUMCH): 1-3
- MSTAT: 1 (married or cohabiting) or 0 (otherwise)
- EDUC: 1 (completed secondary or tertiary education) or 0 (otherwise)
- OCCUP: 1 (currently in a paid occupation) or 0 (otherwise)
- ADDICTION group: 1 (in rehabilitation centre or answered yes to substance or behavioural addictions online question) or 0 (no addiction indicated).

The three variables MSTAT, EDUC and OCCUP were first tested prior to recoding into dichotomous variables for differences in means across their various levels on the dependent variable measuring attachment. The three Analysis of Variance (ANOVA) tests found no significant effect on FACQ-17 scores (see Appendix F), thus permitting the recoding as indicated. In addition to the seven variables above, the target variables DERS-26 (Emotion regulation score, ranging from 26-130) and EQ-16 (Empathy score, ranging from 0-32) were tested for their relationships with FACQ-17 (Attachment score, ranging from 17-85).

However, the GHQ-28 score was not used. Instead, it was decided that, since GHQ-28 had a relatively weak relationship with FACQ-17, a more specific measure of mental health should be determined, having considered the correlations between the GHQ-28 subscale scores and the FACQ-17 scores. When these correlations were computed, it was found that the GHQ subscale with the strongest relationship to FACQ-17 scores, as was the case for the relationship with the addiction variable described in the previous section, was the *Severe Depression* subscale, with a correlation of $r = -.367$ ($p<.0005$).

The negative relationship between depression in fathers and their relationships with their children has been very firmly established in relation to the degree of father-child conflict (Kane & Garber, 2004; Giallo et al, 2014), the quality of the fathers' parenting (Price-Robertson, 2015), and the strength of their attachment to their infant children (Fletcher, 2008; Madsen, 2009; Rholes et al, 2011; Condon. Corkindale, Boyce & Gamble, 2013), thus lending weight to the decision to explore the relationship between these two variables in the present study. Therefore, the variable DEP (*Severe Depression* score on GHQ, ranging from 7-28), rather than the full-scale GHQ score, was entered into the

equation in addition to ADDICTION as a measure of the fathers' mental health that may impact their attachment to their children.

The correlations below show that only the three target variables – DEP (Severe Depression), DERS-26 and EQ-16 – correlated significantly at $p<.01$ with the fathers' attachment (FACQ-17) scores. The relationships between attachment security and both emotion regulation (Schore, 2003; Thompson, 2008) and empathy (Gelb, 2002; Schore, 2003; Weinfield et al, 2008) for children and adolescents have been previously established, suggesting that these variables were closely related for those samples of young people. The correlation coefficients obtained in the present study demonstrated that these variables may also be associated for fathers' relationships with their children. No correlations exceeded .80 – the highest was the correlation between the fathers' age group and their target child's age at .719 – so it was considered that multicollinearity was unlikely to be present (Lewis-Beck, 1980).

Table 3.12: Correlations among independent variables, and bivariate correlations with dependent variable Attachment (FACQ-17)

Variable	Father's age group	MSTAT	EDUC	OCCUP	Child's age	Number of children	ADDICT group	DEP	DERS-26	FACQ-17
Father's age group					.					-.044
MSTAT	.044									.113
EDUC	.154*	**.269****								.027
OCCUP	.144	.173*	**.238****							.133
Child's age group	**719****	-.135	.032	.038						-.044
Number of children	**.230****	.070	-.057	.047	**.216****					-.102
ADDICTION group	-.044	**-.486****	**-.490****	-.189*	.118	.148*				-.186*
DEPRESSION (DEP)	-.005	-.125	-.012	-.027	-.044	.134	.200*			**-.367****
DERS-26	-.033	-.119	-.127	-.109	-.057	.141	**.220****	**.609****		**-.470****
EQ-16	.024	.153	**.291****	.193*	.040	**.243****	**-.357****	**-.318****	**-.571****	**.440****

*p<.05; **p<.01

Predictors of Fathers' Attachment: Multiple Regression

General principles

In order to determine the most influential factors on these fathers' attachment to their children, a multiple linear regression was planned for the analysis of the effects of the three other target variables – DEP, DERS-26 and EQ-16 – and the seven demographic variables above on the attachment score FACQ-17, and subsequently on each of the three aforementioned target variables. A multiple regression analysis is useful in establishing the relative importance of a group of predictor variables in relation to an outcome variable (Lewis-Beck, 1980).

More specifically, the aim of multiple regression is to identify a model or models of one or more independent (predictor) variables that best describe a dependent (outcome) variable by including a minimum number of predictors that explain the most variance in the dependent variable, thus, like factor analysis, operating on the principle of parsimony. Various selection procedures can be used to achieve that purpose. Two common procedures are forward selection and backward elimination. Forward selection of variables involves starting with a model with no predictor variables and progressively adding variables according to the maximum increase in overall variance (R^2) explained by that model, while backward elimination starts with the full model and progressively eliminates variables based on the greatest decrease in R^2 each time (Martella, 2013). As these two methods can produce different final models, the present analysis will use both methods before selecting the most parsimonious model.

A minimum sample size is required for this form of analysis to be considered an appropriate method (Soper, 2015): in this case, the number of respondents required for a sample with an arbitrarily medium effect size of $f^2 = .15$, an acceptable power size of $P = .8$, a global probability level of $\alpha = .05$, and 10 predictors, would be 118 (Soper, 2015), so the sample size of 169 in the present study was considered sufficient to create a stable analysis.

One statistical problem arises when testing for significance of various multiple regression models using several predictors, as it is necessary to control for the 'Type I' error, which is the probability of falsely claiming that an independent variable is significantly related to the dependent variable (in this case FACQ-17). The most common method of doing this is by using Bonferroni adjustments as described previously, which require testing to be carried out at a significance level equal to the global level divided by the number of predictors (Matsunaga, 2007). Thus, at a global significance level of $\alpha = .05$, for the present analysis this method would require that each of the 10 predictors be included in a regression model only if it is significant at a level of $\alpha \div 10$, requiring a probability (p) value of $p<.005$.

However, while accepting that adjustments to the individual significance levels are necessary in order to control the 'family-wise' error rate, Matsunaga (2007) criticised the Bonferroni method for being too stringent, and suggested that a suitable method that reduces the probability of both falsely claiming a significant effect of a variable on the one hand, and of failing to find a significant effect that actually exists on the other, would be to use the less conservative "false discovery rate" (FDR: Matsunaga, 2007, p. 250), which employs a set of descending p-values that better account for the successive probabilities of making false claims of statistical significance. Using the FDR procedure, the individual p-values with k predictors would be α (least stringent), then $(k-1) \times \alpha/k$, $(k-2) \times \alpha/k$, down to α/k (most stringent). Thus, for 10 predictors using FDR at a global level of $\alpha = .05$, the individual significance values required of the predictors would range from .05, through .045, .04, etc., down to .005.

In addition, there are several assumptions generally required for valid and meaningful interpretation in linear regression. These include: independence of participants' responses; linear relationships between each of the predictors and the outcome variable; normal distributions of the error terms (residuals) from the regression equation; a linear relationship between the final regression model and the outcome variable; and homoscedasticity (constant variance) of the residuals for all values of the predictor variables in the final regression equation (Lewis-Beck, 1980). In relation to the first

assumption, the responses of the participants in this study were considered to be independent of each other as they were either given in written form by each man who participated in the rehabilitation centres without discussion with others, or they were individually entered online for those who responded remotely.

Regarding the other assumptions, the graphical relationships between each independent variable and the FACQ-17 scores can be seen in Appendix G (mean plots for dichotomous variables) and Appendix H (scatterplots for numeric variables). Tests for linear relationships between each of the predictor variables and FACQ-17 scores revealed no significant results for non-linearity, although for the non-dichotomous predictors, only the target variables (DERS-26, EQ-16 and DEP) also yielded significant results for tests of linear relationships with this dependent variable (see Appendix H). The assumptions of linearity of the final model, and of normality and homoscedasticity of the residuals (the differences between the observed and predicted attachment scores from the regression equations) were tested after fitting each equation in turn, and will be discussed in the next section.

There has been some inconsistent evidence from previous research regarding the effects of the demographic variables in the present study on fathers' attachment to their children. On the one hand, a father's changed marital status has been shown to impact his relationship with his children through separation or divorce, since living apart from the child's mother tends to compromise his ability to give consistent, effective parenting to his children (Cherlin, 2010). Carlson & McLanahan (2010) also found that the quality of the relationship between fathers and their children depended on the fathers' marital status, principally because married fathers were more likely to live with their children than other fathers. In addition, paternal attachment has been shown to be related to the combination of the amount and quality of the father's involvement with his children (Brown et al, 2007).

However, not all studies found differences between involvement levels of fathers according to their marital status. For example, Qu & Weston (2014) found: "fathers'

preferences regarding their involvement with their child did not vary significantly according to their relationship status" (p. 164). Thus, while divorced, separated and single fathers may spend less time with their children, it is often not their choice not do so, and this is therefore not necessarily reflective of decreased attachment to their children as a result of not living with the children's mother. Regarding education level and occupation status, in as much these factors determine a father's earning power and hence the comfort and stability with which his family can live, these variables can influence the quality of his relationships with both his partner and his/their children (Amato & Dorius, 2010; Furstenberg, 2011). But again, none of these studies has directly linked these demographic variables with lower (or higher) scores for fathers on attachment questionnaires.

Regression Equations predicting Fathers' Attachment (FACQ-17) scores

Hypothesis 1(b)

According to the second hypothesis, the attachment levels of the fathers in the Addiction and No Addiction groups will not only be different, but they will be associated with different predictor variables. As described in Chapter 1, this is due to the complications that addiction can bring to relationships as well as the greater prevalence of traumatic backgrounds for those with various forms of addiction, including disturbance in their own attachment patterns (Mikulincer & Shaver, 2008).

Addiction group

Nine predictor variables – EQ-16, DERS-26, DEP, AGE, CHAGE, NUMCH, MSTAT, EDUC and OCCUP – were entered into a multiple regression model for the dependent variable FACQ-17, with the value of the tenth variable, ADDICTION, set at 1 (Addiction group). Forward and backward regression models were tested, and the best two models were selected: one containing the five predictors EQ-16, AGE, DERS-26, EDUC and OCCUP, and another with the three predictors EQ-16, AGE and DERS-26. The results of these analyses are shown in Tables 3.13 and 3.14 (variables listed in decreasing order of significance). The models that were considered the best were chosen

on the basis of containing a minimum number of predictors, while maintaining the most significant t-values and as high an R^2 value as possible.

Table 3.13: Regression Summary Table for 5-predictor model of FACQ-17 (Addiction group)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	§ FDR value
(Constant)	71.978	5.148	---	13.982	.000	---
EDUC 2-point scale	-3.990	1.679	-.239*	-2.376	.020	.03
Age	-1.668	.708	-.230*	-2.356	.021	.035
Emotion Regulation (DERS-26)	-.111	.049	-.248*	-2.255	.027	.04
Empathy Quotient (EQ-16)	.335	.152	.245*	2.205	.030	.045
OCCUP 2-point scale	3.153	1.782	.181	1.769	.081	.05

*p<.05; **p<.01; § p-values required using FDR procedure; R^2 = .29; Adjusted R^2 = .25.

Table 3.14: Regression Summary Table for final 3-predictor model of FACQ-17 (Addiction group)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	74.030	5.241	---	14.124	.000	---
Emotion Regulation (DERS-26)	-.123	.050	-.275*	-2.447	.017	.04
Age	-1.609	.703	-.222*	-2.289	.025	.045
Empathy Quotient (EQ-16)	.315	.153	.231*	2.053	.043	.05

*p<.05; **p<.01 R^2 = .23; Adjusted R^2 = .20.

Tables 3.13 and 3.14 above display two regression models predicting attachment scores for the respondents in the Addiction group. For the model with five predictors in Table 3.13, the variable OCCUP failed to achieve significance at $p<.05$ using the FDR procedure (Matsanuga, 2007). Furthermore, the second model differed from the first by dropping two demographic predictors without too great a loss in explained variance. Therefore, although the other four variables in the first model produced significant t-values, this model was dropped in favour of the final model in Table 3.14. The latter model still yielded a reasonable R^2 value of .23, and dropped only 3% of total explained variance in FACQ-17 in the adjusted R^2 value (from .23 to .20 within the same model), indicating that the model in Table 3.14 was not greatly affected by excluding the two demographic variables OCCUP and EDUC. In addition, the effect sizes (β-values) in this model all exceeded .15, which has previously been described as medium (Soper, 2015). The final regression equation chosen for respondents in the Addiction group was therefore:

$$\hat{Y}_{(ADD=1)} = 74.030 - .275\,X_1 - .222\,X_2 + .231\,X_3$$

where $\hat{Y}_{(ADD=1)}$ is the predicted FACQ-17 score for respondents in the Addiction group, X_1 is the respondent's DERS-26 score, X_2 is their age group, and X_3 is their EQ-16 score.

Equation 3.1: **Regression equation predicting FACQ-17 scores for fathers in the Addiction group.**

The above equation indicates that, for those respondents in the current study who were in rehabilitation centres or indicated online that they were recovering from an addiction, attachment scores were positively associated with higher empathy scores, and negatively associated with both higher emotion regulation scores and increasing age. Specifically, when emotion regulation scores and age are held constant, a one-unit increase in attachment (FACQ-17) scores is predicted by an increase of .231 in empathy (EQ-16) scores. For fathers recovering from addictions, this result is consistent with the prediction that empathy and attachment are closely associated. Similarly, when empathy scores and age are held constant, a decrease of .275 in emotion regulation (DERS-26) scores predicts a one-unit increase in FACQ-17 scores, confirming the negative relationship between difficulties in emotion regulation and attachment for these fathers.

The appearance of AGE in the equation was not predicted in this research, however. For fathers recovering from addictions in the present study, then, it appears that increasing paternal age (holding all other variables constant) predicted decreased attachment scores. Given that the variable AGE did not predict FACQ-17 scores on its own, this may be a case of variable suppression, in which a predictor variable suppresses the error variance in the dependent variable when in the presence of certain other independent variables with which it is correlated (Ludlow & Klein, 2014).

The relationship between the fathers' age group and the FACQ-17 scores appeared to more closely represent a negative quadratic curve, especially when the six age groups were recoded into four, since the 18-24 and 65 plus age groups had very small numbers, which would create a mixed model, including an x^2 term instead of the x term for the effect of age on attachment level in Equation 3.1 above. This quadratic relationship would indicate that, after controlling for DERS-26 and EQ-16 scores, the fathers aged under 55 in this study who were recovering from addictions were more securely attached to their children than those in the highest age groups (aged 55 and over). See Figure H8.

Nevertheless, the assumptions of normality and homoscedasticity of residuals for Equation 3.1 as it stood were not seriously violated (see figures J1 and J2 in Appendix J), so the less complex linear model was adopted. In fact, in the model in Table 3.16 above (albeit not adopted here), this is the case even when the age of their children is held constant, suggesting that the decrease in attachment for the older fathers (age 55 and over) is not merely due to having older children, since the respondents were instructed to choose a target child between the ages of 2 and 12 if possible.

In the present case, for those fathers who identified as recovering from an addiction, increasing age became significant when in the presence of the variables DERS-26 and EQ-16, which means that for these men, one possible interpretation is that stronger attachment to their children is predicted by increased empathy and better emotional regulation, but tempered by the effects of ageing. However, this is a cross-sectional and not longitudinal study; therefore, an alternative interpretation may involve historical,

rather than developmental, influences. Due to increasing public awareness of the male gender roles of masculinity and emotional awareness in Australia, for instance, it is quite possible that different factors influenced perceived attachment for the younger and older men in the present study.

A better explanation still may be that, since the older fathers in this study would in most cases have been using substances such as alcohol and other drugs for longer than their younger counterparts, the cumulative cognitive and affective aspects of such substance abuse might have had a more profound effect on those fathers' capacity for attachment. Indeed, Australian research has found the effects of prolonged alcohol and drug abuse to include depression and cognitive impairment (Hunter & Lubman, 2010), both of which have an impact on people's capacity to form healthy relationships.

No Addiction group

The same nine predictor variables as those in the Addiction group were entered into regression models, this time with ADDICTION = 0. Forward and backward regression models were tested, and again two principal models were found: one containing two predictors DEP and EQ-16, and the other with just one predictor, DERS-26. The results of these analyses are shown in Tables 3.18 and 3.19.

Table 3.15: Regression Summary Table for 2-predictor model of FACQ-17 (No Addiction group)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	70.684	5.387	---	13.121	.000	---
Depression scale on GHQ	-1.086	.416	-.359*	-2.614	.013	.045
Empathy Quotient (EQ-16)	.403	.173	.320*	2.333	.025	.05

*p<.05; **p<.01 R^2 = .28; Adjusted R^2 = .24.

Table 3.16: Regression Summary Table for one-predictor model of FACQ-17 (No Addiction group)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	81.547	3.571	---	22.836	.000	---
Emotion Regulation (DERS-26)	-.219	.065	.464**	-3.358	.002	.05

*Significant at p<.05; **Significant at p<.01 R^2 = .216; Adjusted R^2 = .20.

Tables 3.15 and 3.16 above display two regression models predicting FACQ-17 scores for the respondents in the No Addiction group. For the model with two predictors in Table 3.15, the variables EQ-16 and DEP each achieved significance at p<.05, and together these variables explained 28% of the variance in the respondents' FACQ-17 scores. The model shown in Table 3.16 contained only one variable, emotion regulation, which explained just under 22% of the variance in FACQ-17 scores. Both provided fairly parsimonious models of the attachment scores again with medium effect sizes; both contained only target variables; and both explained a moderate amount of variation in these scores. Nevertheless, the equation in Table 3.15 was chosen, as it provided a fuller explanation of the variation in FACQ-17 scores. The final regression equation chosen for the No Addiction group was therefore:

$$\hat{Y}_{(ADD=0)} = 70.684 - 1.086\ X_1 + .403\ X_2$$

where $\hat{Y}_{(ADD=0)}$ is the predicted FACQ-17 score for respondents in the No Addiction group, X_1 is their DEP score, and X_2 is their EQ-16 score.

Equation 3.2: Final regression equation predicting FACQ-17 scores for fathers in the No Addiction group.

To test the accuracy of the above equation to predict the FACQ-17 scores for those fathers who reported no addiction, graphs of the residuals were plotted as before. Again, the regression assumptions underlying Equation 3.2 were not seriously violated (see figures J3 and J4 in Appendix J). The above equation indicates that, for those respondents in the current study who reported no addiction, attachment scores were predicted significantly and negatively by their depression scores, and positively by their empathy scores. Specifically, for respondents not identifying with addictions and obtaining a particular depression score, an increase of .403 in their EQ-16 scores resulted in a one-unit increase in their FACQ-17 scores. Similarly, for those with equal empathy scores, a one-unit increase in attachment (FACQ-17) scores was predicted by a decrease in 1.086 units in their depression scores.

Therefore, as predicted by Hypothesis 1(b), the model predicting the attachment scores for men in the present study who indicated that they were recovering from addictions differed from the attachment model for men who indicated no addictions. Both, as predicted, depended on their level of empathy, but while attachment scores for those fathers without addictions were predicted by their empathy and depression scores, for those with addictions their attachment scores were best predicted by their age and their emotion regulation scores in addition to their empathy scores. The result connecting impaired empathy and emotion regulation in particular with those fathers with addictions was also consistent with the prediction in RQ 1.

It may be that the attachment scores for those men with addictions in this study were more dependent on their emotion regulation scores because the latter scores were a little more variable than they were for those men who indicated no addiction: DERS-26 scores had a range of 72 in the Addiction group compared to 60 in the No Addiction group, and the respective standard deviations were 17.01 and 14.35. In any event, the results showed that depression was a greater influence on attachment in the presence of empathy for those in the No Addiction group, while emotion regulation and age became more important for those in the Addiction group.

Indeed, those without addictions were more likely to already have an empathic connection to their children, since their empathy scores were generally relatively high – see Table 3.8 – even if their emotion regulation scores were a little more varied. On the other hand, the attachment levels for those men recovering from addictions varied more on both their level of empathy and their capacity for emotion regulation, as well as apparently being more affected by their age.

Additionally, although it was not included in the final model, the single-variable equation predicting attachment from the emotion regulation scores for those fathers without addictions demonstrated that, in that model at least, their DERS-26 scores were significant and unique predictors of those men's attachment (FACQ-17) scores. Combined with the presence of emotion regulation in the equation predicting attachment scores in the Addiction group, this suggested the importance of the effect of the fathers' healthy emotional expression and emotional control on their relationships with their children, regardless of whether they were struggling with an addiction.

The finding that those men who indicated that they had difficulties regulating their emotions were also more likely to report poorer relationships with their children is supported by the results of the study by Giallo et al (2014), who found that poor emotional control by that sample of Australian fathers (including frequent yelling at their children) was associated with poorer outcomes in the children, even after controlling for the fathers' mental health.

It should also be added that, while the above models only accounted for fairly modest percentages of explained variance in the respondents' reported attachment levels to their children, with the final equations explaining between 22% and 28% of the variance in the men's FACQ-17 scores, such values are not necessarily considered low in social science research (Grace-Martin, 2008). Nevertheless, these models indicate that around three-quarters of the variation in these fathers' attachment scores is explained by factors other than the predictor variables chosen here. Clearly, from the literature reviewed so far, there are other factors not tested here that influence a father's attachment to his children. For example, much evidence has linked his attachment to his own children to

the effect of his own childhood (or adult) attachment security towards his mother (Ainsworth et al, 1978; Devault et al, 2008), his father (Anderson, 1994; Pollack, 1999; Krampe, 2003; Forste et al, 2009; Biddulph, 2010; Dick, 2011), or both (van Ijzendoorn, 1995; Fletcher, 2008; Condon et al, 2013).

In addition, a man's relationship with his wife/partner (and mother of his children) has been demonstrated to be highly influential on his involvement with and attachment towards his children (Sullivan, 2003; Geary, 2005). His relationship with his partner (if not his children's mother) has also been shown to affect his relationship with his children (Anderson, 1994; Ford et al, 2008). Other factors that have been found to influence the quality of a man's relationship with his children are his degree of ante-natal attachment (Condon et al, 2013), including participation in ante-natal fathers' groups (Fletcher et al, 2006), as well as his parenting style (Gottman, 1998; Amato & Gilbreth, 1999).

Furthermore, some of the men in the rehabilitation centres required the questions on the questionnaires to be read to them, and it is possible that there were others who did not fully understand the questions but did not admit this. Finally, other factors were also likely to be at play, including issues concerning access to their children for a number of the men in the Addiction group, particularly some of the residents of the rehabilitation centres. This will be explored further in the next three chapters. More details concerning the possible causes of the fathers' varying levels of attachment to their children will now be considered.

Factors underlying fathers' attachment to their children

Path analysis of effects of target variables on FACQ-17 scores

Hypothesis 1(c)

According to the third hypothesis, a path model can be developed that accounts for the factors underlying the attachment levels for the fathers in this study, even though the multiple regression models predicting attachment levels for the Addiction and No Addiction groups were different from each other. As previously discussed, the data

collection process for this phase of the study occurred through two modes: face-to-face in rehabilitation centres, and online. Thus, since the vast majority of the online respondents reported no addiction, the two groups differed fundamentally in terms of the data collection method as well as the reported presence of addiction. Therefore, do the different regression models essentially suggest different predictors according to the presence or absence of addiction, or do they instead reflect a different interpretation of the questions according to mode of responding and hence perhaps a different factor structure for the questionnaires? And related to this last question: can it be assumed that the factor structures for each of the revised questionnaires (FACQ-17, DERS-26 and EQ-16) are the same regardless of the format of the questionnaire (paper or online)?

Measurement Invariance

The above two questions can effectively be answered by testing for measurement invariance between the two groups. According to Milfont & Fischer (2010), there are three essential steps involved in testing for invariance between two (or more) groups. These involve testing for configural invariance, followed by metric invariance, and then scalar invariance. These three tests, which are run as separate CFAs, respectively compare the factor structure, the factor loadings, and the item intercepts across the groups (Milfont & Fischer, 2010). If the groups are found to be invariant on each of those three dimensions then it makes sense to combine them in further tests, including path analysis.

Configural invariance is tested by "constraining the factorial structure to be the same across groups" (Milfont & Fischer, 2010, p. 115). For the present study, this means running the CFA that determined the factor structure previously for each of the questionnaires (FACQ, EQ and DERS), but this time testing across the two groups (face-to-face and online). Metric invariance is tested by constraining the factor loadings to be equal; this means placing a '1' on each of the latent variables in the structural model in AMOS (IBM SPSS AMOS 23, 2015). The results are then confirmed by conducting a chi-square difference test (Byrne, 2001). Scalar invariance is tested by making the intercepts of the variable items to be equal across the groups (Milfont & Fischer, 2010).

However, for the present study it does not make sense to constrain the item intercepts and hence their means to be equal, since the mode-of-responding groups are closely aligned with the groups based on addiction. Therefore, scalar invariance will not be required across groups in order to meaningfully combine them in the analysis.

The three statistics most commonly used for these tests of invariance are the RMSEA and CFI statistics used previously, as well as the chi-square (χ^2) goodness-of-fit statistic (Byrne, 2001). Cut-scores have previously been articulated for the RMSEA and CFI statistics. A good model fit using the chi-square statistic has generally been accepted as $\chi^2/df \leq 3$ (where *df* denotes degrees of freedom), accompanied by a non-significant p-value (Milfont & Fischer, 2010). The face-to-face and online groups were split, and each test was performed across the two modal groups to assess the goodness-of-fit of each constrained model in turn. The invariance tests were both carried out for the FACQ-17, EQ-16 and DERS-26, as these three questionnaire scores would also be used as dependent variables in the ensuing path analysis. The tables showing the results of these tests can be found in Appendix L.

Invariance of FACQ-17 across modal groups

The factorial structure of the FACQ-17 was first tested for configural invariance. The results, given in Table L1, show that the 17-item, 4-factor model generally provided an acceptable fit across the two groups, with $\chi^2/226 = 1.54$ (< 3) and RMSEA = .057 (< .06) showing good fits, while the CFI value of .882 showed a mediocre fit. Metric invariance was then tested by initially employing a new CFA, which constrained the four existing factors to be the same across the two groups, giving the results $\chi^2/243 = 1.52$, RMSEA = .056 and CFI = .877, likewise showing an acceptable fit, taking the three statistics into account. On conducting a chi-square difference test involving the two ratios of chi-square values to their respective degrees of freedom the result was shown to be non-significant, confirming metric invariance across the two groups for the FACQ-17 model structure (see Table L2).

Invariance of EQ-16 across modal groups

The model structure of the EQ-16 was then tested, first for configural invariance. The results, shown in Table L3, demonstrate that the 16-item, 4-factor model generally provided a fairly good fit across the two groups, with $\chi^2/226 = 1.27$ (< 3) and RMSEA = .040 (< .06) showing good fits, while the CFI value of .905 this time showed an acceptable fit. For metric invariance, as with the FACQ-17, once again the four factors were constrained to be equal across the groups instead of one variable per factor. The results were as follows: $\chi^2/212 = 1.36$ (< 3), RMSEA = .047, and CFI = .862. The first two statistics suggested a good fit, so a chi-square difference test was conducted. Once again, this test produced a non-significant result, so metric invariance was confirmed across the groups for the EQ-16.

Invariance of DERS-26 across modal groups

The DERS-26 was then tested, first for configural invariance. The results, shown in Table L5, demonstrated that the 26-item, 5-factor model generally provided an adequate fit across the two groups, with a good value of $\chi^2/578 = 1.72$ (< 3) and an acceptable value of RMSEA = .066 (< .08), although the CFI value of .836 this time was quite weak. Nevertheless, the first two values provided enough evidence to accept configural invariance. For metric invariance, as for the above two models, the five factors were constrained to be equal across the groups, giving the following results: $\chi^2/604 = 1.72$ (< 3), RMSEA = .066 (< .08), and CFI = .828. Again, although the latter value was quite weak, the first two values provided sufficient grounds for conducting a chi-square difference test for metric invariance. On conducting this test, the result was shown to be non-significant, confirming metric invariance across the two groups for the DERS-26 model structure (See Table L6).

Path Analysis

Given that each of the three questionnaires (FACQ-17, EQ-16 and DERS-26) satisfied invariance across the groups it could be concluded that the mode of responding did not significantly affect either the factor structure of these instruments or, therefore, the different groups' interpretations of the questions. Hence Hypothesis 1(c) was confirmed, and it was thus considered reasonable to combine the groups for path analysis.

Like Confirmatory Factor Analysis (CFA), path analysis is a form of Structural Equation Modelling (SEM), in which models can be developed that attempt to examine the influence of certain underlying variables on other variables. In the present study, the variables of interest for fathers in this study were attachment, empathy, emotion regulation, addiction and mental health. Notwithstanding the evidence for the influence of other factors on fathers' attachment to their children, including the father's age group for those identifying with addictions outlined in the previous section, the present analysis will restrict itself to the above five target variables.

As with the regression models in the previous section, the measure that will be chosen to represent the fathers' mental health in this analysis is the *Severe Depression* subscale on the GHQ, since it correlates more highly with each of the other factors than does the full-scale GHQ score, and it provides a more specific, evidence-based predictor for the other variables. A comparison of the bivariate correlations is shown in Table 3.17. The other relevant correlations can be found in Table 3.12.

Table 3.17: Correlations between two measures of mental health (GHQ full scale and Severe Depression (DEP) subscale) and the other target variables

Variable	GHQ-28 Full scale	DEP Subscale
ADDICTION	.035	.203*
FACQ-17	-.261**	-.367**
DERS-26	.483**	.612**
EQ-16	-.183*	-.317**

*p<.05; **p<.01

Multiple regression equations were conducted on the four variables FACQ-17, EQ-16, DERS-26 and DEP. The ADDICTION variable was a grouping variable for this study and was hence assumed to be an independent (or exogenous) variable in each of the models. Conversely, since attachment (FACQ-17 scores) is the ultimate variable of interest, it was only used as the dependent (or endogenous) variable in these models.

Also, since path analysis assumes unidirectional relationships (Streiner, 2005), not all models were considered.

Predictors of Attachment (FACQ-17 scores)

When the four variables ADDICTION, DEP, DERS-26 and EQ-16 were entered into the regression equation, two models were generated. The first one, using backward regression, identified three predictor variables: EQ-16, DERS-26 and DEP. This model is shown in Table 3.18 below. A forward regression was also carried out, which generated a model containing two predictors, EQ-16 and DERS-26 – see Table 3.19 below. This was used as the final model to predict FACQ-17 scores since both of its t-values were significant using the FDR cut-scores.

As indicated in the previous section, research has consistently shown that a father's capacity for empathy and emotion regulation impact the quality of his relationships with his children. Note that this equation was designed differently from those in the last section, since in this case all the responses of the fathers in the Addiction and No addiction groups were included in the analysis. For this analysis, the FDR values required for the four individual predictor variables to attain significance were .05, .0375, .025 and .0125. Table 3.19 shows that these two variables together provide a reasonably good model for the prediction of FACQ-17 scores.

Table 3.18: Regression Summary Table for 3-predictor path model for Attachment (FACQ-17 scores)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	70.090	3.904	---	17.860	.000	---
Empathy Quotient	.335	.114	.267**	2.926	.004	.025
Depression scale on GHQ	-.378	.203	-.176	-1.857	.065	.0375
Emotion Regulation Scale	-.082	.049	-.183	-1.677	.096	.05

*p<.05; **p<.01 R^2 = .26; Adjusted R^2 = .24.

Table 3.19: Regression Summary Table for 2-predictor path model for Attachment (FACQ-17 scores)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	69.719	3.904	---	17.860	.000	---
Emotion Regulation Scale	-.132	.041	-.293**	-3.191	.002	.0375
Empathy Quotient	.326	.115	.260**	2.829	.005	.05

*p<.05; **p<.01 R^2 = .24; Adjusted R^2 = .23.

Predictors of Empathy (EQ-16 scores)

To assess the best predictors of empathy scores (EQ-16) in this study, the three variables ADDICTION, DEP and DERS-26 were entered into the regression equation. Forward and backward regression was again carried out; this time both methods produced the same model, shown in Table 3:20 below. This model contained both DERS-26 and ADDICTION, which accounted for 37% of the variance in EQ-16 scores, indicating a fairly strong model. Not only does this model explain a reasonable amount of variance in EQ-16 scores, but it also has good theoretical support, as previous research has shown that empathy is negatively predicted by substance abuse or other addictions (McCown, 1990; Giancola, 2003; Martinotti et al, 2009) and difficulties in emotion regulation (Michalska, 2009).

Table 3.20: Regression Summary Table for path model for Empathy (EQ-16 scores)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	29.566	1.530	---	18.996	.000	---
Emotion Regulation Scale	-.183	.025	-.512**	-7.223	.000	.0375
Addiction	-2.941	.893	-.234**	-3.296	.001	.05

*Significant at p<.05; **Significant at p<.01 R^2 = .37; Adjusted R^2 = .36.

Predictors of Emotion Regulation (DERS-26 scores)

In order to predict emotion regulation within this path model, only ADDICTION and DEP were entered into the regression equation, since DERS-26 was already entered into an equation predicting EQ-16, and given that emotion regulation is usually defined as being a component of empathy (Michalska, 2009; Decety, 2010), it was more consistent with the literature to include emotion regulation as a predictor of empathy rather than vice versa. Two models were again generated: one forward and one backward. This time the two-predictor model (Table 3.21) explained slightly more variance in emotion regulation scores at a little over 38% than the one-predictor model (Table 3.22) at just over 37%. However, the t-value for Addiction in the two-predictor model failed to achieve significance, and so it was dropped in favour of the final model in Table 3.22. A number of studies have demonstrated the relationship between a person's capacity for emotion regulation and their mental health (eg Ford & Russo, 2006; Roemer et al, 2009), including depression. Moreover, Melrose (2010) found that depression has been found to often underlie emotional disorders specifically in fathers.

Table 3.21: Regression Summary Table for two-predictor path model for Emotion Regulation (DERS-26 scores)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	30.941	3.148	---	9.830	.000	---
Depression Scale on GHQ	2.839	.317	.592**	8.945	.000	.0375
Addiction	3.378	2.287	.098	1.478	.142	.05

*Significant at p<.05; **Significant at p<.01 R^2 = .384; Adjusted R^2 = .375.

Table 3.22: Regression Summary Table for final path model for Emotion Regulation (DERS-26 scores)

Model Predictor	Coefficient B	Standard Error	Standardised B value (β)	t-value	p-value	FDR value
(Constant)	32.275	3.027	---	10.661	.000	---
Depression Scale on GHQ	2.935	.312	.612**	9.410	.000	.0375

*Significant at p<.05; **Significant at p<.01 R^2 = .374; Adjusted R^2 = .37.

The required assumptions of normality and homoscedasticity of residuals of the final models – represented by equations shown in Tables 3.19, 3.20 and 3.22 (Attachment, Empathy and Emotion Regulation respectively) – were tested, and did not show evidence of major violations. The relevant graphs can be found in Appendix J (graphs J5-J10).

Predictors of Severe Depression (DEP scores)

For the model predicting depression (DEP), only one variable was entered into the equation: Addiction. This is because the direction of influence had already been determined for the Emotion Regulation variable (DERS-26) as the dependent variable from DEP, as explained above. In addition, the Empathy variable (EQ-16) could not be entered into the equation, since path models cannot include a path that runs through any variable more than once (Shipley, 2002). When ADDICTION was entered into the regression equation predicting DEP, there was a small but statistically significant effect. However, the R^2 value was only 4%, so while it is reasonable to indicate that these two variables were correlated ($r = .203$, $p < .05$), it is misleading to identify ADDICTION as a major influence on DEP scores for the fathers in this study. Therefore the relationship between these two variables is shown with a curved line, indicating that they are correlated, but no regression weighting is shown (see Figure 3.1).

Path model

A path model was thus developed to illustrate a pathway of psychological factors from addiction or depression to attachment for the fathers in this study. The model, with arrows indicating the direction of influence, is shown in Figure 3.1. Standardised beta (β) coefficients are also shown to indicate the strength and nature (positive or negative) of each bivariate relationship. The diagram shows that there are three pathways predicting impaired self-reported attachment by fathers in this sample to their children: one for those recovering from addictions, and two for those reporting recent symptoms of depression. Firstly, fathers in recovery from addictions were more likely to score lower on empathy, and consequently their attachment levels tended to be lower than those of other fathers. Alternatively, those fathers who obtained relatively high scores on the *Severe Depression* subscale of the GHQ, regardless of whether they had an addiction were, as expected, more likely to report emotional difficulties, and hence more likely to show evidence of lower levels of attachment to their children, either through reduced empathy (second pathway) or directly through the influence of impaired emotional control (third pathway) on their attachment to their children.

Thus, lower levels of attachment were predicted by the presence of either depression or addiction, and mediated by poor emotional control and lower levels of empathy. Conversely, for those fathers who were recovering from depression or an addiction, their attachment score, and by implication, their relationship with their child, may still have been strong, provided that they could regulate their emotions and/or they had a baseline level of empathy.

Figure 3.1 below shows the pathway from the fathers' depression or addiction through to their attachment to their children. This model provides an outline of the factors that contributed to the fathers' assessment of their attachment to their children according to the results in the present study. The strength of prediction from depression in particular to emotion regulation and in turn to empathy is relatively high. The separate models showed that empathy predicted attachment quite strongly for the fathers with addictions, but not so much for the other fathers. The addiction variable showed a weaker

relationship with empathy in this model, which is to be expected, as it was a grouping variable rather than explicitly tested through a previously validated battery of responses, as was the case for the variables that measured depression, emotion regulation and empathy. It should also be added that, due to the nature, size and design of the sample – it was cross-sectional and not longitudinal – claims of causation cannot be sustained in this study.

This model aims to offer a preliminary explanation for some of the psychological variables that provided the foundations of secure attachment from the fathers in this study to their children, from the fathers' perspectives. Given the variability in the strength of these relationships shown in the model, from the results of the multiple regression models described previously, and indeed from the existing literature, the model is incomplete from a developmental perspective, and indeed the two groups are demographically different, as described earlier. However, the evidence has suggested that these variables generally did not significantly influence the fathers' attachment levels; moreover, the model showed evidence of closely fitting the given data, with fit indices – NFI = .975, CFI = .996 and RMSEA = .034 – all within the range of a close-fitting model as described in the previous section.

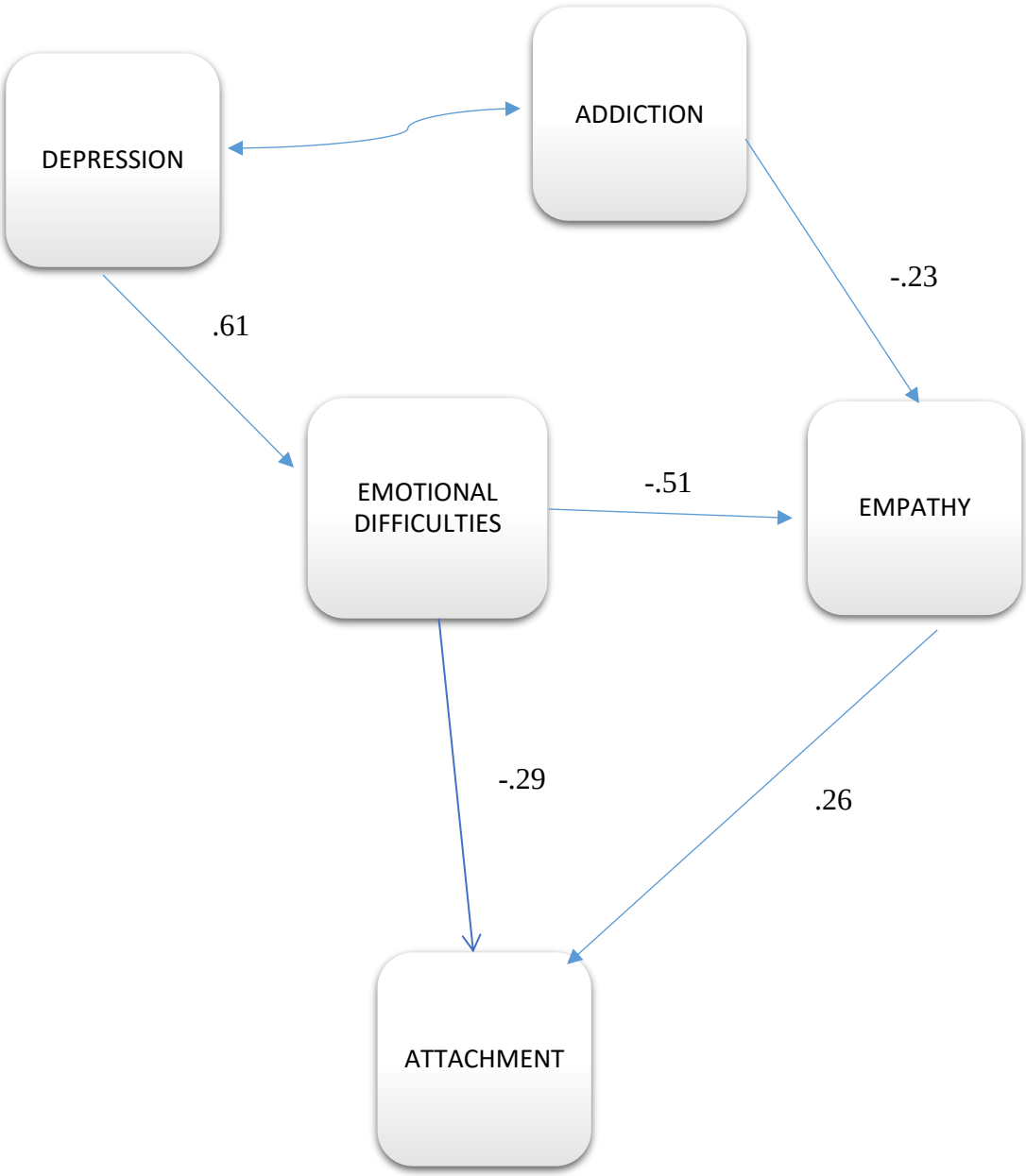

Figure 3.1: Path model for fathers' attachment to their children (FACQ-17 scores) for the present study, showing standardised β coefficients (-1< β<1)

Item analysis of group differences (Addiction versus No addiction)

One further purpose of assessing fathers with and without addictions in phase 1 was to examine where some of the significant differences occurred between the Addiction and No Addiction groups, so that these different areas of functioning could be targeted in the parenting program where possible. Differences (or contrasts) in mean scores between the groups on each of the 138 items on the four original questionnaires (FACQ, DERS, GHQ & EQ, excluding the 20 'filler' items on the EQ) were obtained using independent samples t-tests. Differences on most items were in the expected direction (lower scores for Addiction group on FACQ and EQ, and higher scores on DERS and GHQ).

Starting with a nominal significance level of .05, since there were 138 items – and hence 138 contrasts – it was considered that only those items that differed at a probability level of .05 ÷138 = .00036 (thus $p<.0005$) should be highlighted. These differences were identified before the design of the parenting program was finalised. At that stage of the research, responses to the questionnaires had been received from 120 fathers. Integration of these results into the modification of the *Tuning in to Kids* parenting program is discussed in Chapter 5.

The results of the t-tests revealed nine items (four from the FACQ, two from the DERS, two from the GHQ, and one from the EQ) that distinguished significantly between the Addiction and No Addiction groups. Table 3.23 below shows that the most significant difference occurred on the FACQ item 'I am concerned that I do not spend enough quality time with my child', with a relatively large group difference of 1.16 on a scale of 1-5. This could indicate that those respondents in the Addiction group in particular had concerns that the time that they spent with their children was not sufficiently meaningful or enjoyable; it may also indicate that many of the men in this group were more likely to have limited access to their children as they were in residential rehabilitation programs. Indeed, the three items that subsequently became the *Anxiety about Relationship* subscale of the revised FACQ-17 instrument each showed significant effects on the ADDICTION variable, underlining the previous results.

Table 3.23: Questionnaire items that distinguished between the Addiction and No addiction groups at p<.0005

Item and Scale	Subscale	Addiction Group	No Addiction Group
I don't get much attention or credit from my child (FACQ)	Trust/Avoidance (a)	$\bar{x}$ = 3.56 s = 1.11	$\bar{x}$ = 4.22 s = 0.79
I am concerned that I do not spend enough quality time with my child (FACQ)	Anxiety about Relationship (b)	$\bar{x}$ = 1.92 s = 0.92	$\bar{x}$ = 3.08 s = 1.09
I often worry that I will lose my child's admiration (FACQ)	Anxiety about Relationship	$\bar{x}$ = 2.82 s = 1.20	$\bar{x}$ = 3.59 s = 1.17
It hurts me that my child may be closer to other family members than to me (FACQ)	Anxiety about Relationship	$\bar{x}$ = 3.19 s = 1.24	$\bar{x}$ = 4.00 s = 0.88
I find it hard to know what to do in a social situation (EQ)	Social Discomfort (c)	$\bar{x}$ = 0.69 s = 0.77	$\bar{x}$ = 1.29 s = 0.86
I have difficulty making sense of my feelings (DERS)	Emotional Confusion (d) (e)	$\bar{x}$ = 2.09 s = 1.06	$\bar{x}$ = 1.53 s = 0.74
I am confused about how I feel (DERS)	Emotional Confusion	$\bar{x}$ = 1.99 s = 0.91	$\bar{x}$ = 1.50 s = 0.74
Have you found at times you couldn't do anything because your nerves were too bad? (GHQ)	Severe Depression	$\bar{x}$ = 1.34 s = 0.58	$\bar{x}$ = 1.03 s = 0.17
Have you found that the idea of taking your own life kept coming into your mind? (GHQ)	Severe Depression	$\bar{x}$ = 1.45 s = 0.85	$\bar{x}$ = 1.06 s = 0.24

(a) These items were from the original instruments (Table 3.1), but not part of the revised questionnaires
(b) Following the factor analysis (Table 3.2) this was the name given to the new subscale in the FACQ-17
(c) Following the factor analysis (Table 3.3) this was the name given to the new subscale in the EQ-16
(d) Following the factor analysis (Table 3.4) this was the name given to the new subscale in the DERS-26
(e) The differences between the two groups on the two items from the DERS were significant only at p<.005 (n=120), although these differences increased throughout the program such that, for the full sample of 169 participants, they became significant at p<.0005.

As indicated in Table 3.23, the two items from the DERS, unlike those listed from the other scales, did not distinguish at the level p<.0005 based on the responses from the first 120 participants. However, due to the importance of the capacity for emotion

regulation found in the path analysis above, it was deemed appropriate to include these items in considering the adjustments that may have been needed to the standard parenting program for this particular group of fathers.

Summary of Findings (Phase 1)

The purpose of this chapter was to respond to the first research question (RQ 1) concerning fathers in recovery from addictions and their relationships with their children. This question related to the full sample of 169 fathers (with or without addictions) who completed questionnaires without any parenting intervention, and consisted of three hypotheses. The results of these hypotheses are summarised in Table 3.24 below.

Table 3.24: Summary of results for Hypotheses 1(a), (b), (c) of RQ 1

Hypothesis	Details of Hypotheses	Results of Hypotheses
1(a)	Addiction group to have lower scores for attachment (FACQ-17) and empathy (EQ-16), and higher scores for emotion regulation (DERS-26) and mental health (GHQ-28)	EQ-16 and FACQ-17 scores were lower and DERS-26 higher ($p<.01$) for addiction group, but GHQ-28 difference was non-significant. However, significant differences ($p<.01$) were found between groups on *Anxiety about Relationship* subscale of FACQ-17 (Addiction group lower in attachment) and *Severe Depression* subscale of GHQ-28 (Addiction group higher in depression)
1(b)	Attachment for fathers with addictions predicted by different factors compared to those without addictions	FACQ-17 scores for fathers in Addiction group were predicted by empathy, emotion regulation and age; for those in No Addiction group FACQ-17 scores were predicted by empathy and depression – see Equations 3.1 & 3.2
1(c)	Path model could be developed to represent the predictors of attachment for the whole group	Invariance established across groups, so path model was developed, in which fathers with addictions and/or depression were more likely to have lower attachment scores, mediated by empathy and emotion regulation – see Figure 3.1

The results in Table 3.24 above show that the hypotheses of RQ 1 were largely confirmed, with the addition of two caveats, or secondary results, for Hypothesis 1(a).

These secondary results involved significant differences between Addiction and No Addiction groups related to the FACQ-17 only on the *Anxiety about Relationship* subscale, and related to the GHQ-28 only on the *Severe Depression* subscale. Thus, as expected, those fathers either in recovery centres or otherwise identifying as having an addiction reported more difficulty regulating their emotions and less empathy than the other fathers in this study, as well as more recent symptoms of depression, and more anxiety about their relationships with their children. The latter two results in particular were borne out in the item analysis of the group differences as shown in Table 3.23: the fathers in rehabilitation centres or otherwise disclosing addictions indeed indicated more anxiety about their relationships with their children, as well as a greater number of recent depressive symptoms.

Hypothesis 1(b) was confirmed, as the equation predicting attachment to one's child for the fathers in the Addiction group was indeed different from the one for fathers in the No Addiction group. As expected, both of these equations exclusively involved psychological variables after controlling for the demographic variables in this study, with one exception, which was the appearance of the variable representing the father's age in the equation predicting attachment for fathers with addictions. And even allowing for these different equations, a path model was able to be created, as predicted by Hypothesis 1(c), which described the pathway (Figure 3.1) of prediction for the psychological variables in this study. These quantitative effects will be further illuminated in the following three chapters, in which the stories of the fathers who volunteered to undertake the parenting program will be discussed.

CHAPTER 4. INTRODUCING THE CASE STUDIES: MEN'S STORIES OF FATHERHOOD AND ADDICTION

Introduction

Overview of Chapter

The purpose of this chapter is to introduce the reader to the fathers who agreed to participate in the parenting program, firstly with a thematic summary of the responses of all those who participated in the initial interviews, and secondly by examining in more detail the stories of those fathers who eventually completed the parenting program. These men's voices are reflected through both their words in the individual interviews and their questionnaire responses. This combination of spoken and written responses will form the basis of a mixed-method multiple case study analysis, which commences in this chapter and concludes in Chapter 6.

The participants in this phase of the study (phase 2) were all fathers in recovery from substance or behavioural addictions from one of two parallel residential rehabilitation centres, who volunteered to talk about their experiences of being fathers with a view to participating in the parenting program. The men's narratives in their initial interviews and early group sessions and the responses from their questionnaires will then be compared in Chapter 6 with their post-program interview narratives and their scores on each of the measures: attachment to children, empathy, emotion regulation, and mental health symptoms. As these four constructs were considered central to the fathers' experiences of being in recovery as well as the components of the parenting program, the interview questions, and hence to a large extent the men's spoken responses, were related to these constructs. Specifically, some of the themes that arose concerned trust and closeness to children; conflict with ex-partners; loss, trauma and rebellion during their upbringing; and stress and regret concerning their own behaviour. In all cases, pseudonyms are used for the names of the fathers to protect their identity.

Participation in the initial interviews

Twenty fathers in all gave their consent to participate in the second phase of the study. Sixteen men were interviewed before the start of the parenting program; two men responded to the questionnaires but did not participate any further; and two others were not present at the initial interviews but still attended the parenting program. Most (14) of

the 16 interviewees then commenced the group sessions, but for various reasons not all completed them. Only one of the men decided not to continue the parenting program once he started it; the others either left the rehabilitation program of their own free will or were asked to leave due to using substances or committing other misdemeanours on the premises. In all, six men who responded to the first questionnaires (five of whom participated in the initial interviews) did not commence the parenting program; seven men commenced but subsequently withdrew from the program; and the remaining seven completed the parenting program.

Narrative Analysis and the Fathers' Stories

Narrative Research and Stories of Recovery

As previously discussed, the interview material has been analysed using a narrative methodology. Narrative analysis has been chosen as the method of qualitative research for the present study for several reasons. Firstly, narrative research, unlike some other methods of inquiry, acknowledges the multiple influences on participants (Hunter, 2009). That includes the men's individual needs, hopes and fears; their families of origin; their social circles; their nuclear families; their children's schools; their work (for those who were employed); their church (for some); the criminal justice system (for most); and the overarching narrative of their rehabilitation program, which employed an abstinence model based on the twelve steps to recovery (Anonymous, 1939), in which they were all situated.

Secondly, the narrative approach is appropriate for describing changing stories (Hunter, 2009), and since the seven principal participants were each interviewed more than once, this type of analysis was deemed most appropriate. Indeed, narrative research has been considered very suitable for stories of transformation (Lawler, 2002), including recovery from addictions or illness (Bottorff et al, 2009; Peled, Gavriel-Fried & Katz, 2012; Frank, 2013; Dunlop & Tracy, 2013; Gilbert et al, 2014). Thirdly, one narrative study (Dunlop & Tracy, 2013) found that positive narratives of recovery from addictions predicted future changed behaviour.

Fourthly, narrative research, as part of a constructivist philosophy, assumes that people understand their lives through stories, and it eschews the notion of objective truth (Josselson, 2011): the present study relied mostly on self-report, and did not require independent measures to validate the men's stories. Fifthly, narratives, as with any stories, contain a moral component (Hunter, 2009), which is particularly relevant to this research, as it concerns men who in many cases have been mandated to undergo the rehabilitation program due to their conduct, and the program was set in the context of a religious philosophy of spiritual and moral transformation. Finally, narrative research acknowledges that one of the influences on the results of the study is that of the training, background and expectations of the researcher (Esin, 2011); this served to bring transparency to the research by acknowledging that in some cases, at least, the men may have said what they thought the researcher wanted to hear.

A thematic summary of all the initial interviews has been provided below, including quotes from the men from their initial interviews. For those who completed the parenting program (three men in the first group and four in the second group), a more detailed analysis has been given following the summary of the themes across all the pre-program interviews. The following provides a thematic analysis of the men's responses in the initial interviews. It can further be described as a thematic *narrative* analysis in as much as the themes are driven by how the men's responses and further elaborations related to the research questions rather than the grounded theory method, in which no a priori theoretical assumptions are made (Riessman, 2008), or being principally reliant on the men's use of language in their responses, as in discourse analysis (McMullen, 2011).

Although some narrative researchers have considered a focus on themes across participants within narrative analysis to be reductionist (e.g. Clandinin & Connelly, 2000), others, such as Riessman (2008), have contended that an analysis of the themes across a group can be constructively used to supplement the richer narrative analysis of individual stories. In the current chapter the thematic analysis will be followed by preliminary narrative analyses of the interview data of the seven principal participants, together with basic statistical analyses of their questionnaire data.

Thematic Analysis of Initial Interviews

The following themes surfaced in the men's responses to the initial interview questions that were asked of them (see pre-program interview questions in Appendix A). Themes were determined first by listening to the recordings of each interview and reading each transcript several times. Then, following the method of thematic analysis described by Riessman (2008), key recurring themes among the participants' stories were identified and categorised into the appropriate topics. The themes were co-constructed by each participant and the researcher, as the interview questions were semi-structured, based on the hypotheses of the researcher and the men's independent stories of fatherhood. Following this thematic analysis will be a case-based analysis of the pre-program interview and questionnaire responses from each of the seven fathers who ultimately completed the parenting program.

The second research question (RQ 2) asked: *How do fathers in recovery from addictions experience fatherhood?* To this end, each of the 16 men was asked questions that included 'What's your relationship with your kids like?' and 'What do you enjoy most about being a father?' These and the other questions (in Appendix A) sought to uncover the men's descriptions of their attachment to their children. The overwhelming responses from the men were of closeness to their children and the joy of being a father. Examples from eight of the respondents included: "Great, I love it – that's all I live for"; "It's just the best thing that's happened – it's fun, it's exciting, there's never a dull moment"; "Yeah I couldn't – wouldn't want anything else"; "I can't describe the absolute joy I get out of it"; "It was the best thing that ever happened to me, to be honest"; "I love me kids, mate, a lot"; "I love being a father"; and "It's the best thing in life really: I just love every moment with him and, yeah, just the unconditional love… I put him first in everything instead of me, but that's what I want to do anyway, so yeah, he's the main focus in my life".

The flip side of the love that these fathers expressed for their children was their regret at not being able to spend more time with them. Each man was asked "How often do you spend time with your children?" and "What do you think about the amount of time you

spend with your children?" The vast majority of the men answered that they were not satisfied with the amount of time spent with their children, particularly while they were in the rehabilitation centre, and especially if they were separated from their families. Only one man who was separated from his children's mother – Gary, who saw two of his four children fortnightly but was not seeing his older children at all around the time of the interview – said at that time that he was satisfied with the amount of time that he was able to spend with his children when he was out of the rehabilitation centre.

Some of the fathers spoke of the importance of trust from their children. For example, Alan commented: "They can turn to me to talk to about anything, pretty much, so I find that pretty comforting". He then relayed a story about his 18-year-old daughter, who phoned him from a friend's house to take her home from a party, because she had drunk too much alcohol and felt vulnerable to being sexually exploited. Trust was also an important issue for Simon, who did not have a child of his own, but was engaged to be married to a woman with a 10-year-old son: "I like building our relationship and gaining his trust and stuff like that … I enjoy the time that I actually spend with him."

Some men, including Alan, Sam and Darren, also referred to their children's support for their recovery process, each describing their children's pride in seeing their fathers' strength of commitment to their rehabilitation. Although the men were not specifically asked about their addictions or their recovery processes, a number of them expressed recognition that they were better fathers and closer to their children when they were not under the influence of alcohol or drugs, in terms of both selfishness and actual presence. Dave and Sam described themselves in addiction as irresponsible and more interested in drinking than focusing on their children. Gary stated, "I probably haven't been the best father I've been capable of, due to addiction, I suppose, and you know, not being around as often." Alan reflected:

> Addiction … takes over and you only live through yourself, pretty much. Even though you are there, like as a father, but you are not there, sort of thing – where you're always thinking about [drinking or using drugs] … or being somewhere else… I was still pretty selfish, self-centred, I suppose.

In addition to the description of the contrast between the addicted and the sober self, there was a theme for some of the men of a lack of readiness to be a father. For example, Rod's reflection about becoming a father was: "I reckon I was too young; I wasn't ready for it, but things happen and you've just got to deal with them. I reckon for me it was a bit overwhelming at the time". Some of the stories also revealed a certain immaturity in their relationships with their children, relating to them perhaps more as siblings than parents. For example, Sam stated, "I don't treat them like adults, because they're not, but I treat them more like my friends" and Travis made a similar comment about his relationship with his four-year-old son: "I'm basically his best mate, pretty much". Dave also observed the difference in his relationship with his children in and out of addiction as follows: "I was just a big brother really; I was just – you know what I mean – I was not a father figure".

Two further questions asked of the fathers were 'What do you find most challenging or stressful [about being a father]?'and 'How do you handle that stress?' These questions aimed to reveal the men's descriptions of their capacities to regulate their emotions, among other skills. As expected, the men described themselves as more volatile and less capable of remaining composed under the influence of alcohol or drugs. Some of their responses included:

> (Alan): I was just an emotional mess on the drugs when I would ring them on the phone or they want to talk to you, and you are just like 'wow!' …It just comes back and they just go 'Oh dad's lost it', sort of thing, and worry about you and stuff like that.
>
> (Dave): I wasn't always straight and therefore I was easily – I was very short tempered; I was very impatient; I was very sort of – unfortunately the kids were a lot – were a burden unfortunately… [My kids would say] yeah I'm angry, cranky, scary, yeah, loud, violent, yeah – nothing good.
>
> (Gary): I'm really working hard on being a good parent, and my patience, working through problems with them.

Simon, who had recently served 25 years in jail for a violent crime about which he did not give details, hinted at a concern about a potential loss of control if his step-son were to 'push his buttons':

> I'm fearful, a little bit fearful, but I take great pride in him and his behaviours cause he's a very respectful kid and I'll have to give it to [my fiancée] for that: she's taught him quite well to be respectful apart from the normal childhood behaviours, where sometimes they can be a little bit disrespectful…

Alan observed the following about his children's mental health and their mother:

> She gets into me when I don't spend enough time, and stuff like that, and the kids miss me, and I see the kids having more mental sort of problems – not mental, but social behaviours and stuff like that. I get a bit more emotional and stuff like that – you know when you're there for so long, but then you're not there, and they're trying to understand what's going on with you and all that sort of stuff.

Each man was asked about his relationship with his father growing up, and to compare his own parenting style with his father's style. When it came to talking about their own childhood and youth, there was a strong theme of loss and trauma for a number of the men. Indeed, the fathers of four of the men died early, and the mothers of two other men also died during those men's infancy. Alan, who reported that his father suicided when Alan was a child, described the devastating effect of his father's death on both him and his children:

> He…took his own life when I was 8 – just sort of growing up in a bit of abusive relationship with the mother … and if he had taken his own way he would have taken us kids … on his little suicide mission - he would have taken us … I have never taken [sic] my own life or do nothing like that so it's just – it makes it a little bit difficult. I can just see the hurt and the pain that I've experienced that I don't really want them to experience, but being in addiction you just still get those – experience pain for them, sort of things, where I shouldn't really be. I've been through a lot in my life, so I handle things, and I reassess things, and I think about stuff … and I think sometimes [suicide is] a better option, but sometimes it's not. So, first of all, I [would] break my own kids' heart and my … by keeping distance you know. … I got sent to school the day after my dad suicided … so it was a little bit harsh, and I remember drawing a little picture of a little lobster, and he's all crying and all that sort of stuff, and I found out my son had to go and see a quack and all that sort of stuff. [Now I] put people's needs before my own: that's where I can bring myself into a bit of trouble.

Carl, whose father died suddenly when Carl was just four years old, described his immediate reaction to the loss in this way: "I just remember … that sense of … I'm alone in the world and I am completely – I was scared shitless when I didn't have dad there."

Ray also reported that his father died early; he did not say how young he was, but claimed that he had few memories of his childhood due to severe abuse. A disturbing story of trauma was also told by Jim, who said that he was just 6 months old when his father died, so he had no memory of him. Instead, he recalled a traumatic childhood in which he and his brothers were frequently physically assaulted, and his sisters sexually assaulted, by an abusive step-father. These three men's stories are presented in more detail in the next section.

In addition to the stories of trauma and abuse, another theme was the experience of growing up with non-involved fathers. For example, Travis relayed how his father "ran away" from home when Travis was just 3 years old, and how he had to endure a childhood full of criticism and disinterest from his step-father. Simon also described a childhood in which feelings were not discussed, there were no consequences for misbehaviour, and there was little evidence of love. He added, "[My father and I] didn't have a relationship … I grew up in boys' homes and my father was pretty not there for me, and I need to learn how to be there for my boy". In a similar vein, an old-style masculine, non-involved father figure was referred to by Alan. He described his step-father as: "sort of a man's man – he was emotionally detached, sort of thing". Gary also described his father as mostly absent due to working such long hours, while Jeff spoke of a childhood without a father, who spent most of the time in prison.

Some of the men showed evidence of ambivalent relationships with their fathers. These men generally described their fathers as quite strict, either distant or volatile, and not warm, and the respondents' reason for taking up drinking or using illicit substances in their youth as a form of rebellion against authority rather than the result of abuse or neglect. Ambivalent attachments in adulthood – whether to partners, children, or their own parents – are an example of the possible long-term ill effects of childhood attachment insecurity, according to Bowlby (1969). In the cases where the men in the present study described such relationships with their own fathers they tended to view themselves as 'rebels'. For example, Gary, who said that he did not have a particularly close relationship with his father as a child, observed:

> … It's gotten better with age, I suppose. Once I got out of my rebel issues and started to have children myself, and yeah, we get along pretty good actually… Dad was a good husband, you know, for my mum I suppose; he was a good provider, so… he's been a good role model.

Rod also described his own descent into addiction as a rebellion against his father to some extent, but tried to maintain a positive picture of him at the same time:

> [H]e was pretty strict, and yeah, I kept on rebelling like my son is now, but the way he dealt with it was with a lot of anger and things like that, yeah. I reckon that wasn't the right way, but he didn't know better. So yeah, but otherwise he was a good father to me, yeah. He's always tried to do the best for me… but there was a lack of communication – just things – I don't know if he was stubborn, or just the way he was. Yeah, [instead of] talk about things [there] was a lot of anger and yeah, things like that.

Dave also relayed a type of double story about his father's parenting. On the one hand, he was thankful to him for his support in Dave's recovery process:

> Me dad and mum are still together; me dad dropped me off at detox and then me dad drove me all the way up here, so he's a good dad; he's pretty responsible.

On the other hand, Dave spoke of major deficits in his father's parenting while Dave was growing up:

> There's no love, there's no cuddles, there's no kissing, there's no nothing in our house, you know what I mean, so it was very hard for me to know where I stood… Dad used to demand we kiss him goodnight and like I used to sneak off… he wasn't nothing other than the one that handed out the punishment.

Another theme that arose in response to this question was wanting one's children to have a better experience than one's own. A number of the men gave this response, including Rod, who contrasted how he parented his children with the parenting he received, saying that he aimed to: "Just show them a lot more awareness about things", perhaps relating to both his reflection of his immaturity as a father early on and his father's tendency to become angry rather than communicate effectively with his children. Indeed, when asked how their parenting compared with that of their fathers, most of the men were quick to distance themselves from the parenting that they recalled receiving from their fathers. Scott described his father as "a bit violent at times", describing his own parenting style as "way different – I do nothing the way my dad did it with me". And when asked how their parenting styles were similar, Jeff replied:

> I'm not similar at all; I'm different, like as much as I can I'm there to be with my children. My dad wasn't there for us; he never really tried to be there for us, and yeah I'm different – as soon I get the chance I'm there with my children.

On the other hand, Brian, Barry, Kevin and Darren described their parenting as similar to their fathers' parenting. The first three men appeared to uncritically accept that they parented their children in a very similar way to their fathers, even though Barry and Kevin indicated that their relationships with their fathers were not particularly close. However, Darren reported a very good relationship with his father.

Underneath the proclamations of closeness to their children and (in a number of cases) respect for their fathers, there was a theme of family conflict. In some cases, this manifested itself through recollections of unhappy childhoods, particularly in relation to their fathers, who had clearly struggled with their own issues. More commonly, though, there was a theme of turbulence in their relationships with their partners or ex-partners; these men raised the issue of the difficulty of sharing the parenting with women with whom they no longer shared a meaningful relationship. This was discussed earlier, and has also been found to be a strong influence on the father's relationship with his children (Sullivan, 2003; Geary, 2005). Carl had continual difficulties with his son's mother concerning custody of their son, which preceded and, as will be discussed later, may indeed have precipitated, his addiction. Gary was quite critical of his ex-wife's parenting of their children while he was in rehabilitation. He stated that his relationship with both her and their older children had been fractured since they divorced. Indeed, the theme of dissatisfaction with the mothers' parenting surfaced a number of times during the parenting program.

For fathers not living with their children, in particular, the children's mother has been found in some studies to maintain a type of 'gatekeeper' role, through which the father cannot access his children without her consent (De Luccie, 1995; Zanoni et al, 2013; Qu & Weston, 2014). Some descriptions of these types of circumstances included the following:

> (Rod): Well it became very stressful, like I was always worried about things … because we were all separated for a lot of years and yeah, had a bit of difficulty with the mother and things.
>
> (Dave): It's very difficult because of the situation between their mother and I… there was hope of maybe getting the kids up here for a visit, but like I said, their mother and I don't see eye-to-eye: she doesn't understand that I'm actually in here getting help; she thinks I'm on holidays.
>
> (Gary): And my eldest son – he's really patchy. We were going along okay and then there was a few dramas, a few things said to himself and my ex-wife and then she told, she told my son what was going on. Then he got involved with it and yeah – it sort of, yeah, didn't go too well.

Mick, Travis and Sam were quite critical of their children's mothers' parenting skills, with Mick and Sam explaining that their ex-partners had addictions and tended to neglect their children, which the men found particularly frustrating as they were in recovery themselves. Dave and Gary were also critical of their ex-partners' parenting skills, although both also referred to their own deficits as fathers. And Jim felt greatly harassed by what he described as his ex-partner's constant criticism of his parenting. Some of the men explained that they remained in good relationships with their children's mothers from whom they had separated: Alan reported a respectful relationship with his ex-partner, as they were both committed to raising their children well, although he alluded to some level of uneasy dependency between them:

> She still was emotionally attached, but now it's getting a lot better and I ring them all the time and just let them know where I'm at and see how they're going **…** I don't know – I thought it was a bit … too much and then broke the relationship off with [her]

Only three of the 16 initial interviewees described themselves as married. Each of these men – Brian, Darren and Barry – reported very good relationships with their wives. These men, as well as Kevin and Travis, also reported little stress in parenting, stating that they thoroughly enjoyed being fathers. Barry, who became a father at just 19 years of age, described how he was able to manage three children under three years old by not paying attention to any one child more than the others. Brian, who was the father of five children under 12, also described how he was able to find ways to keep each of his children busy with interesting activities, thereby keeping them happy and reducing his stress as a parent. Interestingly, none of these five men went on to complete the

parenting program. More will be discussed concerning the motivations of the fathers to do the parenting program in Chapter 5.

Two of the themes identified above warrant further comment. Firstly, a number of the fathers described conflict in their relationships: with their own family, including their ex-partners in particular, but notably less so with their own children. However, there was a recognition by a number of men, for all the deficits that they claimed to be present in their children's other parents, that they themselves had been part of the problem, particularly when under the influence of alcohol or other drugs. This example of a level of self-awareness could most likely be attributed to the personal psychological work in which the men had been engaged in their rehabilitation programs, so this aspect of their stories in particular had the effect of distinguishing these men from most addicts not in recovery.

Secondly, many of the men discussed the factors that they believed were most influential in the development of their addictions, even though this information was not requested by the researcher. This demonstrated the importance to these men of the creation of a story about their perceived causes of their addiction, perhaps because they felt that this permitted them to 'set the stage' for a possible positive and dramatic outcome to their narratives. These stories, usually narrated in past tense even if they reflected current struggles, also tended to fall into one of two general types: trauma or rebellion. In the first type of story the men were able to describe a type of upbringing, or in some cases a particular event, which they suspected to have had a strong impact on the onset of their addictive habits.

While not all addicts have recounted such stories (e.g.Grant, 2012), early traumatic events have been found in some studies to increase the severity of an addiction compared to those with addictions who did not experience such events (Thomas et al, 2014). On the other hand, and perhaps in the absence of a broader understanding of the sociological determinants of addiction, a number of the men described themselves in what could be termed a conservative narrative, namely as rebels. Those men were much

less likely to claim that it was their upbringing that 'caused' their addiction, but rather it was their own personalities, or perhaps, depending on whether they professed a religious faith, their own 'sinfulness'. In any event, clearly these possibly changing stories told by these fathers seemed to be very important to their recovery process, consistent with the qualitative research conducted by Dunlop & Tracy (2013).

Multiple Case Study

Application to present study

As indicated in Chapter 2, a multiple case study approach was used as the analytic framework for the second phase of the present study. This approach permitted close examination of each of the narratives and questionnaire scores of each of the seven principal participants in this study. Another benefit of multiple case studies, according to Yin (2013), is their capacity to generalise from these cases to broader theories.

Most of the fathers who participated in the initial interviews proceeded to commence the parenting program. Half of the fourteen men who began these group sessions completed the program, including individual follow-up interviews after the parenting program. These seven men were of particular interest in this study, since the researcher was able to obtain information from them concerning their views on fatherhood, both qualitative and quantitative, on multiple occasions. This permitted an in-depth qualitative analysis of these men's perceptions of their experiences as fathers, as well as some examination of any change processes that may have occurred for these men. This was considered particularly useful in answering the third research question (RQ 3) of the present study, which was: *How might training in empathic parenting provide these men with an opportunity to reassess their capacities as fathers as well as encouraging the development of empathy and an enhanced sense of wellbeing?* This question will be more fully addressed in Chapter 6.

Pre-program questionnaire scores

In addition to the details of the interview responses, quantitative data have been included for each of the individual fathers who ended up completing the parenting program. Table

4.1 below provides a summary of the subscale names and possible scores for each questionnaire. Since some of the men found it difficult to elaborate on their responses in the interviews, the questionnaire data also served to add more detail to their stories. This information has been shown in combined column and line graphs (Figures 4.1-4.28) in which the column graphs represent the mean full-scale and subscale scores of the four questionnaires, namely the General Health Questionnaire (GHQ-28) and the revised versions of each of the other questionnaires: the Fathers' Attachment to Children Questionnaire (FACQ-17), the Empathy Quotient (EQ-16), and the Difficulties in Emotion Regulation Scale (DERS-26).

On each of these scales the expected score for each man was the mean score obtained by those in the Addiction group, with more 'functional' scores obtained by the No Addiction group, namely higher total and subscale scores on the FACQ-17 and EQ-16 and lower scores on the DERS-26 and GHQ-28.

The line graphs within each figure (Figures 4.1-4.28) show each man's individual subscale and full-scale scores on each of the questionnaires compared with the mean scores for both groups, Addiction and No Addiction. Note that, while all differences between the groups' subscale scores were in the expected direction within the DERS-26 and the EQ-16, this was not the case with two of the subscale scores on the FACQ-17 (Addiction group obtained slightly higher attachment scores on the *Mutual Trust* and *Conflict* subscales) and the GHQ-28 (Addiction group obtained slightly lower scores on the *Somatic Complaints* and *Social Dysfunction* subscales).

Table 4.1: Subscale names and ranges of possible scores on questionnaires

Scale	Subscale/Factor	Possible scores
Fathers' Attachment to Children Questionnaire (FACQ-17)	Pleasure in relationship	7-35
	Anxiety about relationship*	3-15
	Conflict*	4-20
	Mutual Trust	3-15
	Total (full-scale scores)	17-85
Difficulties in Emotion Regulation Scale (DERS-26)	Lack of Control	5-25
	Emotional Awareness*	8-40
	Negative attitude to own emotions	5-25
	Concentration Difficulties	5-25
	Emotional Confusion	3-15
	Total (full-scale scores)	26-130
General Health Questionnaire (GHQ-28)	Somatic Complaints	7-28
	Anxiety/Insomnia	7-28
	Social Dysfunction	7-28
	Severe Depression	7-28
	Total (full-scale scores)	28-112
Empathy Quotient (EQ-16)	Cognitive Empathy	0-10
	Insensitivity*	0-6
	Perception of Social Cues	0-10
	Social Discomfort*	0-6
	Total (full-scale scores)	0-32

Higher functioning on all scales and subscales is indicated by higher scores on FACQ-17 and EQ-16, and by lower scores on DERS-26 and GHQ-28. This includes the subscales marked with an asterisk (*) despite their names. Thus, for example, higher scores on the *Conflict* subscale of the FACQ-17 still indicate greater attachment and hence *less* conflict; similarly, higher scores on the *Emotional Awareness* subscale of the DERS-26 indicate more difficulties with emotion regulation and hence *less* emotional awareness.

Group 1

Carl

Carl was a very willing participant in the initial interview and subsequent parenting program. He was articulate and enthusiastic, and clearly enjoyed talking about his son, with whom he reported a very close and happy relationship. His first description of his experience of the time spent with him was "fantastic". Carl differed from most of the other residents in the rehabilitation centres in at least two respects. Firstly, he described himself as a Professional Manager – only two of the 20 respondents referred to themselves as "Professionals", and a third man described himself as a "Manager" – but nobody else described himself as both. Secondly, he was very clear about the moment of, and reason for, the onset of his addiction: he had wanted a child for some time, but reported that as soon as his then-wife became pregnant, she told him he was "no longer required".

As well as the immediate trigger, there was very likely a vulnerability factor for Carl's alcoholism. As indicated previously, he reported losing his own father when he was just four years old, and recalled that he was "absolutely terrified" after his father had died. Furthermore, he described his mother, who raised him alone, as "a fairly [mentally] sick lady". Due to his difficult childhood and feeling unprepared to be a father at an earlier age, he had waited until he was nearly 40 before becoming a father. So for Carl, the combination of having been so keen but waiting so long to become a father, remembering the devastating effect it had on him to be without a father, and then facing the prospect of not being able to see his new child, caused him enormous stress.

Not only did Carl report drinking his "first alcoholic bottle of wine" around this time, but he also developed tumours in both his eyes, which threatened his sight. The threat of the loss of his parenthood before it even started threw his life into turmoil: Carl described the stress and anxiety that led to his alcoholism as follows:

> … I came up to make myself lunch, and… I simply opened a bottle of wine, figuring I'd be having a glass that night, and I sat and had lunch until I finished that bottle of wine and had another one that night. There was something very different about that bottle of wine: I was so strung out and so stressed and under so much pressure that quite simply

> that bottle of wine – I call it that was my first alcoholic bottle of wine, 'cause that one there was just to deaden and numb pain and to relax, if that makes any sense… Eventually all it did was create further need for it, so anxiety when you didn't have it, so yeah, it eventually shot itself in the foot as the cure.

During the parenting program, Carl wanted the group to know that he had to become very psychologically strong to achieve his goal of seeing his son and being an involved father. He continued, "That part was very, very hard, and I did have to go into courts which I didn't think I would ever have to do to fight for custody". Carl was quite forthcoming in his description of the stress – quite severe at times – that he had to endure since his ex-wife's pregnancy. Another ongoing source of anxiety for Carl was finances, which once again he described as having first been created in his childhood:

> After the death of my father, my mother – there was three young boys – and my mother had never worked, and so she had to find some way of generating an income, but I can remember that that was constantly talked about in front of us and… I felt like whatever I ate was costing money, whatever I did was costing money and that type of thing, and that was something that made me very, very anxious, and that was around the money and around the affordability of being able to go on. I can remember thinking 'Okay, that's it; there's a great big black hole and we're all going to be on the streets and then we're all going to die'.

The anxiety that Carl was suffering was not without an empathic component: he reported feeling very concerned for the effect of all of this financial stress on his son, and how he could explain it to him. Carl relayed the following stories about time spent with his son, which were mostly over the previous year, while he was in rehabilitation. Carl described the following in response to the question of what he found most challenging about being a parent. Unlike the other fathers in this study, this was not related to his son's behaviour, the increased responsibility or even the relationship with his (ex-)partner:

> [My son is] very well cared for, and he is very well loved and he's aware, but what I do find very challenging is not being 100% sure of the future I'm going to be able to provide for him. And I would love him not to have to worry about that, but I think he's at an age where he's inquisitive and he realises that we are in the financial position we were, and that things have changed a fair bit – so just the challenges making that change palatable for him so he is not sort of feeling nervous … insecure about that.

Another theme that arose in Carl's narrative was masculinity. For some of the men the tacit reference to masculinity was negative in that they expressed some dissatisfaction with their fathers' lack of warmth and dismissiveness of emotional expression. However,

for Carl, the theme of masculinity was a positive one, albeit partly in contrast to what he seemed to describe as having been let down by the women in his life. In the short time that he knew his own father, he remembered his strong protectiveness and wise words. He contrasted this with what he hinted at as his mother's instability. He also reported that his own son really appreciated the fact that Carl was big, fast and strong himself.

The theme of masculinity was also implicit in some of his parenting stories that contained an authoritarian component. For example, the men were asked to identify a situation in which they responded to their child's emotion (and their own) in a certain way, but could have responded differently. Carl described a scenario in which he smacked his son, although he showed some regret for his actions. In this case he had to say good-bye to his son probably before either of them wanted to, so there were strong emotions on both sides. The issue of having to continually say good-bye to one's child after brief visits or outings has been found to be a significant factor in the distress experienced by separated fathers and their children (Williams, 2014).

> [My son] wanted to go and see the toy shop… I said, 'We can't do it today'. He said 'Dad – just for a minute, just for a minute!'… I said 'No, today we can't'. 'But Dad' – I said 'No, it's not open to negotiation. You have seen the toy shop many times – I have to be back home right now'. 'But Dad!' – and so I gave him a little smack on the bum. And he wasn't happy, and we got back in the car and he said 'You shouldn't have smacked me', and I said 'Yes, well you knew what had to happen' and I said, 'You started yelling, so you got a smack.' Anyway, by the time we got back [there] he didn't want to particularly say goodbye anyway… I wish I had handled it differently from the point of view of telling him beforehand that we had to go and it was a rush.… I was let down by the fact that I went to the smack, because it wasn't a smack situation, but at the time it wasn't just – after again re-training him all day because he is now staying with mum, and… the rules there are just ad hoc and I do get frustrated with her also about the lack of structure and … there's certain rules that when he is old enough to truly understand them he will know, but in the meantime he's going to have to accept my guidance.

At the initial interview, Carl also responded to the questionnaires on attachment, emotion regulation, recent mental health, and empathy. Discussion of his pre-program scores is provided below.

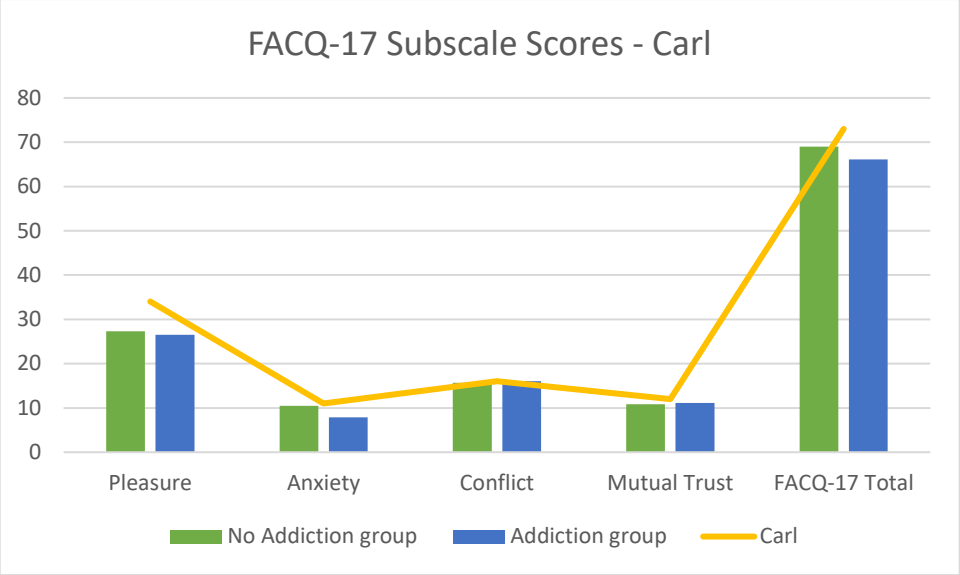

Figure 4.1: Pre-program FACQ-17 scores for Carl compared with mean questionnaire scores for Addiction and No Addiction groups.
Note: For all FACQ-17 scores (including subscales), higher scores indicate closer attachment.

Each of the men responded to the questionnaires at the time of their initial interview. Carl's questionnaire scores are shown in Figures 4.1-4.4. Consistent with his verbal responses, Carl rated his relationship with his son very highly on the Fathers' Attachment to Children Questionnaire (FACQ). His score on the revised 17-item instrument (FACQ-17) was 73 on a scale from 17 to 85, where higher scores indicate higher levels of self-reported attachment to one's child. This included a particularly high score of 34 out of a possible 35 on the *Pleasure in Relationship* subscale of the FACQ-17. Figure 4.1 above shows his attachment scores, which are well above the mean scores of the Addiction group, and at least as high as those of the No Addiction group, on all four subscales.

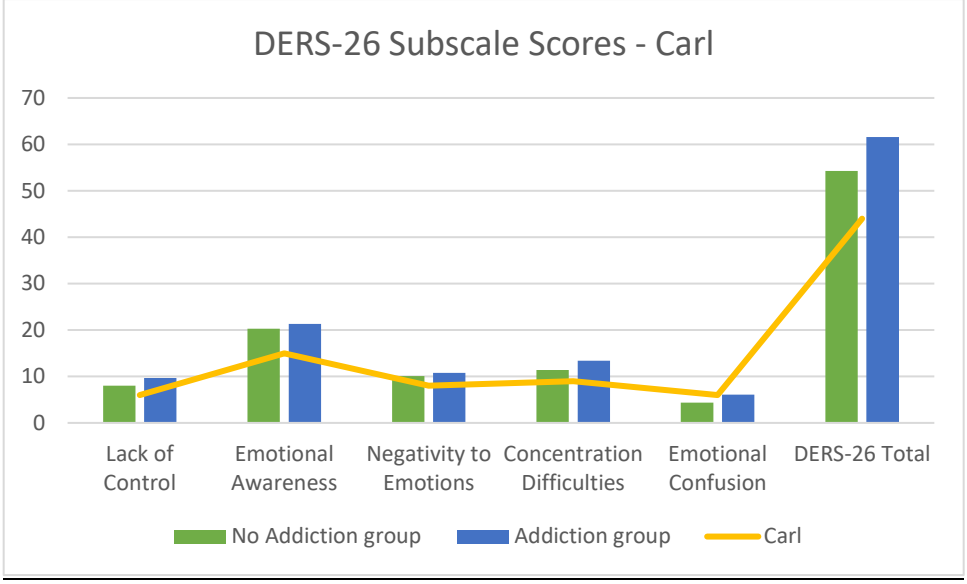

Figure 4.2: Pre-program DERS-26 scores for Carl compared with mean questionnaire scores for Addiction and No Addiction groups

Carl reported relatively few emotional difficulties on the Difficulties in Emotional Regulation Scale (DERS-26), with a score of 44 (possible scores ranged from 26 to 130, with higher scores indicating more emotional difficulties), as shown in Figure 4.2 above. By way of comparison, the mean score on the DERS-26 for the population of fathers identifying as having or recovering from addictions was 61.6, compared to the 'No Addiction' group, who obtained a mean score of 54.3, with Carl's scores being even lower than the latter group on both measures, so these scores suggested comparatively healthy functioning on these dimensions. The one exception was the *Emotional Confusion* subscale, in which his score (6) was equal to that of the Addiction group, but even then his scores on the three questions on that subscale were each only 2 (on a scale from 1 to 5), indicating that Carl rated himself as quite low on emotional confusion.

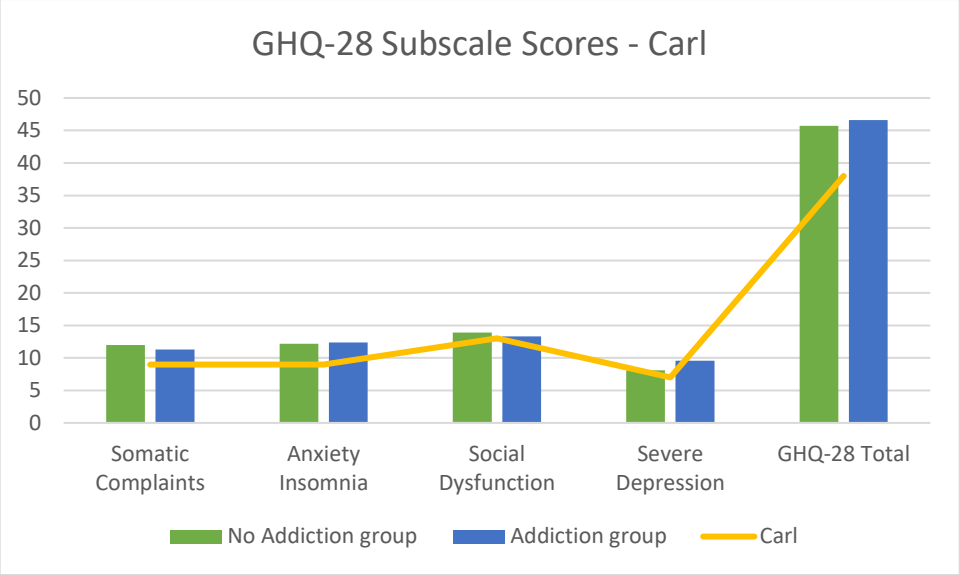

Figure 4.3: Pre-program GHQ-28 scores for Carl compared with mean questionnaire scores for Addiction and No Addiction groups

Carl's scores on the GHQ-28 (see Figure 4.3 above) showed a similar pattern to the DERS-26, with relatively low scores on each of the subscales: *Somatic Complaints*, *Anxiety/Insomnia*, and *Social Dysfunction*, despite having described a reasonable amount of stress due to the limited amount of time he had been able to spend with his son. And Carl scored the lowest possible score (7) on the *Severe Depression* subscale, indicating that he assessed himself as having little to no recent symptoms of depression.

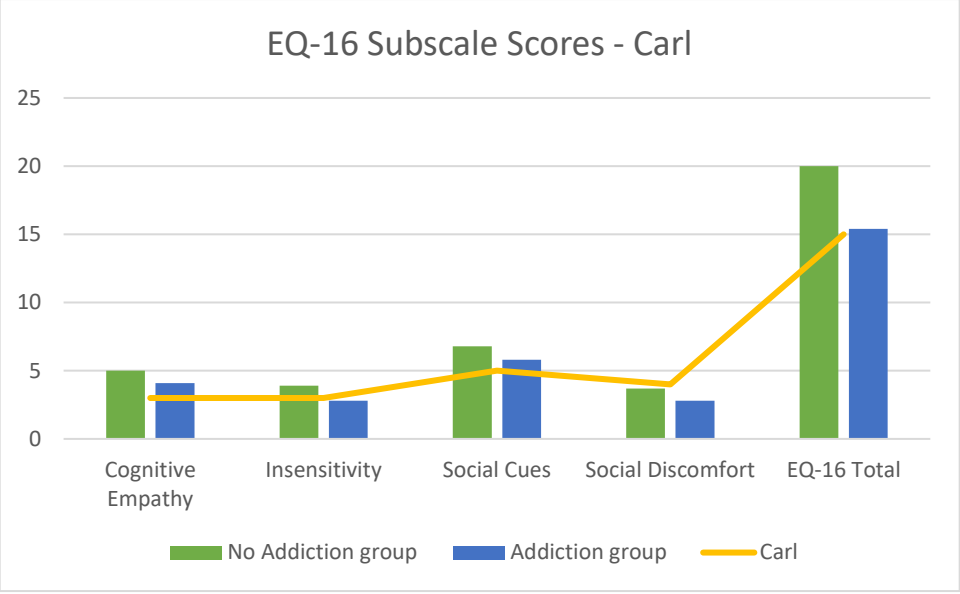

Figure 4.4: Pre-program EQ-16 scores for Carl compared with mean questionnaire scores for Addiction and No Addiction groups

In contrast to his scores on the other questionnaires, Carl's score on the Empathy Quotient (15 on the EQ-16), was approximately the same as the 'Addiction' group at 15.4 – see Figure 4.4. On this questionnaire, some of his responses included agreeing with the statement 'I am able to make decisions without being influenced by people's feelings' and disagreeing with 'I can easily work out what another person might want to talk about'. Carl's scores on the *Cognitive Empathy* and *Perception of Social Cues* subscales were also surprisingly lower than the corresponding average scores for both groups. For example, he disagreed with the statements on the former subscale 'I can easily work out what another person might want to talk about' and 'I am good at predicting what someone will do'. It could be, however, that in the context of living in a rehabilitation with many men with apparently very different backgrounds from his, these questions may have reflected more a culture difference than an accurate measure of his capacity to consider other people's perspectives or care about their feelings.

Indeed, he strongly agreed with the statement 'I really enjoy caring for other people' and strongly disagreed with a statement suggesting that the responder is not interested generally in friendships and relationships. Nevertheless, his empathy scores were not as high as could have been expected, given his scores on the other three questionnaires.

Carl's story is a poignant mix of much sadness and fear on the one hand, and great pleasure on the other. It was clear from Carl's words that his son means everything to him, which of course explains his high attachment scores. At the same time, he came across as not a particularly emotional man, which may account for his low to moderate scores on the DERS. He also presented as intelligent and quite insightful, and he reported that his addiction only started around the age of 40, so unlike a number of the men who started their addictions in adolescence and hence may have been developmentally delayed in their social and psychological functioning, Carl appeared to be relatively mature in his responses and his outlook on life. Even so, he assessed his empathy for people other than his son on this first questionnaire as quite low. This at first appears to be a contradiction, but when it is remembered that he reported being raised by one parent who very likely found raising a family on her own very difficult and was therefore very probably less outwardly focused herself, it makes sense that Carl may have also had more difficulty experiencing a great deal of empathy for people in general.

Ray

Ray was a quiet young man with a seven-year-old son, having become a father at just 20 years of age. He disclosed a very troubled childhood, with a father who was addicted to drugs, spent time in jail, and subsequently died quite young. Ray admitted that he regularly masked his pain with drugs, although when asked later, he was unable to recall any specific incidents in his childhood, which he said he had "blocked out". At the time of his pre-program interview he had been in the rehabilitation centre for just six weeks, having left the previous rehabilitation centre after reporting being bullied there.

Ray explained that a decision was taken by Family and Community Services (FACS) to remove his son from his care as a result of his addiction, apparently due to neglect, so Ray had only been able to communicate with his son on the telephone for the two years prior to his initial interview. At the start of the parenting program he began fortnightly supervised visits with his son. When asked how he saw himself as a father, Ray was generally unsure how to respond. In fact, this was the case with a number of Ray's

answers, and so it was difficult to pinpoint a clear narrative for Ray. When asked how he handled stress, he replied "*Use* drugs" (present tense), and after his son was taken from his ex-partner by FACS, Ray admitted that he "felt like using" at that time as well.

Ray described himself in his opening interview as "easy-going", the same words that he used to describe his father, contrasting that personality trait with that of his ex-wife, who he said was the one with "the problem". And when asked how his parenting compared with that of his father, Ray replied that their styles were "very similar", but then added, "I've learnt that's not the way to go about things, and that's why I'm here to change". He also stated that parenthood "snapped me out of [my addiction]", and that he aimed to "just be there more for [my son]".

Ray was fairly subdued during most of the parenting group sessions, generally only saying a few words when asked. He was also hampered by virtue of the fact that he could not read – he needed me to read the questions on the questionnaires to him – so he did not feel comfortable participating in any role-plays. Nevertheless, he displayed enthusiasm for renewing his relationship with his son, and evidence that he felt hurt when his supervised visits with him did not go well:

> I had an instance the other day where me son just gets up now and he just leaves straight away, like as soon as I say, 'Pack up time', it's like he's like – it's like he's used to doing – like getting up and leaving … just, you know what I mean, like he says … and he's done it so many times now, and it really cut me down, and I felt really bad about the situation.

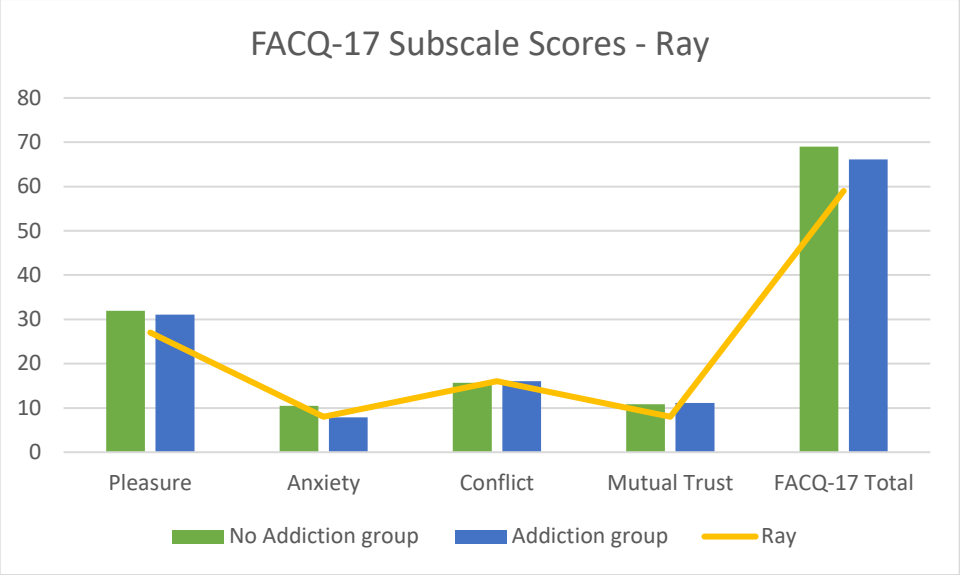

Figure 4.5: Pre-program FACQ-17 scores for Ray compared with mean questionnaire scores for Addiction and No Addiction groups

Ray's confusion was highlighted in his responses to a number of the questions on the FACQ: he responded 'Unsure' to 11 of the 34 questions on the original instrument – more than any other respondent on that questionnaire – though it should be added that the majority of his recent interactions with his son just before responding to the FACQ were over the phone rather than in person, which would have contributed to these responses. Ray obtained a relatively low score of 59 on the FACQ-17, as shown in Figure 4.5. Notably, his score on the *Mutual Trust* subscale of that questionnaire was only 8, approximately three points below the average scores for both groups. The questions on that subscale began with 'My child…' rather than asking for the respondent's own perceptions. Ray's relatively low score can likely be attributed to either his own sense of emotional confusion (see Figure 4.6 below) or to the lack of time spent with his child, or both. Similarly, his score on the *Pleasure in Relationship* subscale, while not especially low, was still four points lower than the average for the Addiction group, reflecting the limited opportunity that he had had to connect with his son.

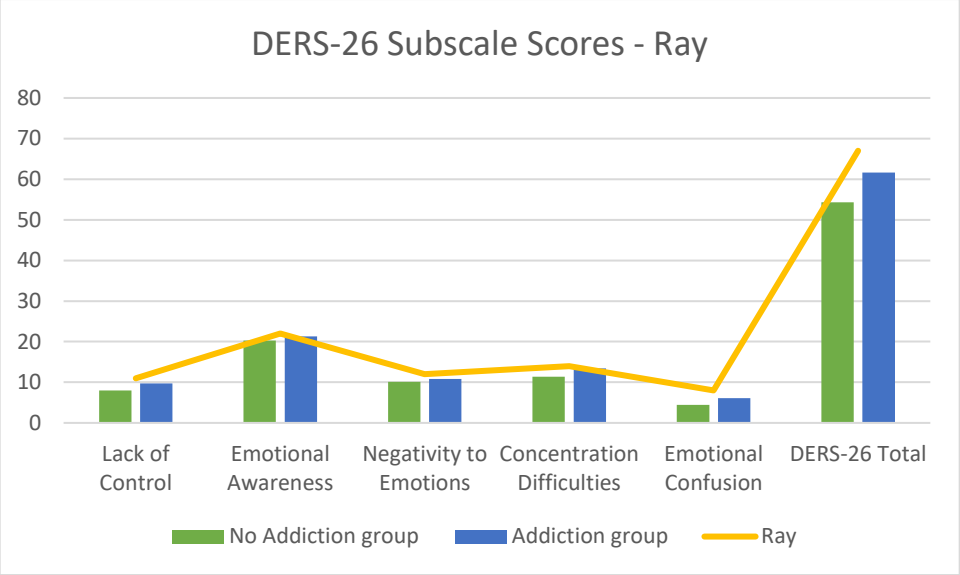

Figure 4.6: Pre-program DERS-26 scores for Ray compared with mean questionnaire scores for Addiction and No Addiction groups

Ray's scores were somewhat elevated on the DERS-26, with a total score of 67 (see Figure 4.6 above) – higher than the average scores for the other men in the Addiction group. In fact, he scored above the mean for both groups on each of the subscales, with the greatest difference occurring on the *Emotional Confusion* subscale, on which he responded to the question 'I have difficulty making sense of my feelings' with 'Most of the time'. Also, reflective perhaps of being fairly early in his rehabilitation process, Ray's responses showed some evidence of relatively poor emotional control, reduced awareness, and greater than average difficulty concentrating on other daily tasks.

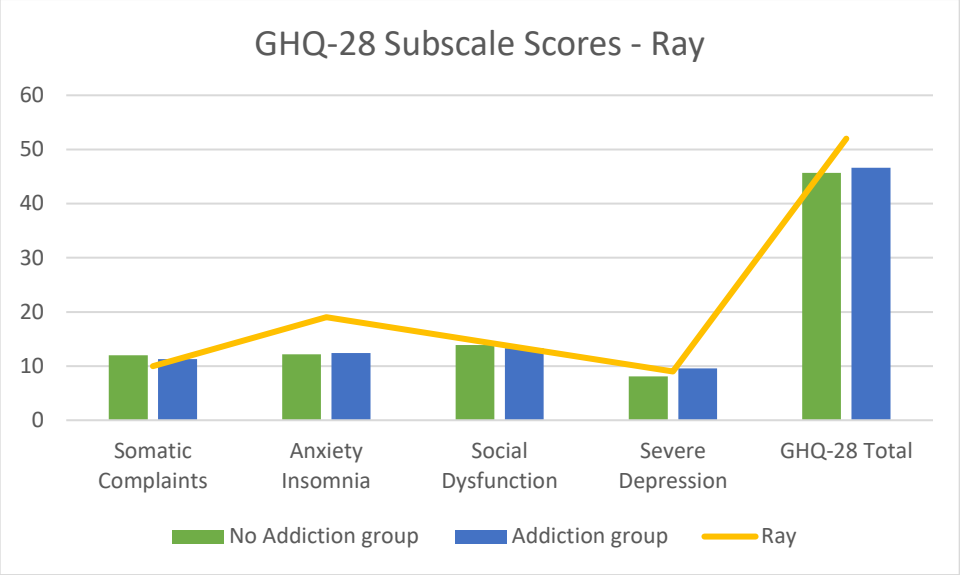

Figure 4.7: Pre-program GHQ-28 scores for Ray compared with mean questionnaire scores for Addiction and No Addiction groups

Ray's emotional difficulties also translated into some mental health symptoms. His total score on the GHQ-28 was 52 (see Figure 4.7), well above the average score for both groups. This included some evidence of depressed mood, as he responded to the question 'Have you recently felt that life is entirely hopeless' with 'Rather more than usual', and on a question on the original DERS, Ray responded to the statement 'When I'm upset, I believe that I will end up feeling very depressed' with 'Most of the time'. Even so, his responses to all other questions on the *Severe Depression* subscale on the GHQ were 'Not at all' or 'Definitely not'. However, his score on the *Anxiety/Insomnia* subscale was particularly high, with a total of 19 (compared to average scores close to 12 in both groups). Again, this is likely to have been influenced by his reported experience of having been bullied recently in another rehabilitation centre.

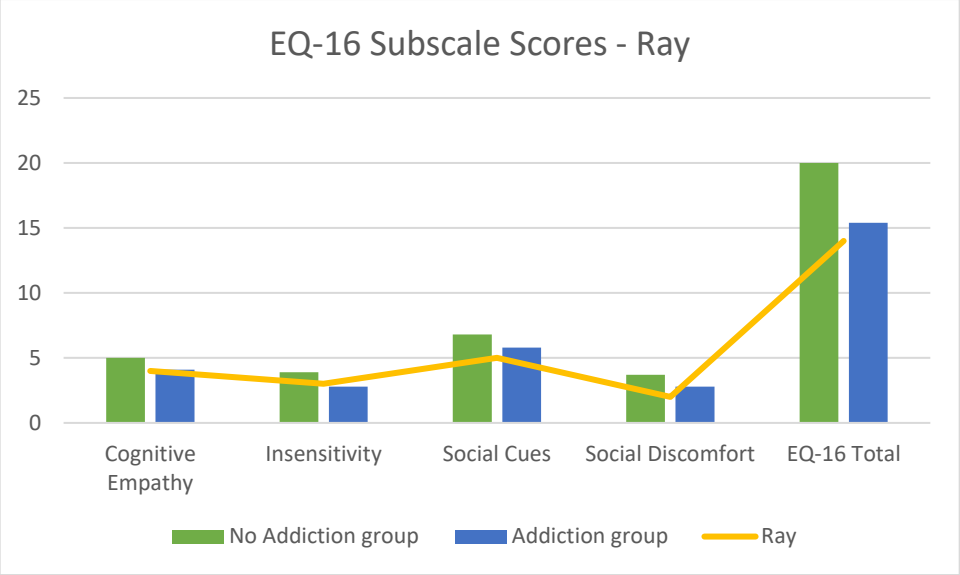

Figure 4.8: Pre-program EQ-16 scores for Ray compared with mean questionnaire scores for Addiction and No Addiction groups

As shown in Figure 4.8 above, Ray also obtained quite a low score of 14 on the revised Empathy Quotient (EQ-16). His scores were particularly low on both the *Social Discomfort* and the *Perception of Social Cues* subscales. For example, he agreed with the statement on the former subscale 'I find it hard to know what to do in a social situation', and he responded only with 'slightly agree' to statements on the latter subscale that included 'I can easily tell if someone else is interested or bored with what I am saying' and 'I can sense if I am intruding, even if the other person doesn't tell me'.

It was particularly difficult to engage with Ray, who appeared suspicious at times as well as lacking confidence. Even after prompting, his responses during the individual interview and, later on, in the group sessions, were often mono-syllabic. The fact that he claimed that he could not remember any specific incidents in his childhood also made it hard to connect with him. Even so, he was able to give what appeared to be quite congruent responses on his questionnaires, which appeared to match his narrative quite accurately.

Jim

Jim's childhood laid the foundation for his addiction. He described his upbringing as being full of trauma: Jim's father died when he was just six months old, and he reported having been raised by a highly abusive step-father. As previously discussed, growing up in a blended family of 16 children, Jim told of frequent violence in which he and his brothers were beaten and his sisters were raped. Jim reflected, "All I really learnt from my family was hate was love, and love was hate".

As an adult, Jim reported suffering from chronically high levels of anxiety: he assessed his stress levels as "ten [out of 10] all the time". He may have also been suffering from post-traumatic stress disorder (PTSD); indeed, his family background might have been sufficient to explain his poor mental health and even propel him towards addiction. He was also on strong doses of psychotropic medication at the time of the interview and throughout the parenting program. However, he described the trigger for his addiction as constant stress related to his partner's relentless criticism of his parenting. For Jim, this may in part have been due to the difficulty of trying to sustain an intimate relationship after being so thoroughly disempowered as a child. Indeed, Jim spoke of being either overly compliant or aggressive with other adults; only his relationships with his children appeared to offer him any peace.

Jim's stated aim of doing the parenting program was to connect better emotionally with his children. He described them on a number of occasions as "the best thing that ever happened" to him. But forming attachments with them – particularly his eldest daughter – had proved difficult, due to both his own and his children's traumatic backgrounds. After his ex-partner left him, Jim was distressed that history was repeating itself: he revealed in one of the early group sessions that his ex-partner became involved with an abusive partner, who was also violent towards Jim's children. Jim described how his daughter was often the target of that man's violent rages. Jim then "caught up" with that man and was himself later charged with assault.

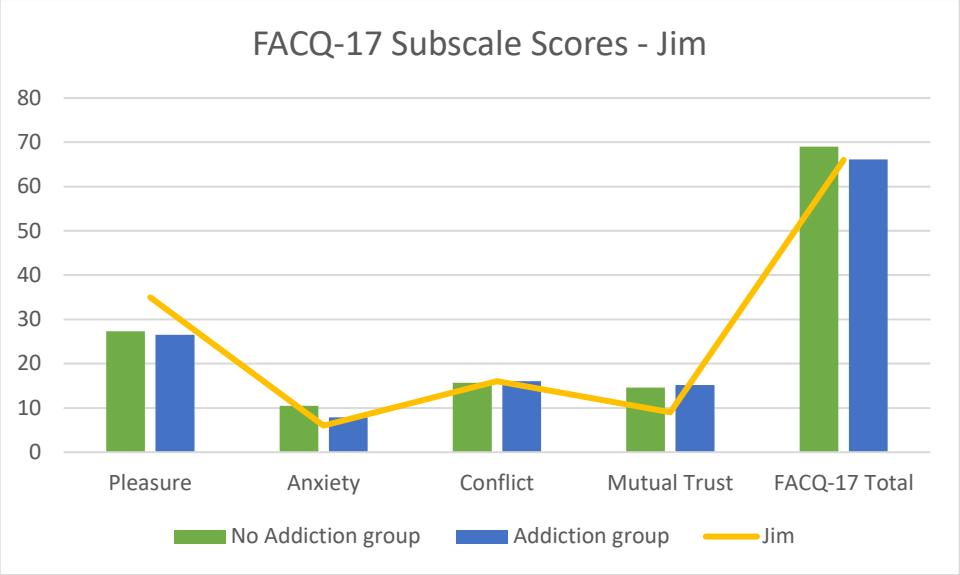

Figure 4.9: Pre-program FACQ-17 scores for Jim compared with mean questionnaire scores for Addiction and No Addiction groups

Figure 4.9 above shows Jim's FACQ-17 scores; he chose to focus on his relationship with his six-year-old daughter, which he described as challenging, in responding to that questionnaire. Although he was very positive about the effect that his daughter and his other children had on him, he agreed with the statements on the FACQ: 'I often feel resentful that I don't have enough time for myself' and 'I often worry that I will lose my child's admiration'. Jim's total FACQ-17 score was unremarkable: he obtained a total score of 66, which was approximately equal to the average full-scale score for the other men in the rehabilitation centres. However, some of the subscale scores were quite disparate, as he obtained reduced attachment scores related to (lower) trust and (higher) anxiety, but he also obtained the highest possible score on the *Pleasure in Relationship* subscale at 35, mirroring his statement that his children were all he lived for.

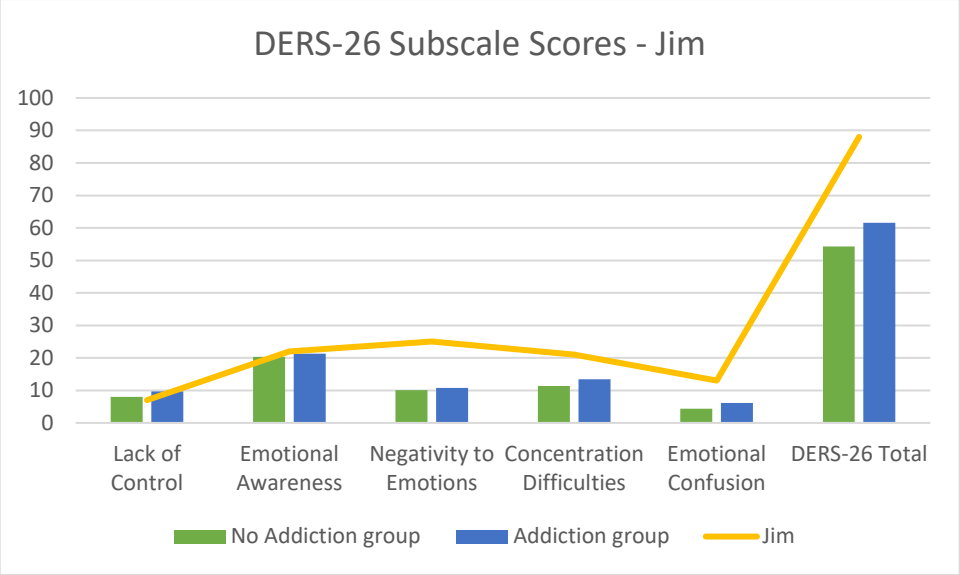

Figure 4.10: Pre-program DERS-26 scores for Jim compared with mean questionnaire scores for Addiction and No Addiction groups

On the DERS-26, Jim's scores were particularly high on three of the subscales (see Figure 4.10): *Emotional Confusion*, *Concentration Difficulties*, and *Negative Attitude to Own Emotions*. Examples of responses indicating emotional difficulties on the first two subscales included "I have difficulty making sense of my feelings" and "When I'm upset, I have difficulty focusing on other things". As a further indicator of Jim's confusion about his emotions (as well as difficulty controlling them), he replied 'Unsure' to seven of the questions (more than any other respondent on the DERS). And Jim obtained the highest possible score (25) on the *Negative Attitude to Own Emotions* subscale, for example responding 'Almost Always' to the statement "When I'm upset, I feel ashamed of myself for feeling that way". Not only did Jim seem to have difficulty understanding his emotions, but he also appeared to judge himself very harshly for experiencing strong emotions, which could well relate to the severe trauma that he reported experiencing during his childhood, which included physical punishment for expressing opinions or emotions, particularly at the hands of his step-father.

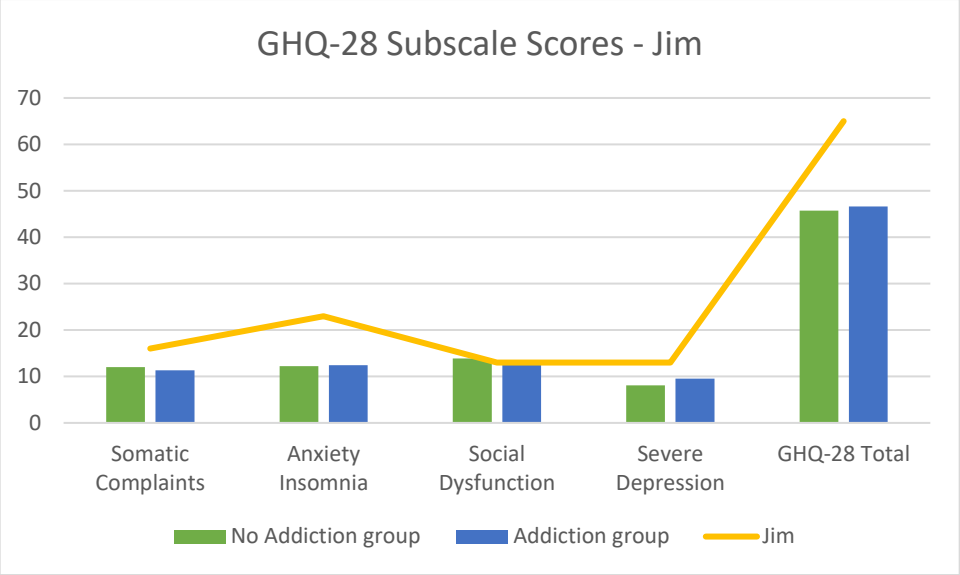

Figure 4.11: Pre-program GHQ-28 scores for Jim compared with mean questionnaire scores for Addiction and No Addiction groups

Like his DERS-26 score, Jim's responses on the GHQ-28 emphasised the problems that he was having with his emotionality, and his general and mental health. His scores were especially high on two of the four scales of the GHQ (see Figure 4.11): *Somatic Complaints* (bodily symptoms of stress or illness) and *Anxiety/Insomnia*. His score on the *Severe Depression* subscale was also relatively high, though it is possible that his relationships with his children prevented his score from being even higher and as elevated as those on the first two subscales. The combination of individual therapy and anti-depressant medication also may have helped ameliorate his depression levels.

Jim did disclose some symptoms of severe depression, however. For example, he responded to the question that asked whether he had recently been thinking of himself as worthless with 'Much more than usual', and to the question that asked if he had recently felt that life was entirely hopeless, he responded 'Rather more than usual'. And symptoms of highly elevated anxiety levels were evidenced by his responses of 'Much more than usual' to the questions 'Have you recently been getting scared or panicky for no good reason?' and 'Have you recently been feeling nervous and strung-up all the time?' Indeed, Jim's elevated anxiety and depression levels, combined with his

recounting of the severe physical abuse that he suffered throughout his childhood, were consistent with a diagnosis of PTSD.

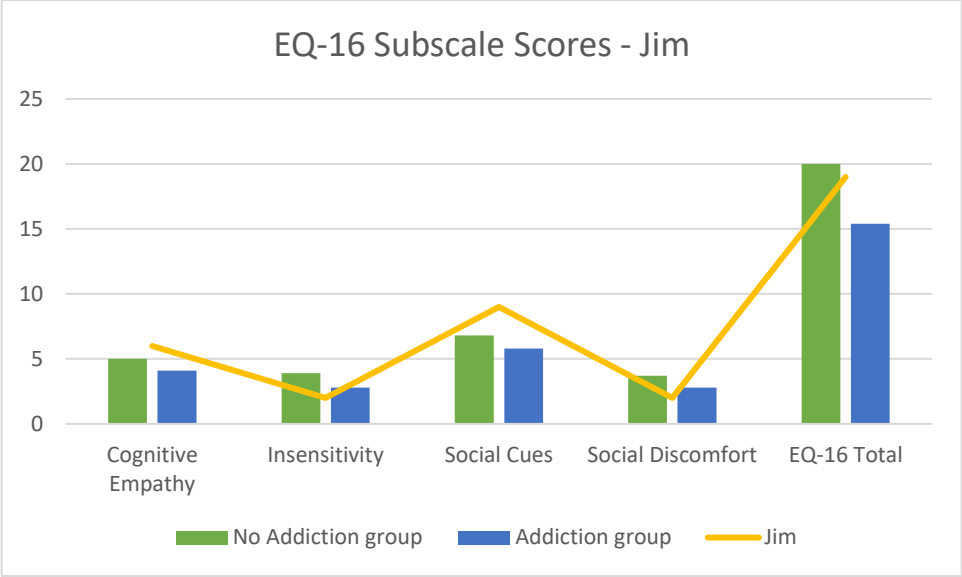

Figure 4.12: Pre-program EQ-16 scores for Jim compared with mean questionnaire scores for Addiction and No Addiction groups

Jim's scores on the full scale and subscales of the EQ-16 are shown in Figure 4.12. Unlike his DERS-26 and GHQ-28 scores, Jim's full-scale EQ-16 score was quite high, and much closer to the average for those fathers in the No Addiction group than the Addiction group. However, like Ray, Jim scored lowest on the *Social Discomfort* scale, agreeing with statements such as 'I often find it difficult to judge if something is rude or polite' and 'Friendships and relationships are just too difficult; I tend not to bother with them'. He also obtained a low (on empathy) score on the *Insensitivity* subscale, for example strongly agreeing with the statement 'People sometimes tell me that I've gone too far with teasing'.

However, he scored a high 9 out of a possible 10 on the *Perception of Social Cues* subscale, for example agreeing with statements that included 'I can easily tell if someone else wants to enter a conversation' and 'I can usually appreciate the other person's viewpoint, even if I don't agree with it', and perhaps even more surprisingly he obtained a higher *Cognitive Empathy* score even than the average for the No Addiction group. On that subscale Jim strongly agreed with the statements 'I can tell if someone is

masking their true emotion' and 'I am good at predicting what someone will do'. Given Jim's degree of mental ill health (and perhaps also the strong medication that he was taking), a high score on cognitive empathy would not have been predicted. However, rather than interpreting such responses as evidence of sound mental functioning and insight, these responses could be considered in light of his history (and perhaps also his personal therapy), and so it would appear that Jim may have learnt to survive by screening quickly for possible signs of unpredictable behaviour from others.

Group 2

Gary

Gary, who was in his mid-thirties at the time of the initial interview, is the father of four children. He explained in his initial interview that he started his addiction to alcohol in his teenage years, when he had "rebel issues". He was married at just 18 years of age and became a father soon afterwards. After a stormy marriage, Gary and his wife divorced; he recently became engaged to another woman whom he had known for over two years. He expressed how difficult the father role had been for him:

> That was probably the hardest thing I did find about being a dad, was working long hours and being continually tired and not in the right head space or, you know, physically feeling good to do stuff with the kids, you know. And I think it's a big thing these days, you know, the way things are, people working a lot longer, and I definitely know [for] myself, I was doing twelve-hour days and six days a week and then, you know, the Sunday you have off or the Monday: it's – you're basically just recovering. And now the kids want to spend some time with you, and you just – you don't have anything in you… [you] feel like you're just a pay cheque with legs, you know, as a father. It can be quite difficult.

Gary added that he did not appreciate the value of the time that he was spending with his children while he was still in the midst of addiction:

> I used to take for granted the time that I did spend with the kids, so now I suppose it's probably more fruitful. We get a lot more done, do a lot more things, more quality time.

Through the years of his addiction, Gary's relationships started to deteriorate to the point of separation from his then-wife and even from his two older children. Gary described in detail the painful experience of being a separated father:

> I used to suffer anxiety a lot, and that was when I first separated from the wife – like just seeing other families together… you start crying and stuff… My stomach would turn, and I'd go hot and sweaty and just felt like the world was just closing in on me.

Gary stated in the initial interview that his aims for the parenting program were to learn to be more patient, and also to mend the fractured relationships with his two older children (aged 15 and 13) and their mother. Gary said that he had been sending text messages to his children while he was in rehabilitation, but recently his older son, having been brought into an argument between his parents, had asked him to stop texting him.

Gary found it a struggle, not only with his older children and their mother, but to some extent also with their younger son, who was a very fussy eater, that he might have been developmentally behind where he should have been. Gary blamed these issues on his son's mother and the teachers at his pre-school. He also reported difficult relationships with his step-daughter – whom Gary reported as having ADHD and high levels of anxiety – as well as the ex-husband of his fiancée.

Being in the second group, Gary responded to a questionnaire at the start of the first group, and then a second one six weeks later, just before the parenting program started for his group. He chose to respond to the attachment questionnaire (FACQ) the first time with his four-year-old son in mind. However, for the second sitting of this questionnaire he chose to respond with the difficult relationship with his teenage son in mind. Gary was the only participant who chose different children in the two sittings of the attachment questionnaire.

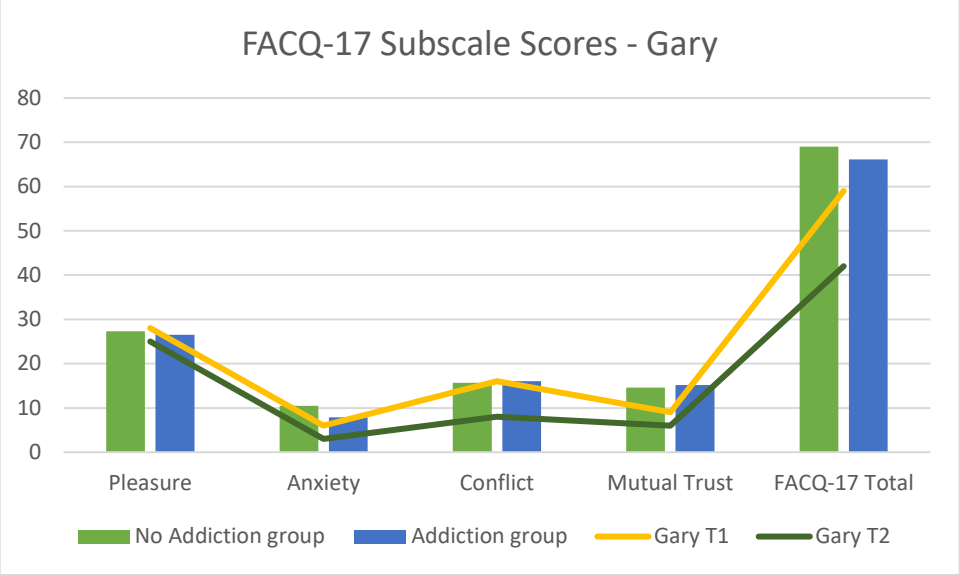

Figure 4.13: Pre-program FACQ-17 scores for Gary compared with mean questionnaire scores for Addiction and No Addiction groups. Note that Gary chose to focus his responses on his relationship with his 4-year-old son at T1 and his 15-year-old son at T2.

Figure 4.13 above shows Gary's attachment scores on two separate occasions. His total score (59) on the FACQ-17 on the first occasion in relation to his four-year-old son was below the average attachment score for the Addiction group, but not especially low. However, his FACQ-17 score the second time – concerning his relationship with his 15-year-old son – was substantially lower. Gary admitted at his initial interview that this relationship with his older son in particular needed mending, and his total score of just 42 on that questionnaire reflected this. The most notable difference between the two FACQ-17 scores was on the *Conflict* subscale, in which he scored 16 in relation to his younger son, but a much lower 8 (on a scale from 4 to 20 for which lower scores indicate greater conflict: see Table 4.1) concerning his relationship with his older son.

As well as indicating a turbulent relationship with his older son, Gary scored the lowest possible attachment score when focusing on his relationship with that son on the *Anxiety about relationship* subscale, strongly agreeing with each of the statements 'I often worry that I will lose my child's admiration', 'I am concerned that I do not spend enough quality time with my child', and 'It hurts me that my child may be closer to other family members than to me'.

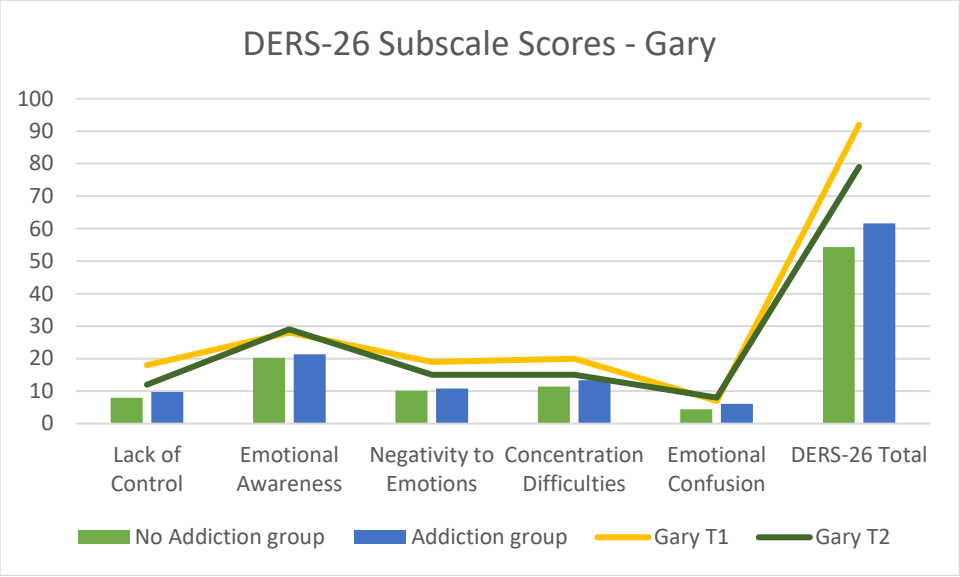

Figure 4.14: Pre-program DERS-26 scores for Gary compared with mean questionnaire scores for Addiction and No Addiction groups.

The graph in Figure 4.14 above shows Gary's two scores on the DERS-26 which, unlike his scores on the FACQ-17, were fairly close to each other. In this case, the fact that he answered the FACQ questions with a different child in mind from the first time would have had little influence on these results, which aimed to assess his level of difficulties with emotion regulation. These sets of scores indicate that Gary was indeed feeling that he was having difficulties in a number of areas concerning his emotionality, particularly the first time – his total DERS-26 scores were 92 and 79 respectively – both well above the average full-scale score for the men in both groups. Gary obtained particularly high scores on both the *Negative attitude to own emotions* and the *Concentration Difficulties* subscales, again especially on the first occasion. In fact, all of his subscale scores on both occasions were higher than the average for the Addiction group, indicating that Gary was not confident about his abilities to identify, make sense of, or control his emotions or his behaviour. In fact, this was corroborated in a sense by a later interview with his ex-wife, who claimed that it was Gary's violence towards her that precipitated the breakdown in their marriage.

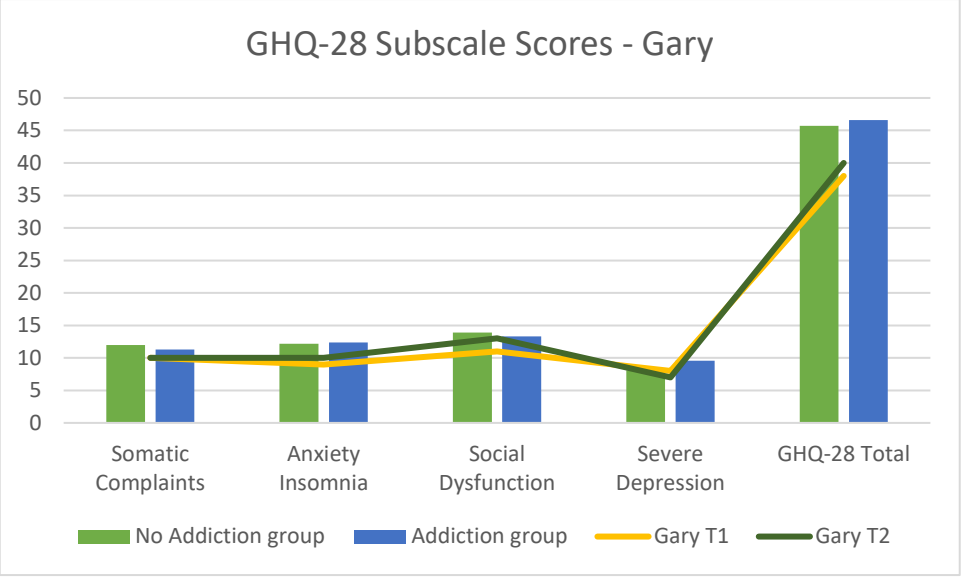

Figure 4.15: Pre-program GHQ-28 scores for Gary compared with mean questionnaire scores for Addiction and No Addiction groups.

Figure 4.15 above shows Gary's scores on the GHQ-28. It can firstly be seen that his scores on the two sittings of this questionnaire were even closer to each other than were his DERS-26. Gary's full-scale GHQ-28 scores were below the average for both groups, indicating that on both occasions he reported relatively few general health symptoms in the four weeks prior to responding to each questionnaire, as was indicated in the instructions to respondents on the GHQ (see Appendix B). In particular, his scores on the *Severe Depression* subscale were quite low, scoring 8 the first time and the minimum 7 the second time. So while Gary reported problems with his emotionality on the DERS, this did not appear to translate into self-reported mental health problems in his case.

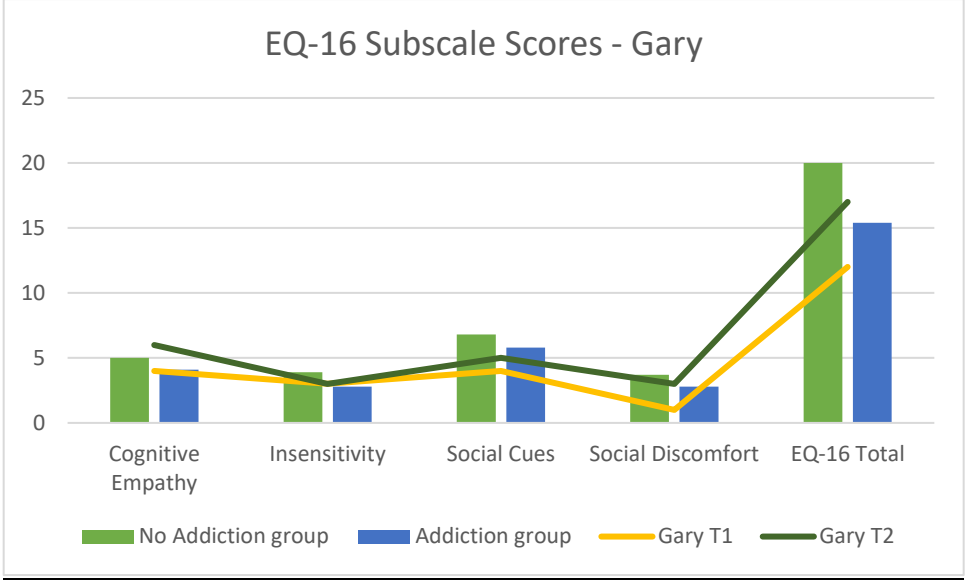

Figure 4.16: Pre-program EQ-16 scores for Gary compared with mean questionnaire scores for Addiction and No Addiction groups.

Gary's EQ-16 scores are shown in Figure 4.16. He scored quite low on the EQ-16 the first time in particular, with total scores of 12 and 17 respectively, reflecting a possible difficulty taking other people's perspectives and considering their emotions. Like some of the other men in the rehabilitation centre, Gary obtained fairly low scores on the *Social Discomfort* subscale of that questionnaire, especially the first time. For example, when he completed the EQ on the first occasion, for the statement 'I find it hard to know what to do in a social situation' he selected 'Strongly agree'. Gary also obtained relatively low scores on the *Perception of Social Cues* subscale on both occasions, for example only 'slightly' agreeing both times with the statement 'I can easily tell if someone else is interested or bored with what I am saying'.

Thus, Gary demonstrated particular difficulties in the areas of emotion regulation and empathy, especially the first time he responded to the questionnaires. This may appear to conflict to some extent with the change in his attachment scores over this six-week period prior to the start of the parenting program, which showed greater levels of anxiety and conflict the second time than the first. However, as these two sets of responses to the FACQ concerned two different children, it may be that, among other possible explanations, at the time of the first sitting of the questionnaires his relationships with

his children or indeed with other significant people were more troubled: for example, fellow rehabilitation residents, clinical staff, or his ex-wife.

It is also possible that in the second sitting Gary felt more of a contrast between his attachment ratings to his older son and the other questionnaire scores, which were somewhat more positive on the EQ and DERS, and so he may have responded accordingly. Moreover, the fact that Gary's empathy scores improved somewhat from the first to the second sitting of the questionnaires could be indicative of other factors occurring in his rehabilitation process. For example, since he was further along his own recovery, he may have had a clearer mind on the second occasion (notwithstanding his reporting of his troubled relationship with his older son at that time), and he may have had the opportunity to gain more insight into himself and other people over that ensuing six-week period between the two sessions.

In examining Gary's story and questionnaire profiles, what really stands out are his attachment scores, even concerning his relationship with his younger son, which he reported as being good, as those scores were at or below the average scores for the fathers in the Addiction group on three out of the four FACQ-17 subscales. Indeed, Gary expressed his regret during the parenting program that he became a father so early, without the time to enjoy his youth and his relationship with his then-wife as a couple before becoming a father. As he described his own father as being so rarely present, it is clear that he did not have a very consistent role model as a father, which would have exacerbated the difficulties that he experienced in his own parenting, in addition to the more recent factors that were present in the breakdown of his marriage.

Sam

Sam was the oldest father in the group at 50, and his children, in their early teens, were older than most of the children of the other fathers. During our initial interview, Sam touched on his own childhood, which began in a small European village. While he had some fond memories of that time, he described his relationship with his father as "volatile", in which he and his brother were "beaten up" by their father on several

occasions, to the point of having bleeding noses. Sam then described himself, by the time his family came out to Australia, as “an angry young boy for some reason”, as he was in trouble with the police by the time he was just 11.

Sam’s marriage was also turbulent. He admitted that he and his wife had been violent towards each other, sometimes in front of the children, who were quite young at the time. Sam reported that his wife developed an addiction early on in their marriage – he had custody of the children at that time – and Sam stated that he subsequently developed a dependency on alcohol and drugs himself. In fact, Sam’s addiction was so severe that he described how he had to drink enough alcohol to be almost “unconscious” in order to get to sleep. Sam reported that he was divorced seven years before the interview, and he saw a lot less of his sons in that time, a situation that he regretted. He appeared to place most of the blame for the breakdown of his marriage on his ex-wife.

Sam also revealed that, not long before he entered rehabilitation, he offered his younger (13-year-old) son some marijuana, after his son asked him about it. Sam said that he was himself stoned at the time, and also defended his action in part by explaining that the experience turned his son off the substance, but Sam still revealed some guilt and regret about his actions. In the interview Sam expressed his aims for the parenting program as working out how he should act when with his children, and also how to get along better with their mother.

In relation to his 13-year-old son, Sam’s major concern during the initial interview and the parenting program was his son’s welfare, as he was living in Sam’s ex-wife’s house, in which Sam reported that she was frequently intoxicated and invited whichever men she chose to stay with her. Sam also relayed a story in which his son invited a group of friends around to their house one evening, and the other boys smoked pot. Sam denied that his son was smoking pot at all at the time of the parenting program, but he expressed anxiety about this situation, and how it could affect his son. Sam was also upset about the fact that his ex-wife had apparently asked their son to look after her

marijuana plant in the house. Their elder son was living with his grandfather during this time, so Sam was less worried about him.

For all the anxiety and regret that Sam expressed in the opening interview (and in some of the parenting group sessions), Sam's overarching description of his experience of being a father was very positive. For example, when asked how he felt about spending time with his children, Sam replied, "Oh it's great; I love it… I can't get enough of them.". It was clear that he loved his sons, and he stated on more than one occasion that he was relieved that they "turned out pretty good kids compared to their parents". However, Sam also showed some awareness, as discussed above, that he had not been as good a father as he could have been, stating that he had a tendency in addiction to take for granted the time that he had with them.

There were some inconsistencies in a couple of Sam's statements, as he showed a tendency to make strong statements in order to make a point. For example, Sam said during his initial interview, "I've never, never taken that out on - if anything I've taken it out on myself", although he described later in the interview in some detail two incidents in which he had hit his sons (albeit as an illustration of an exception rather than a rule). And during one of the group sessions, Sam proclaimed: "I never raise my voice at my boys", but clarified that statement after one of the other fathers challenged him on that claim.

Sam showed some appreciation for others' feelings and perspectives, For example, in response to seeing one of the *Tuning in to Kids* DVDs depicting a father responding to his son, Sam commented, "I like how in the first one the dad stooped down to his level", and when Dave shouted during one of the group sessions Sam observed, "With your voice, you could say 'Oh, gees I love you mate', and you [would] scare the shit out of him". However, Sam had more trouble conveying such empathy on a consistent basis, even though he showed evidence of a very close attachment to his sons. For example, at one point Sam described his pleasure in his relationship with his sons as follows: "I could just lay there and cuddle them and just play with their hair and just look at them

and they – they just sit there and watch tele, like it's a pet cat or something". And after he told the story of offering his son marijuana, his assessment of that event in the opening interview was more defensive than empathic, as he rationalised his action by saying that his son put "pressure" on him to try some; Sam also stated that it had not affected him too badly: "So he's more aware of it and he's shied off [marijuana] now because of it".

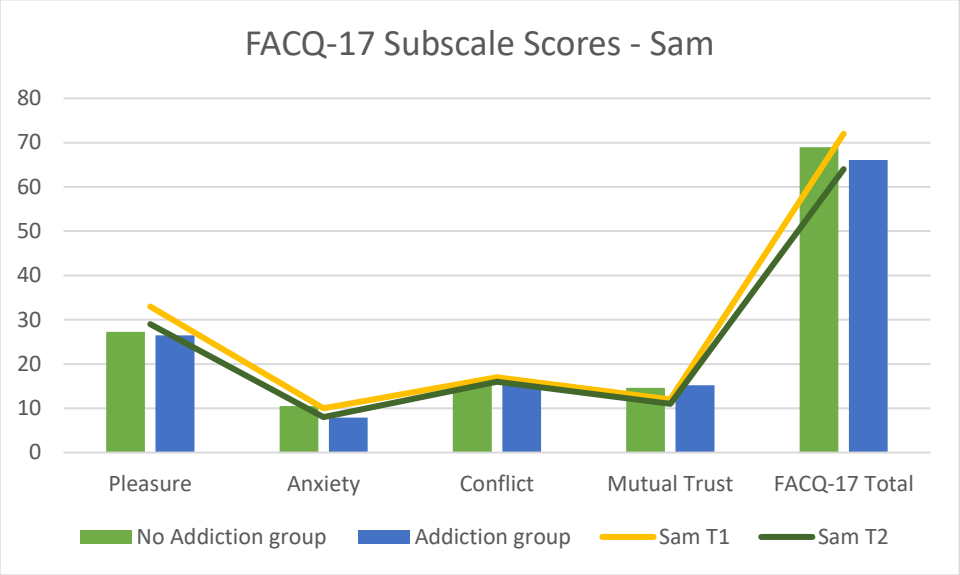

Figure 4.17: Pre-program FACQ-17 scores for Sam compared with mean questionnaire scores for Addiction and No Addiction groups.

Sam's score on the FACQ-17 (see Figure 4.17 above) was high the first time, scoring 72, suggesting that he felt quite secure in his relationship with his son at that time, although it dropped somewhat the second time to 64, still before the parenting program. Sam's subscale scores on both occasions were close to the average scores for the Addiction group, with the one exception being his *Pleasure in Relationship* score the first time, which was slightly higher than the corresponding average score for the No Addiction group. That score decreased from 33 to 29 the second time, with the difference due to changes in response from 'Strongly agree' to 'Agree' on questions such as 'I often feel proud of my child' and 'I feel a great deal of affection for my child'.

His responses to the second questionnaire also indicated a little less confidence in his relationship with his son related to anxiety and conflict. For example, where Sam indicated that he disagreed the first time with the statements on the *Anxiety about Relationship* subscale: 'I often worry that I will lose my child's admiration' and 'It hurts me that my child may be closer to other family members than to me', he selected 'Unsure' the second time for both of these answers. The change in Sam's responses could have been due to the instability in his moods associated with his addiction recovery process, as he displayed rather heightened anxiety during a couple of the parenting program sessions, although this explanation is not entirely consistent with his improved DERS-26 scores over the same time period (see below). More likely to be the case is that circumstances at home surrounding his son may have been more difficult the second time he responded to the questionnaire.

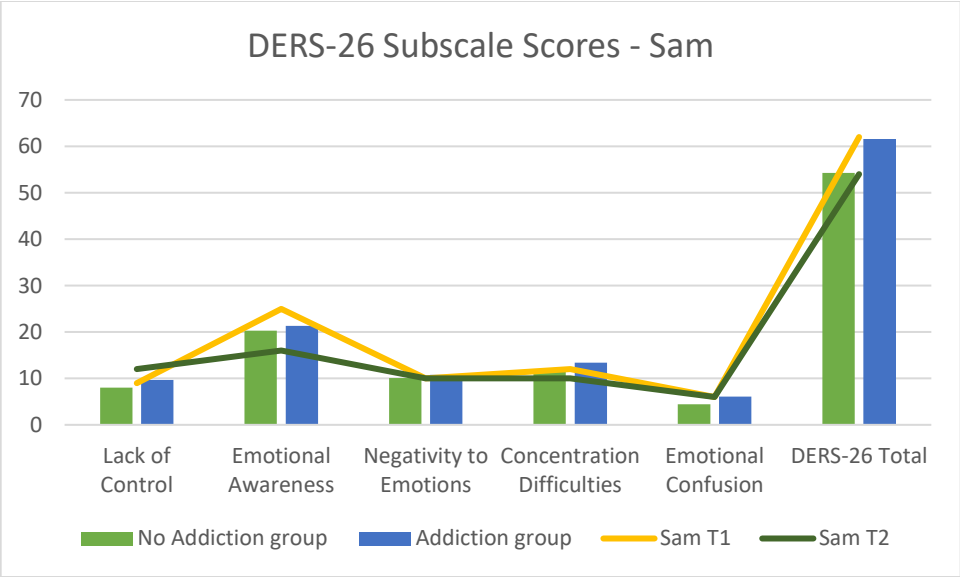

Figure 4.18: Pre-program DERS-26 scores for Sam compared with mean questionnaire scores for Addiction and No Addiction groups.

Sam's scores on the DERS-26 are shown in Figure 4.18 above. His full-scale score improved from 62 to 54, suggesting that he may have been experiencing less difficulty with his emotions when answering the questionnaire the second time. For example, to the statement 'When I'm upset, I believe that my feelings are valid and important' on the *Emotional Awareness* subscale he responded the first time with 'Sometimes', while his

response the second time demonstrated a little more self-confidence in this area, as he responded with 'Most of the time'. However, his subscale score on the *Lack of Control* did not improve; for example, he only responded with 'Sometimes' both times to the statement 'When I'm upset, I feel I can remain in control of my behaviours'. Sam's scores on the *Emotional Confusion* subscales were also quite high, as he responded to the statements 'I have no idea how I'm feeling' and 'I have difficulty making sense of my feelings' both times with 'Most of the time'. Taking these scores together with his scores on the *Emotional Awareness* subscale, it would appear that Sam's emotionality may have been becoming more stable due to his recovery process.

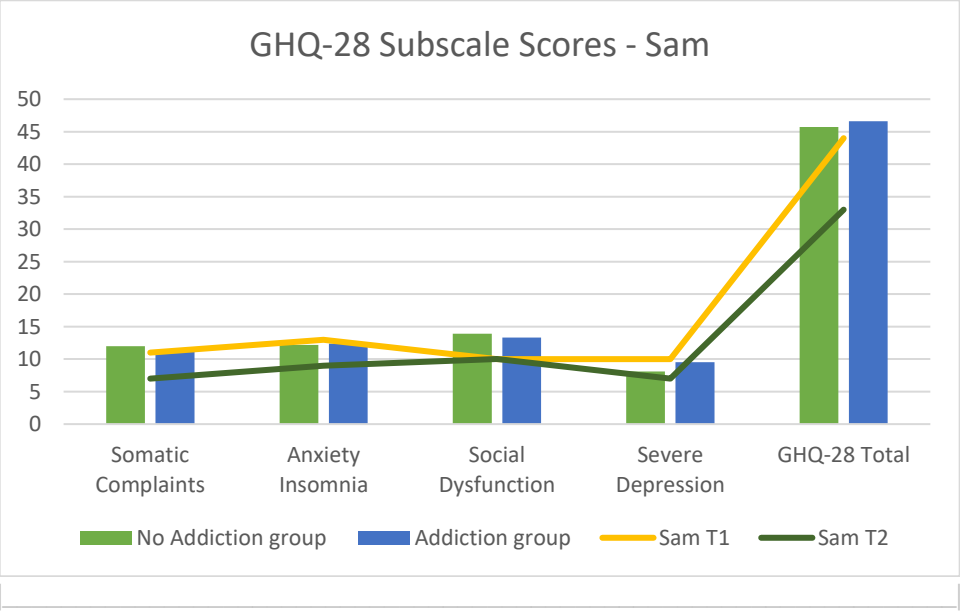

Figure 4.19: Pre-program GHQ-28 scores for Sam compared with mean questionnaire scores for Addiction and No Addiction groups.

Sam's GHQ-28 full-scale scores showed evidence of fewer self-reported mental health problems than most of the other fathers (see Figure 4.19 above), and like his DERS-26 score, his score improved from the first time (44) to the second (33). One area in which he answered with more confidence the second time was on the *Severe Depression* subscale. For example, the first time he responded to the questions concerning the possibility that he might 'do away' with himself or consider 'taking [his] own life' with 'I don't think so', while the second time those responses changed to 'Definitely not'. His

score on that subscale improved from 10 the first time to the minimum score of 7 the second time. Sam's scores also improved on the *Anxiety/Insomnia* subscale. For example, he responded to the question 'Have you recently lost much sleep over worry?' the first time with 'Rather more than usual'. The second time his response was 'No more than usual'.

In fact, his subscale score had decreased the second time (reporting fewer symptoms of anxiety and insomnia) from 13 to 9, which was consistent with his reported reduction in depressive symptoms, but not in his anxiety concerning his relationship with his son, which was greater the second time. It appeared, then, that Sam was reporting more mental health symptoms in the four weeks prior to the first time that he responded to the questionnaire, but while these symptoms may have generally subsided for him, he had simultaneously become more aware of problems at home with his son.

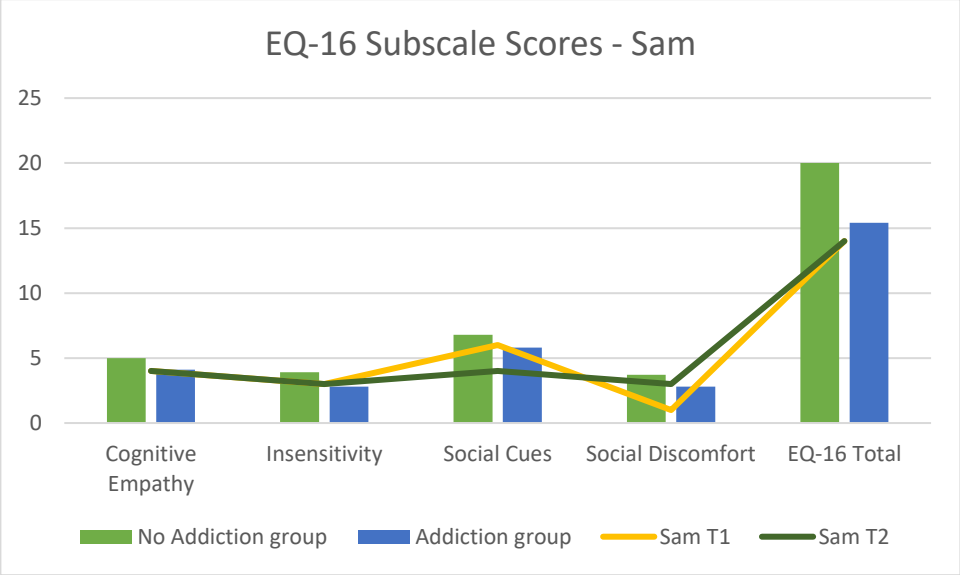

Figure 4.20: Pre-program EQ-16 scores for Sam compared with mean questionnaire scores for Addiction and No Addiction groups.

Sam obtained relatively low full-scale empathy scores of 14 and 13, slightly below the mean EQ-16 score for the Addiction group both times (see Figure 4.20 above). Sam's responses on the *Social Discomfort* subscale of the EQ-16 indicated difficulties taking other people's perspectives, particularly the first time. For example, Sam agreed with the

statement ‘I find it hard to know what to do in a social situation’ the first time that he responded to the questionnaire, and he indicated his agreement the second time with the statement ‘Friendships and relationships are just too difficult; I tend not to bother with them’. Sam’s subscale scores on the EQ-16 were generally closer to the averages of those of the Addiction group than the No Addiction group. This was fairly consistent with his subscale scores on the DERS-26, particularly in the areas of emotional confusion both times, and (lack of) emotional awareness, especially the first time.

Thus, while his EQ-16 score actually decreased slightly, when considering the improvement in both his DERS-26 and GHQ-28 scores, Sam appeared to demonstrate some evidence of higher functioning the second time he responded to the questionnaires, even allowing for his lower self-reported attachment scores. Again, this may have been related to some progress in his recovery in the six weeks between the first and second sittings of the questionnaires, notwithstanding the lack of increase in his empathy scores. Indeed, empathy levels may not progress as readily as at least some areas of emotion regulation, particularly as a number of the questions on the EQ concentrate less on feelings or emotional symptoms, which naturally fluctuate over time, and more on attitudes, which are more ingrained.

Dave

Dave described himself as “single”, and the mother of his three children as his “ex”. In an emotional interview before the start of the parenting program, Dave expressed remorse for his past actions, particularly to the extent that they had hurt his children. He vividly described the type of father that he felt he had typically been:

> The kids…were a burden unfortunately. I was an addict…I’d rather try and get away as quick as I could to go and get a high… I did not grab that responsibility…I was…a dad [but] I was a big brother really… in and out of addiction…since I was 13, and I’m 35 now and I’ve got three kids during addiction…me daughter was born while I was in jail.

Having already commenced his rehabilitation program a couple of months before joining the parenting program, Dave showed some insight into the relationship between his upbringing and his own parenting patterns, when discussing the athletic abilities of his son and himself:

> My eldest boy [said]: 'You hate me – you don't love me!'…I know the way I treated him unfairly or bully-like is the reason he was unsure and unwilling to try…harder.

Dave linked this experience with his son to his own as a boy playing baseball:

> [My parents] wanted me to play against the boys that were throwing balls at you and I started crying, 'No way, dad!'…and dad took me behind [the pavilion] and gave me a clip, and he said 'Get out there and have a go!'…and I smacked a home run.

He also reflected that his parents' lack of affection towards him as a child was part of the catalyst for his addictions, adding, "and so I've naturally found balance in drugs and alcohol".

Dave typically found it very difficult to cope with his nine-year-old son's anger with him: in a subsequent interview his ex-wife explained to me that Dave said on more than one occasion when he telephoned her to speak to the children, "Don't make [the nine-year-old] talk to me". Dave informed me in the initial interview that he was finding these phone calls with his children and their mother so stressful that he decided to turn off his phone and ask his case worker to speak to them instead. He also shared the following in one of the group sessions, in relation to his two-year-old son and himself: "And it's just in him…it was in me too: just loud, just boisterous, just wanted to wreck stuff…I guess we get all the attention…it's all about 'me'"; and about his parents, in particular his father: "We've had some pretty heavy fights…I've trashed them; I've stole off them". Dave's questionnaire responses provided some more insight into his state of mind leading into the parenting program, as outlined below.

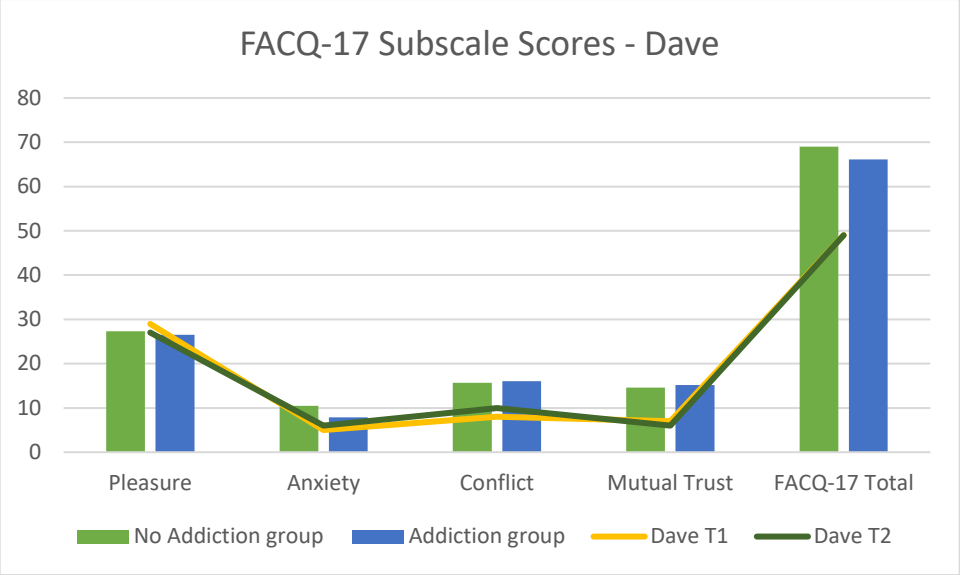

Figure 4.21: Pre-program FACQ-17 scores for Dave compared with mean questionnaire scores for Addiction and No Addiction groups.

In responding to the FACQ, Dave considered his most difficult relationship with his eldest (9-year-old) son. He obtained a relatively low score of 49 on both occasions on the FACQ-17. In fact, all of his subscale scores on both occasions were below the average attachment scores for the men in the Addiction group. In particular, his scores both times on the *Conflict* and *Mutual Trust* subscales reflected quite a troubled relationship with his son, as shown in Figure 4.21.

Indeed, Dave was the only father who agreed both times with the following two statements on the *Conflict* subscale: 'I get frustrated with my child' and 'I am constantly yelling and fighting with my child'. Based on his description in the opening interview, Dave is likely to have placed most of the blame for this turbulent relationship on himself. This conclusion is supported to some extent by a number of his responses on the *Pleasure in Relationship* subscale, in which he paradoxically agreed with statements such as 'I feel my child is good' and 'I often feel proud of my child'.

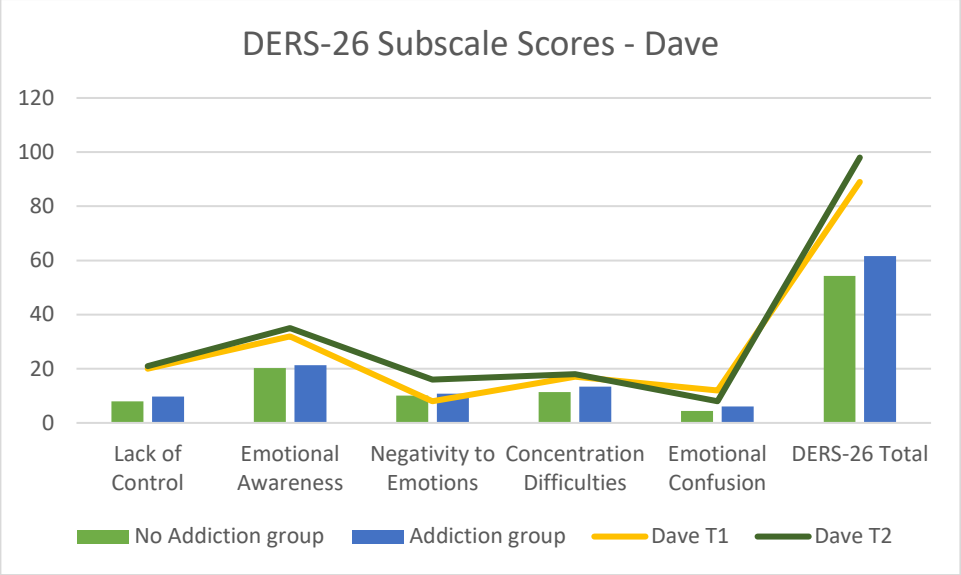

Figure 4.22: Pre-program DERS-26 scores for Dave compared with mean questionnaire scores for Addiction and No Addiction groups.

Dave also indicated a very high level of difficulty controlling his emotions, scoring 89 and 98 on the DERS-26 – well above the mean total score for both groups – and scoring high on each of the subscales (with one exception) both times, as shown in Figure 4.22. Dave's responses indicated that he was struggling in particular with control of his emotions and actions: his score of 21 both times on the *Lack of Control* subscale was well above even the Addiction group's mean score of 9.7. His scores both times on the *Emotional Awareness* and *Emotional Confusion* subscales were also high, indicating a lack of emotional clarity and some difficulty making sense of his emotions. In addition, Dave obtained high scores both times on the *Concentration Difficulties* subscale, and the second time on the *Negative attitude to own emotions* subscale, which contained descriptions of feeling 'ashamed', 'angry', 'guilty' or 'embarrassed' when one is upset.

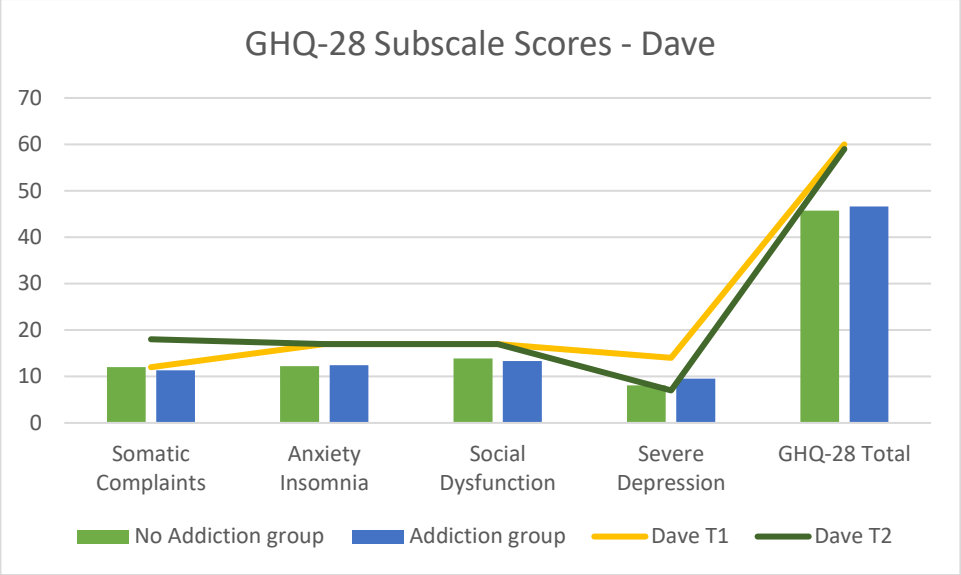

Figure 4.23: Pre-program GHQ-28 scores for Dave compared with mean questionnaire scores for Addiction and No Addiction groups.

Dave's scores on the General Health Questionnaire showed evidence of mental health symptoms, with full-scale scores both times a very high 59 (group averages were both below 47). Dave's GHQ-28 scores are shown above in Figure 4.23. He reported trouble with his recent mental and physical health on all subscales including the *Severe Depression* subscale the first time, with a high score of 14, although the second time his score was the minimum 7. This is consistent with the higher score on the *Negative attitude to own emotions* subscale the first time, in which Dave agreed that he felt negatively towards himself for feeling upset. Dave also reported some distress through high scores on the *Anxiety/Insomnia* subscale, agreeing both times that he had recently 'felt constantly under strain' and 'been getting edgy and bad-tempered'.

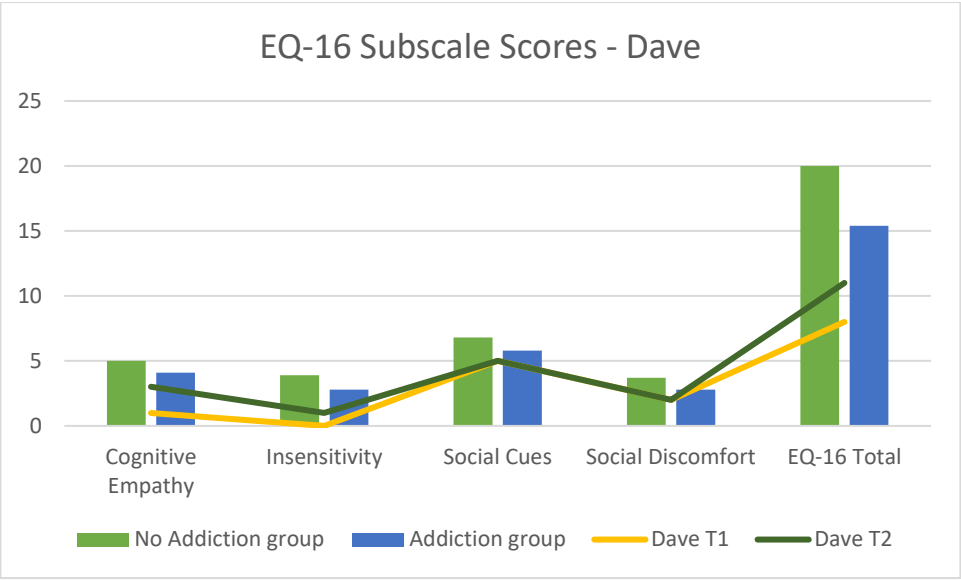

Figure 4.24: Pre-program EQ-16 scores for Dave compared with mean questionnaire scores for Addiction and No Addiction groups.

Dave's scores on the EQ-16 – 8 and 11 on the two occasions – suggested quite a limited general capacity for empathy on all subscales: see Figure 4.24. His scores were particularly low on the *Cognitive Empathy* and *Insensitivity* subscales, especially the first time. For example, on the former subscale, Dave disagreed the first time with the statement 'I can tell if someone is masking their true emotion', and he disagreed both times with the statement 'I find it easy to put myself in somebody else's shoes'. And on the latter subscale, Dave agreed both times with the two statements 'People sometimes tell me that I have gone too far with teasing' and 'Other people often say that I am sensitive, though I don't always see why'.

Although Dave obtained very low empathy scores (as well as low attachment scores), he displayed some evidence that his general inability – or even unwillingness – to empathise with others, was not necessarily reflected in his feelings towards his children. In that domain his remorse was consistently related to the negative effects that he felt his actions had had on them. He said that he would have been happy to continue with his excessive drinking and even go back to jail were it not for his children. He explained that fatherhood was much easier when he was in the throes of his addiction than in recovery, because his identity as an addict shielded him from having to take more

responsibility. According to his responses in this interview and in the group sessions, Dave's decision to undergo the rehabilitation process was almost exclusively motivated by his concern for his children's welfare.

Mick

Although Mick was not present at the initial interviews, he spoke briefly about his situation before he attended his first parenting program session, and so his story as presented below was obtained from that conversation and his first few group sessions. It also meant that, unlike the rest of the fathers, he completed his second questionnaire during the parenting program instead of before it, so those results are interpreted with that in mind.

Mick was an articulate man in his early thirties who described himself as a professional labourer and a keen musician, and was very keen to join the parenting program even though the interviews and first group sessions had already been completed. While he was seeing his young children (20-month-old twins at the time of the parenting program) infrequently – he was separated from his wife at that time – he was a willing participant in parenting courses: this was his third, and he intended to do a fourth.

Mick described how his life was turned upside-down when his best mate had an affair with Mick's wife; Mick attacked him, was charged with assault, and went to prison. He endured quite a harrowing 18 months as a result of this, since not only did he spend time in jail and then have an AVO out against him, but his ex-mate and ex-partner had complete custody of his children, and he felt that he could not even visit suburbs close to where they were living. This was due to both his ruined reputation and his extreme anxiety at desperately wanting to see his children, but equally desperately wanting to avoid his ex-partner and her new partner. Mick spoke of the anxiety that he was experiencing as a result of all of these factors:

> I don't know if I've got a cure at the moment for that, apart from I don't want to get on valiums or anything… I've got to realistically look at the point of view when I get through my time here to move [out of this area]. I really don't want to. I've got work, I've got family [here], but to protect me I've got to do it, you know what I mean? It's

not something that I really want to do because I don't like change. I'm very apprehensive about it. I can see positives in moving but the negatives outweigh the positives – but I have to do it. So… that's probably all based on my own protection but mainly probably … it's anxiety. It's knowing that if I'm put in a situation, I won't deal with it. Knowing that I can – if I'm drinking I've got no chance of handling the situation but I'm still quite capable of making a bad choice… because I've still got that resentment and I've still got that hurt.

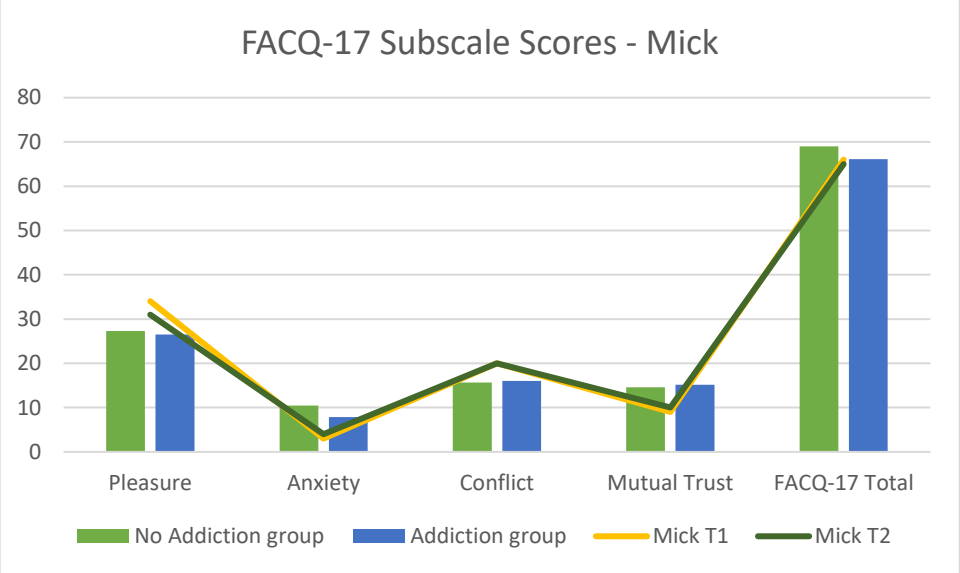

Figure 4.25: Pre-program FACQ-17 scores for Mick compared with mean questionnaire scores for Addiction and No Addiction groups.

Figure 4.25 above gives an indication of Mick's attachment to his young son (whom he chose as the focus of attachment for this questionnaire), as reflected by his FACQ-17 scores. It was clear that Mick was very devoted to his young children: he spoke with fondness about his time spent with them, and often expressed his regret at not being able to be with them more often. However, his total scores on the FACQ-17 were 66 and 65, about average for the fathers in this study who identified as having an addiction. Like a number of the other men in the recovery program, Mick's scores on this questionnaire were lowest on the *Anxiety about relationship* subscale, indicating greater anxiety and less confidence about his relationship with his son. For example, he agreed with the statements 'I often worry that I will lose my child's admiration' and 'It hurts me that my child may be closer to other family members than to me', selecting 'Strongly agree' for the first statement the first time. The 'family members' that Mick had in mind when he responded to that question may well have been his ex-partner and his ex-mate. Mick also

obtained relatively low scores on the *Mutual Trust* subscale (again indicating less secure attachment in that area), although this may also have been related to the fact that his children were very young and not yet able to articulate their feelings towards him.

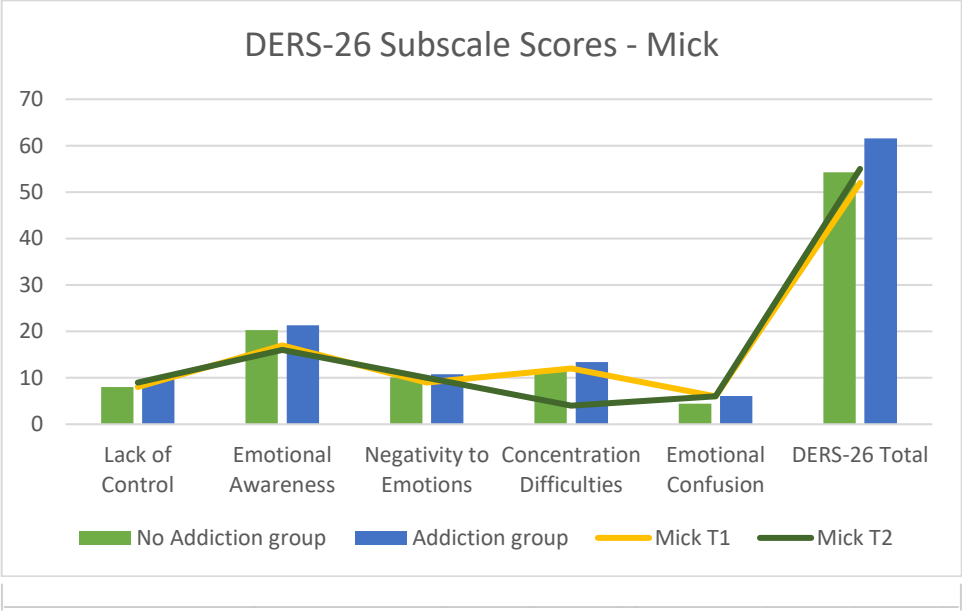

Figure 4.26: Pre-program DERS-26 scores for Mick compared with mean questionnaire scores for Addiction and No Addiction groups.

Mick's full-scale and subscale scores on both sittings of the DERS-26 are shown in Figure 4.26. Mick's behaviour as recounted in his narrative throughout the parenting program naturally suggested significant difficulties with controlling his emotions, although his total scores at the two sittings of the DERS-26 were, at 51 and 55, somewhat lower than the average total score for the fathers who identified as having an addiction; moreover, his scores on the *Lack of Control* subscale were – again despite his admission of his violent behaviour towards his former best mate – both below the average relevant subscale scores for the Addiction group. The most notable scores within Mick's DERS-26 were on the *Concentration Difficulties* subscale. For example, the first time his response to the statement 'When I'm upset, I have difficulty focusing on other things' was 'Most of the time', and the second time his response was 'Sometimes'. And his response to the statement 'When I'm upset, I have difficulty

thinking about anything else' was 'Sometimes' the first time and then 'Most of the time' the second time.

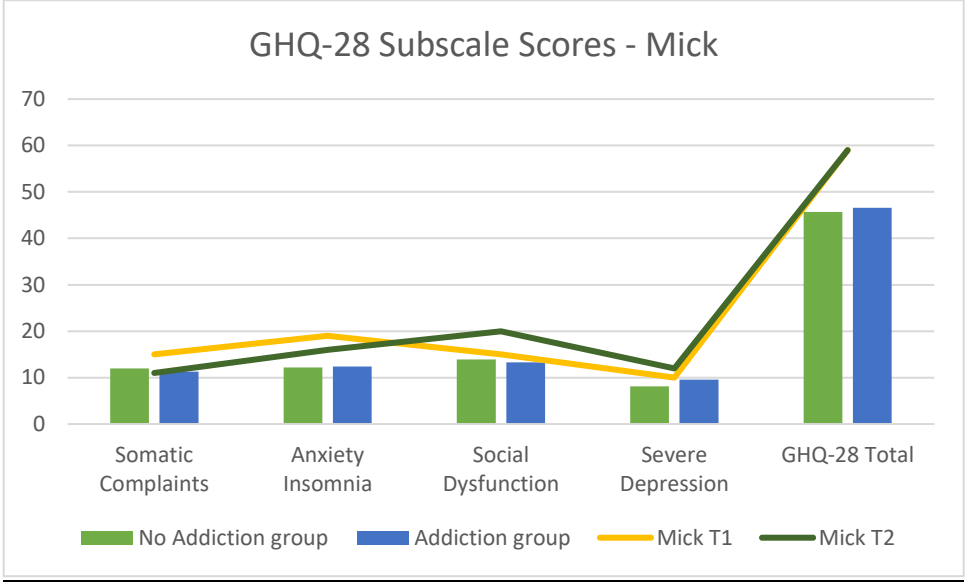

Figure 4.27: Pre-program GHQ-28 scores for Mick compared with mean questionnaire scores for Addiction and No Addiction groups.

Figure 4.27 above shows Mick's scores on the GHQ-28. He obtained elevated scores on all subscales, notably on the *Anxiety/Insomnia* and *Severe Depression* subscales. For Mick, difficulties in concentrating (from his DERS-26 score) may also have been a symptom of an underlying depression, as his scores on that subscale were, at 12 and 14, both well above the average scores for the fathers in the Addiction group. Indeed, Mick's full-scale GHQ-28 scores both times were 59, which was well above the mean score for those fathers who identified as having an addiction. His other subscale scores were also elevated, including his reporting of symptoms on the *Anxiety/Insomnia* subscale – a clear indicator of the stress that he was experiencing in relation to his children and his former partner.

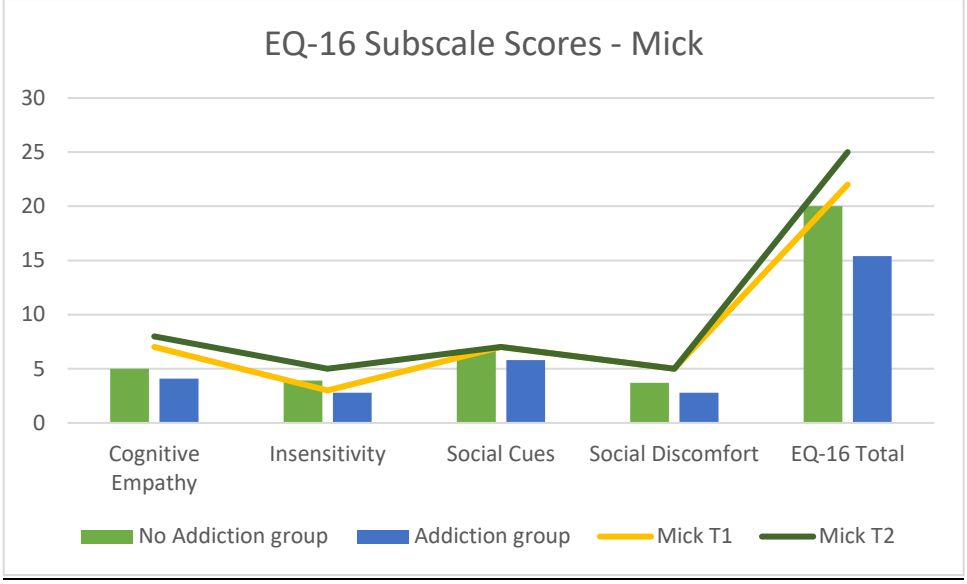

Figure 4.28: Pre-program EQ-16 scores for Mick compared with mean questionnaire scores for Addiction and No Addiction groups.

Figure 4.28 shows Mick's scores on the EQ-16. Mick's total scores indicated that his general empathy levels were not low: he scored 22 and 25 respectively on this questionnaire. In fact, these scores were above the average score for the sample of respondents who identified as having no addiction (mean EQ-16 score 19.9). There could of course be a number of reasons for these scores being higher than expected, one of which may have been the fact that Mick had already completed two parenting programs before the current one, and these programs may well have also helped to foster more empathy in the participants (which was indeed one of the aims of this program), or at least he would have known the answers that he 'should' have given. It could also be in part a measure of a slightly more thoughtful nature (paradoxical though that hypothesis may be, given Mick's actions).

For example, Mick was one of the few men who disagreed with the statement 'I am very blunt, which some people take to be rudeness, even though this is unintentional' (none of the 20 selected 'Strongly agree' for that statement); he was again one of just two men to select 'Strongly agree' in response to the statement 'I can easily work out what another person might want to talk about'. In fact, his score on the *Cognitive Empathy* subscale was easily the highest of the seven participants who ultimately completed the

parenting program. Nevertheless, like some of his fellow residents in the rehabilitation facility, Mick scored lowest within this questionnaire on the scale labelled *Insensitivity*, at least the first time.

In some ways Mick's responses were quite contradictory: although he reported relatively high levels of depression and anxiety through his responses on the GHQ, and his anxiety was also reflected in the relevant subscale of his attachment questionnaire, he reported rather low levels of emotionality on the DERS, and his responses on the EQ suggested quite an enhanced capacity for empathy. But Mick came across as quite an intelligent man, and together with his experience with parenting courses, this may have partly explained his relatively high empathy scores, at least. He was also keen to join the current program even after it had started and he had been initially discouraged to do so, due to a desire to obtain the certificate at the end of the program to show that he was indeed worthy of looking after his children.

Coming Chapters

As indicated earlier, following the initial interviews, most of the fathers in both rehabilitation centres who responded to the questionnaires then commenced the parenting program. The components of that program and how it impacted the fathers and their stories will be presented in Chapter 5. The material provided in both of these chapters will then lay the foundation for the full phase 2 analysis in Chapter 6, which will seek to answer the second and third research questions. These questions asked how fathers in recovery from addictions experience fatherhood (RQ 2), and how participating in an empathic parenting program might help them reassess their parenting capacities and affect their levels of empathy and mental health (RQ 3).

CHAPTER 5. DYNAMICS, CHALLENGES, HEARTFELT MOMENTS

Introduction

In this chapter the parenting program, which included both child-focused and self-focused emotional skills, will be described in detail in terms of the planned content, as well as the themes and dynamics that emerged during these sessions. I will trace how the seven fathers who participated responded to both the program content and the interpersonal relationships with the other fathers. There was some friction among some of the men, particularly in the sessions that explored anger. But there were also some special moments, in which some of the men offered empathic and supportive comments when others described apparently hopeless personal circumstances.

The Fathers' Parenting Program

From Initial Interviews to Parenting Program

In the previous chapter, we have been introduced to each of the fathers in the recovery centres who volunteered to be part of the program, and the general themes that emerged concerning their childhoods, their relationships with their own fathers, the development of their addictions, and their experience of being a father currently in recovery from an addiction. Most of the fathers who gave their consent to participate decided to continue into the parenting program. Of the 20 fathers who completed the first sitting of the questionnaires, 14 commenced the parenting program, including two men who did not attend the initial interviews.

What motivated these men to be part of the parenting program? Firstly, of the six men who did *not* commence that program, four had dropped out of the rehabilitation program before the first parenting program session. Reasons were not given for their absence, but one of the clinical staff explained that the most frequent reason for leaving the rehabilitation program before completion was using substances on the premises. The remaining two, who continued with their rehabilitation process, told me that they did not wish to commence the parenting program. Darren, who described himself as being in a happy marriage, said that he felt the program would not be relevant for him, and another

father also elected not to participate in the parenting program, so he did not attend the interview either.

In relation to what might have motivated the men to join the parenting program, firstly the contact staff in the rehabilitation centres were provided with a flyer, which they were asked to display. It was headed 'What's it like being a Dad?' The text on the flyer simply invited fathers to participate in the research. To an extent, the individual interviews also aimed to uncover the men's motivation for participating. In addition to the questions outlined in the previous chapter, each man who attended the initial interview was asked: "If you could change something about the way you father your children, what would you change?" Most of the men responded that they would like to be free of their addiction and spend more time with their children. In addition, a few of the men said that they would like to improve their moods and behaviour around their children; one man said that he wanted to communicate better with his children, and another man said that he also wanted to "brush up on a few [parenting] skills". Most of the men's responses were not specifically related to undertaking a parenting course, so the men were each asked for their goals for the program in the first session as well. Those goals will be discussed in the next section.

It should be added that, although the research information provided to the directors of the rehabilitation centres that participation in the program needed to be voluntary, and that one of the specific exclusion criteria was having legal custody issues, exceptions were made to both of these conditions. Of the two men who missed the initial interview, one told me that he was advised by the rehabilitation program manager that he "should participate" in the parenting program (he was facing an impending court trial – he did not ultimately complete the parenting program), and the other said that he really wanted to join, even if he had missed a couple of sessions. The implication – which he later confirmed – was that he could benefit from the recognition, rather than the skills, from having completed the program. In addition, some of the men asked in the first session if they would receive a certificate at the end of the program. So although the aim was for

the men to benefit from intrinsic goals, the reality was that for some of the men, at least, their motivation was likely to have been extrinsic.

Choice of Program

The program initially chosen as the basis for the intervention component of the present study was the *Tuning in to Kids* (TIK) parenting program. This program was chosen for the following reasons. Firstly, the TIK program was designed for parents of young children with behavioural and emotional disturbances (Havighurst et al, 2004), which was expected to be the case with many of the children of the fathers in recovery from addictions chosen for this study. Secondly, the TIK program was founded on the principle of emotion coaching (Gottman et al, 1997), which is one clear means by which empathy could be conveyed from parents to their children. As the literature reviewed in Chapter 1 indicated, children require empathy from their parents for healthy emotional growth (Siegel & Hartzell, 2004; Manczak et al, 2016); empathy has been shown to be lower on average in men than in women (Christov-Moore et al, 2014), and specifically lacking in people with addictions (Ferrari et al, 2014), even those who had been abstinent for some time (Martinotti et al, 2009).

Thirdly, another component of the TIK program was the focus on the parents' own attachment patterns, which Bowlby's (1969) theory predicted would continue throughout their later relationships, including those with their children. Disorders of attachment were considered to be likely to underlie the emotional and behavioural problems for the children of the fathers in this sample (Dubois-Comtois. Moss, Cyr & Pascuzzo, 2013). Finally, the TIK program was normed on Australian parents, providing more relevance for the present study. The standard six-session format of the TIK program for parents of children of pre-school and primary school-age is as follows (Havighurst & Harley, 2009):

1. How to raise emotionally intelligent children
2. Naming the emotion
3. Understanding your child's emotional experience
4. Problem-solving and self-care when Emotion Coaching
5. Emotion Coaching your child's anger
6. Emotionally intelligent parenting: now and in the future

The authors of the TIK program also provided an alternative eight-session format, which was designed to slow down the program and allow for more review of the skills, where relevant (Havighurst & Harley, 2009). The extra sessions were on self-care and skills consolidation.

Adaptations to the Parenting Program for men in addiction recovery

As explained in Chapter 1, while the TIK program was considered the most appropriate general parenting program for the purposes of the present study, the participants in that program had previously mostly been mothers (Havighurst et al, 2009), and TIK was not specifically designed for parents with addictions. On examination of the content of group programs used in studies involving participants with addictions (e.g.Ford & Russo, 2006), including a program for addicted parents (Plasse, 1995), it became clear that certain changes to the TIK program would be necessary in order to cater for this clinical sample of fathers. In addition, the TIK program was developed principally to enhance both the parents' relationships with their children and their children's healthy emotional development (Havighurst et al, 2004). While the researcher also considered those two aspects to be of high importance in the delivery of the parenting program in the present study, the primary focus in this case was to be on the fathers themselves.

One of the central themes in the literature on addiction has been emotion, including difficulties in emotion regulation (Gratz & Roemer, 2004; Mennin, 2006; Fox et al, 2007; Buckholdt et al, 2015) and reduced emotional intelligence (Kun & Demetrovics, 2010; Sudraba, Rancans & Millere, 2012). Accordingly, training in emotional awareness and management has been increasingly employed with addicted clients in individual and group therapy (Ford & Russo, 2006; Azizi, Borjali & Golzari, 2010), including addiction

recovery programs (www.salvos.org.au; www.odysseyhouse.com.au; www.southpacificprivate.com.au).

Therefore, one of the key additions made by the researcher to the parenting skills in the present study was training in emotion regulation, using particular interventions advocated by practitioners experienced in this area, including Daitch (2007), Armstrong (2008), and Leahy et al (2011). In addition, Flores (2001) concluded from his analysis of the theory and evidence on group programs that addiction could be characterised as a disorder of attachment, and Bowlby (1973) identified the two principal emotional states related to separation from one's attachment object – a common occurrence for these fathers – as anxiety and anger. Thus, specific skills in managing fear, anxiety and anger (Dietz, 2003; www.kidsmatter.edu.au) were also incorporated into the program.

Data from the first phase of the present study were also used in determining the composition of the parenting program for the current sample of fathers in recovery from addiction. The differences between fathers with and without addictions according to their attachment to their children, and their levels of emotion regulation, mental health and empathy were examined via the item analysis, which was carried out in Chapter 3. This revealed significant differences on nine questions (see Table 3.23). The general themes on those nine items for the fathers in the Addiction Group were anxiety about, and a lack of trust in, their relationships with their children (these were from three responses on the Fathers' Attachment to Children Questionnaire); emotional confusion; severe depression; and social discomfort.

The actual content of the three questions on the FACQ on which the men in the Addiction group scored significantly lower than the No Addiction group was considered very useful in informing some of the questions to be asked by the researcher in the group sessions. Specifically, many of these men were anxious about losing their children's admiration and in some cases, their entire relationship with their child. This spoke to the anguish that these men might have been enduring, but also perhaps their motivation to do something about it.

All sessions were to centre around the men's relationships with their children, but the researcher considered that a full session should also be devoted to the issues of handling their own anxiety and helping their children with anxiety. Of the other three discriminating themes – emotional confusion, depression and social discomfort – another session was already planned to include psycho-education about emotions and practice in handling strong emotions generally (from TIK program content), as well as meditation practice each session to support the men to just 'sit with' their emotions, which is also employed in programs to help reduce the impulse to resort to using substances (van Dijk, 2012).

Concerning severe depression, the researcher included in the first group session a statement that all the information given by the participants throughout the program would be kept anonymous and confidential from all staff at the rehabilitation centres unless the men were to make any threat of harm to themselves or others. In addition, each man in the rehabilitation centres had his own case manager, and in many cases also a psychologist, so the researcher considered safety issues to be appropriately managed. The other circumstances in which the participants' depression might be relevant was considered to be when anxiety and anger were to be discussed, and when the topic of attitudes to one's own emotions ('meta-emotion' using the TIK terminology) were explored in another session. On each occasion the researcher was careful to monitor the men's reactions to the information presented. And regarding social discomfort, the group format provided an opportunity for the men to safely explore and discuss their emotions and experiences with their children without judgement, thereby aiming to reduce the need for such discomfort, at least in this setting.

More relevant still, the information gleaned from the individual interviews with the fathers who volunteered to participate in the parenting program was used to help inform the content of the program's sessions. Firstly, the men were asked in those interviews what their aims were for the parenting program, and so this information, together with a summary of some of the themes that arose from those interviews, was included in the parenting program. Some of the other major themes that arose in those interviews

included (i) the joy of spending time with their children; (ii) their sense of helplessness in potentially losing those relationships; (iii) the effect of their addiction on their families; (iv) their lack of readiness to be fathers; (v) their children's mental health; (vi) their own grief and loss; (vii) their relationships with their own fathers (or step-fathers); and (viii) their relationships with their children's mothers.

Among the themes listed above, numbers (i) and (v) were already planned to be part of the program content, and it was expected that issues (ii), (iii) and (viii) would naturally arise in the group conversations. In addition, space would be created to sensitively explore issues (vi) and (vii) if anyone wanted to open up within the group concerning these topics, and issue (iv) would be expected to form part of the whole group process since this parenting program can be considered a developmental intervention for these fathers since, as discussed in Chapter 1 under the topic of masculinity and fathers, boys in our society are socialised (in various ways) to become men, but not naturally to become fathers.

In addition, the researcher considered it important to tailor the program to the particular needs of men, who have been found generally to be less likely than women to seek or respond positively to counselling/psychotherapy. Therefore, while therapeutic interventions such as training in emotion regulation were included, the researcher adopted a less formal and more phenomenological approach in order to help put the men at ease. Another feature of men's groups traditionally found to be enriching and effective has been to allow space for story-telling (King, 2005; Biddulph, 2010; Henry, 2013), so a priority was to be placed on hearing the men's individual experiences throughout the program.

Researcher Training

In preparing to run these parenting groups the researcher, who is a registered psychologist and has a background as an adult educator, first undertook training to become a TIK facilitator. This involved attending and participating in a two-day workshop that was run by the creators of the TIK program. In the workshop, participants

were given a combination of lectures on the background to the program, group discussion, skills practice sessions (including participants role-playing parents or children), worksheets and other resources, and training in how to use them as a TIK group facilitator (Havighurst & Harley, 2009). Following that training, the researcher gained two more days of training, firstly in group-work skills related to working with men (King, 2005; Henry, 2013), and then specifically in working with fathers with addictions (King, 2005).

Within this training, the researcher gained the opportunity to receive feedback from the trainer on his group leadership skills, as well as education and discussion concerning advanced group leadership skills with these populations. This latter training helped give the researcher the extra skills required to be able to tailor the program to this population of fathers with addictions. In addition, through supervision and consideration of his roles as a father, a son of an addicted father, and a trained therapist, the researcher was able to adopt a position of reflexivity (Palaganas et al, 2017), in which he was able to reflect on his influence both on and by the research, and was careful to remain open to the men's descriptions of their own experiences.

Program Outline and Delivery

Based on the above information and training, the researcher planned to run eight weekly sessions, incorporating extra emotion regulation skills and the other content as described above into each session. These sessions were set against the backdrop of the residential rehabilitation program, so the fathers who volunteered to participate in the parenting program were by necessity choosing to miss out on whichever activity or group was planned at that time. During the sixth session of the first group, it transpired that the men were required at compulsory activities at that time in the ensuing weeks, and so the researcher had to take the decision to make the following session (the seventh) the final one. Therefore the final program outline, delivered to both groups, was revised, as shown in Table 5.1.

Each session included a relaxation/meditation exercise, usually at the beginning. Some of the program content was already part of the men's rehabilitation program (notably, the skills of anger management), so the aim of the program in such cases was to build on such skills in the context of being fathers. The session content of the program as delivered to the men can be found in Appendix D.

Table 5.1: Parenting Program for Fathers in recovery from addictions: Weekly Program Structure

Session 1:	Introduction; group goals; small group sharing
Session 2:	Emotions: awareness, attitudes to your emotions; strategies for handling strong emotions
Session 3:	Handling strong emotions: recap on positive and negative strategies for your own emotions; handling your children's strong emotions
Session 4:	Introduction to emotion coaching
Session 5:	Anxiety: handling your own anxiety; emotion-coaching your children when they are anxious
Session 6:	Anger and sadness: managing your own anger and sadness; emotion-coaching your children when they are angry or sad
Session 7:	Revisiting goals; practising emotion coaching; completion of post-program questionnaires; feedback

Two groups of fathers in parallel rehabilitation centres joined the parenting program. The first group started approximately six weeks before the second (see Table 2.5). Six men commenced the parenting program in the first group, while eight commenced in the second group, with 50% completion rates in both groups. See Table 5.2 below (all names are pseudonyms). While the discussion of each session refers to all 14 participants, the analysis in the next chapter focuses exclusively on those seven fathers who completed the parenting program.

Table 5.2: Participants in Fathers' Parenting Program

Group 1: Carl*, Rod, Ray*, Jim*, Simon, Gavin

Group 2: Brian, Dave*, Sam*, Kevin, Travis, Mick*, Gary*, Scott

*These participants completed the parenting program

Reflections on Group Sessions

Overview

The program consisted of a reasonable amount of phenomenological content regarding the men's experiences of being fathers, as much as the psycho-educational components of the skills adapted from the TIK parenting program and additional exercises. This was because one of the purposes of running these groups was to answer the second research question (RQ 2), which aimed to discover the men's own spoken experience of being fathers in recovery from addictions. Another reason for running the groups in this way was that the literature has shown that fathers – particularly fathers with substance dependence and hence, in many cases, underlying stress and trauma – need their losses in becoming fathers to be acknowledged (Levant, 1997).

Group 1

Session 1 – 'Being a Dad is hard'

General

In the opening session, the group was reminded of the most common responses in the individual interviews to the questions that asked the men what was most stressful about being a father, and how they handled that stress. Among their responses were the following: finances; not getting enough time with their children (especially while in rehabilitation); loss of youth in becoming a father; and a much greater level of responsibility compared to before becoming a father. Their responses to how they

handled the stress were: joining a breast-feeding mothers' group; connecting with other fathers; and doing relaxation exercises (the latter response was after I led them through one). After I read out this summary I asked the men to share their goals for participating in the parenting program. Their responses were as follows: To become a better parent; to gain more insight; to learn new skills; to understand modern challenges for children (e.g.Facebook); and how to cope with their daughters' boyfriends.

Despite being in a rehabilitation facility, the participants seemed on the whole interested in doing the parenting program. When it came time for a break in the first session, one of the men (the 'leader' – Carl) was keen for them to have a 'bunger' (cigarette smoking) break, so I did not challenge this. For me it was to be a pay-off for getting commitment to and genuine engagement in the group. I believe that the men truly appreciated being acknowledged for the stress and difficulty of being fathers. They also responded positively to the relaxation exercise, and the prospect of discussing emotions.

Group goals

This session provided opportunities for setting up the group rules and for the men to get to know each other in a different group setting. On the whole, the men stayed on task, although a couple of the men did make some 'in-jokes' that seemed to be poking fun at a couple of others, for whatever actions they supposedly committed that precipitated their entry into the rehabilitation program. Overall, I felt optimistic that the group had started well. I was pleasantly surprised by the fact that the men appeared to respect the group rules, were open to discussing emotions, responded well to the relaxation exercise, and displayed some level of self-awareness regarding areas that they may have needed to work on as fathers.

Session 2 – 'Feelings are OK – sometimes'

General

The men showed an openness to discussing emotions in this session. Even in the section on meta-emotion, where I was advised that this population of men (those with or recovering from addictions) could be quite sensitive and volatile, most of the men

seemed quite comfortable or at least capable of discussing the messages they received as children in this area. This is likely to be due to the fact that this was encouraged in their rehabilitation program. Those who disclosed the messages that they received concerning emotions as they grew up each chose to give an example of their parents' (or other significant others') continual lack of acceptance of their emotional experience.

Emotional awareness

We started this session with an exercise in which the men were asked to give names to feelings on various faces. The men had problems identifying the 'ecstatic' face, as well as some difficulty distinguishing between curious and helpful, and between anxious and upset. One man (Ray), who reported having been bullied at another centre, showed courage – more than awareness – by admitting that he had been feeling anxious coming into the present centre, although he was unable to say how he knew that he felt anxious (ie bodily signals). Two of the older men (Carl and Simon) were able to articulate in some detail their bodily sensations, indicating that they could probably identify their own feelings as well as those of others, in particular their children.

Attitudes to emotion ('meta-emotion')

The men responded positively to the short film segment that I showed. Carl offered that if they showed fear in his family growing up it was an invitation to be intimidated by their mother. He said that it made him very aware of the need not to make his son feel fearful. Jim disclosed that "girls were raped" and "boys were bashed" in his family if they spoke up at all. He also said that his stress levels were "always at 10 out of 10". He added that he wanted more than anything else to give his children the opportunity to have a life that he never got to have. His other goal was to become completely clean so that he could connect more emotionally with his children. Simon added that displays of emotion were punished in his family. He even said "I can't ever remember shedding a tear when I was a child". He added that he found it quite challenging when his new step-son displayed emotion, but was learning to cope with it. Both of these accounts provided examples of the effects of growing up in a violent, hyper-masculine environment in which emotional expression was punished.

Dealing with emotions

The men were asked to think of a time when they felt a particular feeling, and how they responded.. They were then asked to consider whether their response was effective, and if not, what might have worked better. Ray, who spoke up in the emotion awareness exercise, said that he felt like reverting to the drugs when his 'ex' had their son taken from her by Community Services, but he managed to ride the "depression" and refrain from using, saying, "things are better now". Simon identified his expectation of receiving extra appreciation from his fiancée when he came home from work, and when he didn't get it an argument ensued. He admitted that he should have been more attentive to her feelings instead, and things wouldn't have become so tense. Thus he was able to consider a less 'selfish' way of responding, but found it difficult to articulate another response that could have helped both him and his partner to get their needs met.

Carl explained that, when his son's mother said she was moving and again taking their son with her, his immediate instinct was to prepare for battle, which previously meant court and more drinking. This time, however, he gave a clear, assertive response instead to her, and she was then prepared to "come to the table and negotiate". Jim admitted to exacting a violent revenge on some men who tried to kill a friend of his. He said that he felt ashamed afterwards of what he did, and then "turned to drugs and alcohol to push it aside". We didn't have the opportunity to discuss specific alternative strategies with Jim (that was to be left to the next session), but a couple of the men agreed that meditation was very helpful in reducing stress for them.

This was a very intense session. The youngest group members (Ray and particularly Gavin) did not have much to say, but the others appeared quite engaged in the discussions. Carl and Simon indicated that they had been working through some painful feelings and memories related to their experiences in their families of origin. However, Jim's disclosures were at quite a different level from those of the other men. While Carl and Simon gave powerful examples of suppression or disparagement of feelings in their families, Jim spoke instead of severe dysfunction, as well as life-and-death struggles in his social relationships. This may have been designed to shock the rest of the group, but I rather think that it was more about the fact that 'normality' was set at a different level

for him. Indeed, after he told one of his dramatic stories, I asked the group to give me a rating of their stress levels. Everyone in the group except Jim rated themselves as quite low on stress at that time.

There was some attrition after the first session: one of the men who was at the previous week's session, Rod, was not present at this session, even though he was still present at the rehabilitation centre. This may have been because he felt uncomfortable in the group last time, either because his children, at 19 and 20, were much older than the others (whose ages ranged from 2 to 10), or because one of the men in the group hinted at the crime with which Rod was charged (assault).

Session 3 – 'This is how I parent my kids'

General

This group had the same composition as last week, and was again well engaged in the discussions, although it was dominated by the two oldest men (Carl and Simon) again. This time we moved from awareness of feelings to strategies for dealing with moderate to strong feelings, to helping one's children with strong feelings. We started by looking at positive and negative strategies for handling their own strong emotions, and then we embarked on discussions about their children; in fact, most of the group seemed keen to talk more about their children than about themselves, perhaps because they saw their children as more capable of being able to make a good life for themselves than they themselves had done. Indeed, one of the men – Jim, who was only in his late twenties, had remarked that he wanted his children to have a better life than he had had, as if he had already missed his opportunity to do so, despite his age.

Awareness of one's own emotions

A couple of the men were able to be quite specific about the bodily changes that they experienced when they started to become angry. This included perception of changes in blood pressure, changed feelings in their stomach, chest, jaw and breath; Simon even referred to sensations in his genitals when he started to become very angry. I then used

these examples to open a discussion about noticing anger and other strong emotions in their children.

Responding to their children's emotions

Carl, who had a 7-year-old son, and Simon (10-year-old step-son), spent most of the time discussing anger in their children. Although they were quite different, there were some commonalities reported: for example, the child initially withdrawing, then building a case for why he should get what he wants, followed by descending into a tantrum. The experience reported by Jim, who had a history of trauma, however, was again very different. His children displayed major tantrums, including screaming and hurling themselves onto the floor; he also reported that his daughter had experienced a number of severe nightmares. Jim spent much of the session disengaged (or very tired) as a result of the medication, but his examples were again strikingly trauma-laden, and his fatigue could also have been due to his body becoming overwhelmed during these discussions. I did not experience Jim's contributions in any way as undermining the group's agenda. In fact, his stories in some ways helped to put the others in perspective. His trauma was apparently being repeated in his children's current behaviour, as well as his ex-wife's and his mother's current experiences of domestic violence. Jim consistently described his children as his one ray of hope.

I then asked the men to discuss two things that they really liked about their child(ren), and two things they found particularly challenging. The latter behaviours included testing boundaries, displaying temper tantrums, being stubborn or rude, and failing to accept responsibility for poor behaviour. This then led onto a discussion of how the men responded to displays of emotion – especially anger – by their children. A couple of the men agreed that they felt hurt if their children became angry with them. It was encouraging that one of the men (Simon) gave a clear example of being empathic in the face of anger or a tantrum displayed by his son. This was significant, as Simon had a history of violence, and I had not actually used the word *empathy* (or other versions of it). While the literature shows consistently diminished levels of empathy, not only in

addicts, but in those recovering from addictions, there was evidence here that these men in recovery were quite capable of empathy, at least with their children.

This session was essentially about emotion regulation, though again I did not describe it as such to the group. Once again, I found the openness of at least three of the men quite refreshing. It would be fair to say that each of the men had, to varying degrees, very negative experiences in their families of origin of how to manage emotions. I understood Carl's and Shane's stories to be motivated by the desire to let the other people present know that they had to do a good deal of work to redress that aspect of their lives. Similarly, but at a completely different level, Jim seemed to want those present to have a sense of his ongoing trauma, but he was able to show some evidence of resilience through the love of his children, and through his experience of psychotherapy.

Session 4 – 'What is Emotion Coaching?'

General

This was another encouraging session, as there was positive participation from the group – especially Carl – but also from the younger group members. There had also again been some attrition in the group, as Simon had completed his rehabilitation program and had gained employment, so was unable to participate any further in the parenting program. Again we started with a meditation, focusing on feelings and bodily sensations, followed by a recap of emotion tuning from last week, and then an introduction to Emotion Coaching (EC). The men again commented that they felt relaxed after the meditation. I surveyed the group regarding their motivation levels; all were high except Gavin's, who gave a frivolous response to my question concerning how I might be able to help raise his motivation.

Watching an example of Emotion Coaching

After explaining the steps involved in EC, I showed the group one of the parenting examples from the TIK DVD, which promoted some good discussion (notwithstanding some of men's criticism of the children's acting!), as I chose the examples involving fathers for today's initial practice session. Carl spoke of negotiating both the activity and

especially the timing of the activity. He said that it gave him the opportunity to teach his son about responsibility and helping his dad as well. The men also appreciated the scene in which the dad physically came down to his son's level in order to connect with him. Even Ray said that he would use that with his son (and indeed reported back to the group in a subsequent session that he did so). This then led into Jim's description of his patience levels being so much better out of addiction than in it.

Developing empathy and being an Emotion Coach

In describing the principle and value of empathy, I relayed a story in which I complained to a government department after there was excessive noise from roadworks outside our home for several nights that prevented me from sleeping. I told the men that when I phoned to complain, I received, to my surprise, a very empathic response from the woman at the end of the line, which made quite a difference to me. This story seemed to 'go down' well with the group, and Carl responded that the example was a good explanation of how empathy could "take the anger out of the issue".

I invited two men to read a scripted role-play of a parent using in turn 'emotion dismissing' and 'emotion coaching' examples of responding to his daughter. Although there was some frivolity (one of the men had to play the daughter), the men generally seemed to understand and appreciate the principles of Emotion Coaching (EC). There was also some acknowledgement by at least three of the men that their moods and energy levels could affect their ability to enact these skills. For me this meant that the disparity between theory and reality was decreased somewhat. I didn't actually ask the men what they would normally say – and perhaps what they could instead say – in those darker moments, in order to increase the likelihood that they could use the EC skills.

I distinguished between the concept of *tuning in* and *giving in* to kids, in order to cater for this 'audience', who each seems to hold fairly traditional conceptions of fatherhood. The worksheet also gave reasons why EC can (and often does) improve children's behaviour. I think that these sections were well received because they did not challenge their role as the traditional authority. The role plays were a little more problematic: the guys either didn't want to participate (because they either were embarrassed or had

literacy problems), or they didn't take them very seriously when reading one of the parts. Gavin was able to say quite quickly that the first scenario showed emotionally dismissive parenting, and Carl elaborated on it, saying that he would like to do EC all the time (but I suspect he did not want to give up on the authoritarian approach when he needed it either).

Carl seemed to interpret EC as some type of transactional compromise from the parent, more than a means of understanding one's child and responding accordingly. And in fact, Ray and Jim joined Carl in describing EC as 'picking your battles', otherwise ignoring incidents. So while the men seemed to appreciate the value of this approach to parenting (and I emphasised that parents would not normally use this more than 40% of the time), there was also a generally agreed description of parenting as a series of battles. This gave me insight into their relationships with their children much of the time.
Even so, Jim emphasised the fact that if you do just let things go without addressing them at the time, the kids can stew on them and the tantrums may come out much worse the next time. And indeed, although Carl had been a little disparaging of Jim's motivation for participating in the TIK program, Jim's response seemed to have affected Carl's next comment, which was: "I would tend to think that like the first few times they feel that emotion you should do it, no matter what".

<u>Understanding Emotion Coaching</u>

We discussed the scenarios on the EC worksheet. Gavin and Jim seemed to join Carl in being able to connect the emotion with the experience in their responses. This showed quite a good example of the ability to show cognitive empathy. The limits of EC were discussed, particularly relating to rudeness and safety, which Carl especially appreciated. Nevertheless, some of the men, including Carl, had some initial difficulty identifying two of the examples as not really suitable for EC responses. Interestingly, Carl, who showed some evidence of preferring an authoritarian parenting style at times, was quite open to incorporating EC into his parenting. In any event, Carl showed that he possessed the cognitive capacity to be able to balance discipline with empathy. Ray and Jim also gave some responses that indicated their understanding of, and willingness to adopt, the

EC approach. Gavin did give one good response, but he did not generally appear motivated or engaged in the group discussions.

Session 5 – 'I can cope as long I am not more anxious than my kids'

General

This was at times quite a confronting session due to the nature of the topic. In retrospect, it might have been a little too heavy on the psycho-education and a little too light on inviting stories. And asking the men to recall a childhood incident that involved anxiety was a little risky, given that a couple of the men had a history of trauma. I wanted the men to get in touch with their anxiety now and as a boy, and hence be better able to connect with their anxious child, assuming that this could be difficult for men with a history of addictions. In addition, I wanted at this point for the program to contain a therapeutic element – this was perhaps also a little idealistic. Indeed, the youngest man left early, without saying anything (though I later learned that this was probably because he had just found out that he would have to return to jail). The scenes from the TIK DVD in which parents were doing EC with their fearful children was quite well received.

Understanding anxiety

As mentioned, this was quite an intellectual exercise, but the men, to their credit, stayed with it, and a couple of them told relevant and helpful stories to describe situations in which they experienced anxiety. The man who seemed to have suffered the most trauma, Jim, described anxiety as: "normally induced by something that's in the home that they try and cover up to make a happy family, but it's not really a happy family". He described both his childhood and his current life at home as abusive experiences full of anxiety. And having heard that story, Carl described his situation as "mild anxiety", even though what he was describing was clearly quite a distressing scenario for him, also touching on childhood issues. This included finances (having to sell the farm), health (sight), and worry about how it would be affecting his son (the last thing Carl wanted for his son was to have to endure the early loss of his dad like he had to do). Carl also described his "first alcoholic bottle of wine" – one that he used to medicate against his stress and anxiety. Jim added that, in the face of anxiety, he tended to be either a

‘doormat’ or to become violent (if his kids or food were under threat) – there was little in between.

Dealing with anxiety

Gavin had very little to say before he left early, except that he offered one strategy that could help him was “time alone”. Carl added that meditation, communication with trusted people, and being part of a supportive group were all effective strategies for him. When I read from the sheet inspired by Andrew King’s ‘Survival Cards’, there was silence during some of the deeper existential concepts that I raised – these issues were clearly too hard for most of the men to handle (perhaps due to a traumatic past), as Carl observed: “That’s very close to home with one or two people around here: they feel there's no meaning in things”. The men responded fairly positively to the CD titled *Anxiety Reduction Meditation*.

Responding to their children’s anxiety

I invited the men to recount a time when they were about 7 (three of the four had 7-year-olds), so that they could get an idea of what it would be like for their son or daughter to be feeling anxious. This was quite a confronting activity; I aimed to make it a little less so by telling a story of an anxiety-provoking event when I was 7. In return, Carl recounted a story of anxiety about money arising from his loss of his dad (his mum had trouble finding work) – this meant that the loss of a son and worries about money both touched on the fear and pain from his past. He said that he even feared that they might die as children as a result of their poverty. Ray came in late and was again fairly quiet, but one contribution he did make to group discussion was that he used drugs to cope with his anxiety, from the age of 15.

Carl said that when his child is worried or anxious, reassurance or hugs can be the most comforting for him. A couple of times Carl added that he wanted his son to know that he would always be around, and would always love him. Jim observed that his daughter, who suffered the most trauma as a child (from witnessing his mother’s assault and rape), had been waking from nightmares, screaming at night and throwing violent tantrums

during the day. He said that he had been able to help her come out of her extreme anxiety by being very gentle and patient with her, not shouting, and getting down to her level. He also observed that she had been through the most similar experiences to him. He described in quite moving words how he parented her in those times. I then went through the 'Doing the Noodle' worksheet, where again most of the men were quiet except Carl, who said that he already used a calming activity similar to that with his child.

Emotion Coaching anxiety

I asked what was the most effective part of the two DVD scenes in which mothers were coaching their children who were anxious. Carl replied that the fact that the child was able to be involved in the problem-solving process was the most effective. Generally, the responses to these two scenes were not as positive as they were in the case of the scenes with the fathers, together with the fact that one of the families was from another culture.

As with the previous three sessions, this session was quite intense, this time with more silence from the men than previously. That could have been due to the content – especially the exploration of existential concepts – but also because they were aware that Gavin was probably going to have to return to jail. Regarding the real-life examples that the men used, Carl described his level of anxiety as "mild", as discussed earlier. However, it is likely that Carl felt that he could respond to a certain level of his son's anxiety (up to the point that he had experienced it), but maybe not to the level that Jim was describing. Thus, although the literature has shown that people with mental health problems – such as Jim – have more difficulty with empathy, these examples suggest that if parents with mental health issues receive the right type of support they may even be able to handle greater anxiety in their children than others can.

Session 6 – 'I'm still not sure if it's OK to be angry'

General

The group had now settled down to its final composition of just three participants: Carl, Jim and Ray. This was again quite a confronting session at times, but in a different way

from the previous session. This time the topic of anger spilt over into a simmering resentment between two of the men (Carl and Jim) – the only two present in the first half of the session. There was again some good self-disclosure concerning anger from the participants, as well as examples of how they had dealt with their children's anger, albeit very differently in very different circumstances.

Understanding and Dealing with anger

I asked the men how they understood the meaning of anger. Carl was quite forthcoming with his response, which was in part: "I can't see anything positive in it". I read out the exercise from TIK (which included suggested ways of handling anger) to ask the men what strategies they used (and aspired to use) when they were angry. Carl said he used self-control, exercise, time out, sometimes seeking social support, and working through what may be his part in a confrontation. Carl and I also incorporated into our stories positive strategies, including communication and humour.

Causes of children's anger

Carl said that he would try to find out why his son might be angry, particularly if it was directed at him. He found his son's anger/distress quite difficult on occasions; he relayed a story in which his son was so upset that some crabs were to be killed for dinner at a restaurant that Carl asked a friend of his to pretend that she was going to release the crabs to prevent them from being killed. Another strategy was to make the rules about a potentially difficult scenario with his son (e.g.going shopping) before they would leave to go there. Carl said that tiredness, sickness and hunger (on the worksheet) were also potential triggers for bad moods or anger, as well as unreasonable expectations created, he stated, by his son's mother. Jim added low self-esteem as a cause of his children's anger. He also agreed that other emotions can lie beneath children's anger, especially since they did not yet have all the tools to deal with it. Carl agreed with that point.

Helping their children to express and control anger

Carl said that listening, patience, talking and working on a solution were the most effective ways of helping his son through his anger (also part of the TIK EC approach).

He also related to the example that I gave about my child walking along a wall, and not being 'off balance' ourselves. Ray then relayed a situation in which his child was misbehaving and he asked the child support worker if she had given him too much cordial. As he rarely got to see his son, he said that he would let his son "control the visits" and do what he wanted to do. When we looked at some other strategies, such as having quiet time in one's room, some tension started to arise between Carl and Jim when the latter said that could be a good strategy for Carl, who replied that doing 'the turtle' (a TIK anger management strategy) could help him control himself (half-jokingly I suspect) from attacking Jim. More positively, Carl said that he and his son used running and jumping to let off steam. But the tension continued to simmer between them.

Emotion Coaching anger

I asked the men to do a role-play, which was similar to the videoed version that they saw. Jim volunteered to be the father, and Carl the son. I asked the men to stick to the script, partly because they had a tendency to not take role-plays seriously, and also because of the tension in the room. Carl ended up disagreeing with the father's EC response, as he said that he tried to put his son in the wrong after he himself had failed to follow through on a promise that he had made earlier. He admitted that this may have been due to the fact that Jim was playing the part of the father. He found it difficult to let that issue go. I then asked if they would like to share a case in which they handled their child's anger in a certain way but would have preferred to use a different way. Carl told a story in which his son lost his temper when he was told he couldn't go into a toy shop because they were out of time, so Carl said he smacked him. Carl said he would have preferred to make the rules clear from the start, and admitted that he should not have smacked him in that particular case.

Jim then relayed a very different story in which his 3-year-old daughter set fire to the curtains and nearly burnt the house down. He regretted the fact that he yelled at her, because he knew how much stress she had been experiencing. He also admitted that his stress levels were very high when his children fought (the twin boys very violently at

times), and he said that their stress levels were also very high (though he had previously indicated that his sons had not been traumatised anywhere near the extent to which he and his daughter had been).

I added the information that Steve Biddulph had given on the long-term benefits of fathers being able to calm down their children when play-fighting with them. I expressed some concern just before the group finished about the level of friction between Carl and Jim, although they reassured me that everything was OK. It appeared that, in connecting with their anger, Carl and Jim allowed those feelings to spill over into a certain level of resentment towards each other, though Jim appeared to be doing more goading and Carl more threatening, and there was ultimately a playfulness to it on both sides. Yet in playing the part of the child in the role-play with Jim as the father, Carl disagreed quite stridently with the father's comment "it looks like we both stuffed up", even though I felt that both the dad and the child both did make mistakes in the way they behaved in the scenario. It may be that it is difficult for Carl to empathise with someone and remain objective at the same time, which may explain why he tended to resort to a more authoritarian parenting style sometimes with his son.

Session 7 – 'How can I apply these skills to my child?'

<u>General</u>

I decided before the start of this session that it would have to be the last one since the men were going to have activities for the following two weeks, and it would have been too disruptive to miss two consecutive weeks. Only Jim and Ray were present at the start: we commenced with a meditation, and then revisited their group goals. It turned out well that just those two men were there for the first half of the session, as it permitted them each some more 'air time' before Carl entered in the second half.

<u>Re-visiting group goals</u>

Jim said that he felt he could do the whole thing again; to me this was an indication of the disjunction between how much he wanted to parent his children as well as possible, and just how difficult it was for him to do so, given their level of symptomatology, and

perhaps also because he was drowsy much of the group time from the medication. Ray was perhaps a little less mature than Jim and, while he may not have experienced the same degree of trauma as Jim, his drug use may have adversely affected his son as badly as family violence. Therefore I was a little surprised that he responded that he didn't need to use the tools in the program, claiming, "My son's pretty good". This more likely indicated either a lower level of self-awareness or less honesty than Jim. He had previously given a hint that he was concerned about his son's behaviour, particularly a tendency towards aggression at times. Perhaps Ray also considered that emotion coaching can only be used when children do not behave well, so there was still a lack of understanding as well from him.

Practising Emotion-Coaching

We revisited an exercise that we had looked at a few weeks before ('Spot the EC Opportunity'); this time I asked for the appropriate examples of what they would actually say to their children. In the first example, in which a child was very quiet going home from school, Jim replied that he would give his children time and then let them know that if there was anything he could do, he would be there for them when they were ready to talk. In the next example, Ray did not know how to reply, but after some prompting came up with an example of his own in which he reported feeling "cut down" after telling his son that visit time had ended, only for his son to walk away without saying anything. Ray admitted to feeling guilty for not being there during his years of drug abuse.

In the third example, in which a child was refusing to stay at a friend's house so that the parents could go out, Ray suggested trying to come up with solutions to fix the situation – this showed that he was listening in a previous week, and that he was potentially capable of problem-solving in these situations – although prefacing that step with empathy may have been beyond him at this stage. Jim added that he would get down to eye level with his children, but Ray replied that when he tried that, his son told him to stand up! At least he tried it, I thought, and in hindsight, he is much shorter than Jim, he may not have been as close to his child as Jim was, and his son probably did not

experience the same level of overt trauma (perhaps he shut off his feelings more than Jim's children did?).

For the next example, in which a child became upset and refused to talk after she had been asked to share a toy with another child, Jim gave a good response in which he said that he would let his child know that it would be good to swap toys for a few minutes with this other child, or lend him hers for a short time as he didn't have one. He said that if his child repeated it he would speak a little more sternly about it, and on the third occasion would sit her on the 'naughty chair', or pack their toys up if necessary. He referred a few times to this technique which, while making an example of one's children in this way may not necessarily be the recommended approach (by TIK or other experts), it was a much more positive way of dealing with misbehaviour than the examples that he had reported witnessing in his family. Ray didn't comment on this example. Carl, who wasn't present for this activity or the following one, did however give feedback when he joined us. He said that he would have liked more instruction on how to communicate with his child (though to an extent that was what we did while he was out during the first half of today's session). In fact, his lower FACQ-17 score for the questionnaire that he completed at the end of this session may have reflected this.

Dealing with sadness

Interestingly, Carl and Jim were in almost complete agreement about their approaches to sadness and emotionality in general. Carl added that he would allow himself to be sad because it was a necessary part of life, and that his son showed understanding beyond his years when his dad had to end a relationship with a woman who had adult children with addictions. Jim also affirmed Carl's son's behaviour. Jim added, "It breaks me heart when I see me kids sad" – no doubt because of the extreme intensity of the sadness that he and his children had to endure.

Close

The men were thankful and complimentary when it came to closing the program. Carl did say subsequently that he felt that 'others' (probably Ray, and perhaps Jim) were

there more to get a certificate than to really learn skills, but I believe that it was good for the men to receive the materials that they did, and after all, this was just Carl's opinion, and while at one level his participation in the group was the most significant of the three men, I don't think he was able to fully appreciate the backgrounds of the other two men, and how their responses reflected their history and current circumstances, to a large extent.

General re-cap on the program: Group 1

This was a valuable and interesting experience for me. I felt grateful for the help I received in preparing for it from my supervisors, and from Andrew King, who gave me some very valuable pointers in running groups. I was also fortunate that I had received support from the directors of the centre. Finally, the inclusion of Carl in the group really helped me to become more relaxed and connect better with the men, as he was an intelligent, articulate man who, like me, was older than most of the other men, but with a child much the same age as theirs; he also related to a number of the stories I told.
In fact, Carl (and his stories) was the main constant running through these sessions. Although Jim and Ray also attended all the sessions, Ray was much quieter and seemingly less mature and self-aware than the others, and Jim spent a reasonable amount of the time asleep, or at least drowsy, although the contributions that he did make were highly valuable from my perspective, given the acute level of trauma that he and his children had clearly suffered, and his apparent ability to be a competent parent despite his major mental health challenges. It emphasised to me that if a parent loves his or her children sufficiently, mental disorders do not need to be a barrier to effective and empathic parenting.

Group 2

Session 1- 'Being an ex-partner is more stressful than being a Dad'

<u>General</u>

The sessions were run in the same format and with the same content as with the first group. There were seven men present at the first session for the new group, and most were pretty forthcoming with responses. The exceptions were Kevin, who had very little

to say throughout, and Scott, who had older children and wasn't to return. Brian, who remained very positive about his kids and perhaps didn't feel the need to be doing such a program, was also relatively quiet much of the time. But Travis, Gary, Dave and Sam were pretty open about their relationships with their children and (ex-)partners.

Group set-up and dynamics

There was a protracted discussion concerning the group rules and the best time to run the group. There were two issues associated with this: while the men nominated a particular time that they thought would work best for them each week, this proved to be more difficult than expected, because there appeared to be more competing demands on the men at this centre than at the last one, and at least one of those – the weekly anger management group – changed their time a few times during the course of our program, making it very difficult to keep a consistent group time and personnel. However, the men appeared to be motivated to do the parenting program, so we all did our best to accommodate the changing times each week.

As with the previous group, the men were in agreement with the group rules, and each of them appeared to be respectful of the other group members. The men also commented favourably on the relaxation exercise. A couple of the men asked in the opening session what they would receive at the end of the program, so again the issue of external reward was prevalent, if not unexpected. One group member, Dave, seemed keen to take on the role as the group 'jester'. While he made some good contributions, he also made a few jokes at others' expense at times; this was to re-surface in a later session in this group. Other roles that emerged in the first session were those of the anxious fathers of teenage children (Sam and Gary), the confident, positive fathers (Brian and Travis), and the quiet observers (Scott and Kevin). And, consistent with these roles, the first two men remained engaged throughout the parenting program, while the last two left early – Scott after the first session, and Kevin after the third.

Group goals

As with the previous group, I reminded these men of the most common responses in the individual interviews to the questions that asked them what was most stressful about

being a father, and how they handled that stress. This time their responses to the stresses consisted essentially of the following two issues: their relationships with their children's mothers (and in some cases the children themselves); and not getting enough time with their children (especially while they were in the residential program). Their responses to how they handled the stress included: Resorting to their addiction; getting more time with their children; and working on better relationships with their ex-partners.

I then asked the men to share their goals for participating in the parenting program. Their responses were: for their children to trust them; to learn more about their children; how to support their children better; how to 'be' when with their children; to connect better with their children; to repair the relationships with their children; and, for one man (the youngest), to be a positive role model to his son like his father was to him.

Other themes that came out of this first group session were connecting with one's children, broken relationships, frustration with their children's mothers, being the sole breadwinner (and discipliner), determination to be better fathers than their fathers were, guilt at not having been a better father to date, and strategies to reduce tendency to aggression. After the group had finished disclosing about their family circumstances during the group goals, Dave asked me about my family circumstances. In keeping with my decision to provide judicious self-disclosure I gave them this information. The fact that I was an older father with a younger child was interesting – and entertaining – for some of the men.

Session 2 – 'I am finding ways to accept myself and my child's feelings'

General

This was a productive, if frustrating, session on a few counts: we had some significant work to get through but, without notice, had to start about an hour late due to a full meeting of the centre at the time we were due to start. We did get through a lot, but in an hour instead of an hour and a half; there were also problems with showing the short segment of film, and only five men were present today after seven were there the previous week. There were good contributions to each of the three exercises, particularly

from Travis, Sam and Gary. The relaxation exercise was again well received, and the men participated well and seemed to benefit from it, as they each appeared calmer for the rest of the session.

Emotion awareness exercise

At first some of the men questioned the usefulness of this task, but once they got into it they seemed to enjoy it and gain some benefit from it. On the whole the men were relatively accurate with their emotion recognition of these faces. For the second half of this section of the session I started with a general introduction into recognising the onset of a strong emotion. A couple of the men indicated that they actually don't usually show emotion at all when they first start to become angry, but Travis gave a good bodily example of how he experienced his own developing anger. Then Gary added one of his own regarding anxiety attacks in seeing happy families, since he was not in one himself. I suspected that, for him, this rise in anxiety may also have been the first step in an attack of rage.

Attitudes to emotion

I briefly introduced this topic (aware of the time available) by linking the concept of our emotional awareness to our judgement of our own emotional experience. I relayed the same story about our family rules about displaying sadness – though with less feedback from this group than the other group – and then played (on audio only) the short section of the film. Interestingly, Travis's response to the father's preventing his son from retaliating against his attackers was to say that he felt that the father "disregarded his son's emotion without explaining it". While there was some truth to the second part of his assertion, the first part revealed his own history of attitudes to his emotion in his family of origin. I explained that in fact the father in this film didn't judge his son's strong emotion; he simply protected him from getting into a fight which could have made things worse for him. Travis's response to that was to talk about his step-father's attitude to Travis's emotions (and developing personality).

Sam added a detailed example of how he reacted to a situation in which his son had some of his (12-13-year-old) friends around to his place, and they were smoking pot (but

not his son, according to Sam). He spoke at some length about his pride in his own response to his son and the other boys' behaviour, in that he took him aside and then said they were going out, rather than shouting at him in front of his friends. So it wasn't actually an example of acceptance of his son's emotion as such (although he was aware that his son would have felt shamed had Sam reacted with anger as he had on previous occasions), but it did demonstrate an acceptance of his son regardless of his behaviour (not smoking, but inviting friends over who did).

Dealing with emotions

The men contributed well to this task – there was not time to listen to the music, but we came up with some useful strategies for dealing with strong emotions. Specifically, the men offered the serenity prayer (Sam), being in one's own 'bubble' (Travis), and talking about it with someone, rather than yelling retaliation or bottling up emotions (Sam). They also added thinking before acting, assertiveness (my word) and setting boundaries (Brian), empathy (their description was actually listening and seeing it from someone else's perspective), prayer, and being physically active. Again we had to rush through this task, but I assured the men that I would compile their responses and include them in the resource folder for them for next time.

Session 3 – 'My kids' mum and their school aren't pulling their weight'

General

This was a shortened session due to the general meeting, and then two of the men had to leave early. To an extent the session was also 'hijacked' by some issues not directly related to the experience of emotion, though at the same time it was driven by Gary's strong emotion. He had evidently had a bad weekend with his ex-partner and the kids, and he also missed the meditation exercise at the beginning of today's session, so his frustrations about his ex, the school and his kids led the session to a large extent. In fact, the general feeling in the room when we discussed issues after the meditation and before Gary entered was relatively positive, but it changed when he entered, mainly I think because he didn't have the opportunity to relax and observe – more than reacting to – his emotions like the others.

Responding to your children's emotions

As with the previous group, the men seemed keener to start talking about their children than about themselves. So Gary started off the conversation with a story about his son throwing a tantrum over a really small issue. Due to the emotionality in his story, it was harder to keep them right on track the whole time. A common theme here was the children asking dad to say yes if mum had said no, and vice versa. This resonated with a number of the men, indicating that any stress that they experienced with their children was mostly related to their relationship with their children's mother (only Brian was in a stable relationship). Gary relayed another example of frustrating interactions and was told by Sam that it was because his relationship with his ex was the problem, not with his child.

Nonetheless, it did send the conversation off in a different direction, in which the schools and mums came in for continuing criticism. Therefore I asked, 'So what's the core of the frustration here?' One response was the relationship with the partner (Gary), and a later response was expecting better outcomes from the other situations (Travis), for example his son's pre-school. In other words, they felt helpless that they couldn't help with their children's education better while stuck in the rehabilitation centre. The subject of food then came up – quite a major issue for parents of toddlers and pre-schoolers. Travis relayed a good strategy that he had used with his son, in which he gave him very good reasons why being big would help him and would be best achieved by eating everything on his plate. So, in this case, the father had used a type of reframe with his son about food. Travis wanted to explain to the group that it was possible to get a successful outcome with one's child by being positive, as his step-father had always been very negative with him.

Emotion Tuning & Emotion Coaching

I started by outlining the steps in these methods and asked "How do you notice if your child is starting to get upset?" A few of the men noted that their child would start by becoming quiet (withdrawing – as indeed a few of the men had noticed about themselves), or becoming aggressive. They also identified the situations in which this

type of behaviour was more likely to occur. Travis relayed a story of his 4-year-old swearing at people in another car because he had seen a friend of his do the same. Travis also said that sometimes his son would ignore him when he asked him to do something, but observed that his son was more likely to listen and connect with his dad if he got down to his child's level first. When I asked the men if anyone could think of an emotion-tuning response that they felt they could have given better, Brian told a story about his kids driving dune buggies along the beach and ignoring him when he told them to stop. We did agree that since that was an example of a safety issue, however, this method was not really relevant.

There began a protracted discussion, again led by Gary, in which frustration about their children's diet and refusal to eat properly at meal times was the main theme. I tried a few ways to put a boundary on Gary's frustration – looking at strengths, looking for an exception, summarising – but none seemed to work. However, when I reminded him of Travis's strategy of encouraging his young son of the importance to become big and strong, it did give Gary some pause for thought. Sam said he was able to get his son to eat better by asking him to help him cook and prepare it. At that point Gary revealed that he and his new partner had been able to reduce her children's lolly intake. I reinforced the men's ability to maintain their values by calmly and consistently disciplining their children when it came to food.

The session was again cut short soon after this discussion, so we didn't really get too much of an opportunity to discuss EC, except for two men reading out the 'Dad & Sarah' role-play. As with the first group there was some frivolity in reading out scenarios such as these. There was some hope here, though, in that a couple of the men were able to recognise that the Dad "sympathised" or "tapped into how she was feeling". Today's session illustrated firstly the difference relaxation/meditation makes to the men's perception of their issues, and secondly the tendency (more so perhaps under stress) to ignore feelings and try instead to jump into fixing an issue.

Session 4 – 'My ex isn't looking after my kids properly'

General

This was another shortened session that became dominated by one man's (Sam's) issues with his son and ex-partner. Only three men were there: Sam, another existing member (Brian), and a new member (Mick), after one of the group members (Travis) apparently had an argument with the management of the rehabilitation centre and subsequently decided to leave, and Kevin, who was still in the rehabilitation program but had been very quiet in the first three sessions, did not attend. The reduced numbers were also due to the Anger Management group changing its time (again) to coincide with our group, meaning Gary couldn't attend, despite my liaising with the program manager, although it may be that the rehabilitation centre was just trying to fit too many groups into the one day. Nevertheless, the tight time boundaries may have helped to some extent keep the group quite task-focused today.

Watching an example of Emotion Coaching

We spent a short time focusing on the men's emotions with the relaxation exercise, a check-in with each of them, and some brief words from me. I started by giving a re-cap on Emotion Tuning from last week, followed by an introduction to Emotion Coaching (EC). However, when one of the other men read from the TIK manual the words: 'Emotion coaching creates a strong emotional bond between parents and children, so children are more responsive to their parents' requests', Sam used this as an opportunity to discuss an incident that had happened with one of his children over the previous weekend. The trigger for him in entering into this story was perhaps the word "responsive" in the TIK manual, because he felt that his 13-year-old son had not responded well to him about his concerns that the boy's mother was asking her son to look after her marijuana plant, and Sam said that he asked his son to stay with his grandfather instead, but his son refused.

While these issues were ostensibly about his son, at a deeper level it seemed to be about managing his own feelings of frustration and helplessness, and perhaps even some underlying guilt, as Sam himself had offered his son pot a couple of months earlier. He

remained quite exercised for much of the session. We spoke about helping one's child become aware of their emotions, and Mick (who had completed other parenting programs) observed that it can be more difficult to help their child become aware of the reason behind his/her anger. I showed the TIK videos with the fathers, and two of the men described the father's first strategy as bribery. Sam also admitted that he would have acted more like the father did the first time (what he described as 'bribery'), and would not have cared about his toolbox being knocked down by his son in anger. Mick described the child's behaviour (to quote 1-2-3 Magic – the previous parenting program that he attended) as "Minor but annoying", but described the outcome in the second (EC) version of this example as "win-win".

While there was some criticism of the EC approach in these videos – Sam said, "Well, sometimes you *do* know whose fault it was" – both he and Mick praised the father for getting down to his son's level. I then discussed the finding that EC can improve children's behaviour, and Mick countered that it can also spoil kids in a sense. This seemed to be at odds with what he said before, when I described an issue as minor ("Yeah, minor in the adult part, but massive in the kid: they're really disappointed, and you don't see it as a big thing, but they do"), but this time he was talking about his ex-partner's child, for whom he would have had less empathy than for his own children. The topic of playing one parent off against another continued from last week. Brian added that he might say no to one of his children, who would then get his mum to overrule him. This served as the segue into Sam's revisiting the story about his younger son having friends over at his house smoking pot because their mum permitted it. He described the frustration he felt after contacting FACS and the police to get rid of the pot and warn her and the kids but, he said, to no avail. I tried some solution-focused questions with him, but in the end it was more effective just empathising with his sense of frustration and asking him if he was OK to 'park' the issue, which he was.

Understanding Emotion Coaching

We looked at the examples where the men were asked to decide whether or not they would use EC methods in each case. Sam thought at first that one could emotion-coach

his child when the parent was described as ‘furious’, but the rest of their responses were correct, some showing insight. I did get the message, though, that they preferred not doing school-like ‘question-and-answer’ sessions, and preferred instead to share experiences. I also had the sense that understanding of the EC principles was not the main issue for them; rather, the question for them would be: how could they put these principles into practice, particularly given their situations?

Session 5 – ‘My anxiety gets out of control when I have to communicate with my ex’

General

This was a very intense and, I felt, quite a productive group today. It was also quite different to the corresponding session with the men in the first group. I was careful to avoid going into detail about the existential themes that I raised with the previous group, as that seemed to deflate their spirits. I also avoided the potentially disturbing story that I relayed to the first group, partly because of its nature, and partly due to time constraints. The main features of today’s session were the anxiety experienced by Mick in his battle with his ex-wife and her new partner, his assault charge and subsequent time in prison, and his feelings of angst around not being able to even go near the suburb he lived in, but at the same time longing to be with his kids as they grow up. Sam added to the stories with some reflections of his own after last week’s turbulence for him with his ex and the other boys smoking pot in their home. Gary also had a reasonable amount to say about his son’s (and step-daughter’s) anxiety, particularly in relation to keeping up a good image on Facebook.

Understanding anxiety

The men, led by Sam, showed quite a good understanding of the symptoms of anxiety. There was also some evidence that they had had some education about the relationship between anxiety and using alcohol. Two of the men contributed with examples of their own: Sam, with his feeling of a lack of control in the situation with his son’s mother and his friends smoking pot around him; and Mick, who desperately wanted to see his children, but could not do so due to various reasons, including the AVO that his ex-partner had taken out against him.

Dealing with anxiety

I asked the men what helped them with their anxiety (other than addictions or other medications). Sam addressed the issue of hope and goals. Brian offered thinking positively, while Mick referred to his faith as a preventative measure, but observing that at the same time, the anxiety was always there, given the 'right' circumstances. He was very troubled about the fact that he might not get to see his kids again, at least for some time, because of the volatile relationship between him and his ex's partner, and also the immediate community. It was clear that this was an agonising decision for Mick, who seemed to be arriving at the decision that he would need to cut himself off from his children, at least for the time being, in order to preserve his own sanity. So why was he so keen to join the group, even after it had been going for a couple of weeks?

After Mick's story, Brian, who had generally been fairly quiet during this and the earlier sessions, then gave a wonderfully supportive account of how, despite being prevented from seeing his young children for eight years, his kids still sought him after all that time: "At the end of the day, man, they will always come and look for you". The sense of deep angst in the room was, momentarily, lifted.

Another solution to anxiety, according to Sam, was to get more control back in your life. I concurred, adding that getting good support from mates, as I was seeing in the room for Mick, was clearly an important factor. For Gary, finding a new partner and "getting [his] life together" was the best panacea. We then spoke a little more about the left and right columns in the table. Then I played the CD, explaining the value of relaxation for anxiety. The men reported feeling calmer at that point, but even so, once they started to talk about their children's anxiety, they became visibly more agitated again.

Their children's anxiety and Emotion Coaching

The men seemed pretty adept at identifying the signs of anxiety in their children quite readily, e.g. mood change, trying to control things, becoming quiet, misbehaving, screaming without apparent reason, or biting their nails. When it came to solutions there was a lot less confidence, though. But Sam, who was in a better state of mind than the

previous week, suggested playing sport with them, asking them what's happening for them, and making them laugh, while Mick added not judging them, particularly their emotion. That was a particularly significant response I felt, because Mick was saying that helping children with emotional awareness wasn't enough; they also needed their emotion validated and accepted. It was clear that most of the men were often too overwhelmed by their own situations to be able to focus clearly on emotion-coaching examples, especially with their ex-partners: "We're all in the same situation", said Sam. However, they were all clearly motivated to help their children through their anxiety where they could.

But like the last group, anxiety – whether it was their own or their children's – presented a particular challenge to them, probably more than other emotions. This may have been due to their insecure attachment to their parents (and for some a chaotic upbringing), their poor relationships with their children's mothers (and in some cases with former friends), or their ingrained habits of medicating against their anxiety with alcohol or drugs, even if they had been abstinent for a period of time. In reality, it was likely to be a combination of the three factors for most of the group participants.

Session 6 – 'I know my anger triggers – I just can't always control them'

General

The group had now settled into its final composition: Mick, Sam and Gary were re-joined by Dave, who returned to the rehabilitation centre, having been sent home four weeks previously for threatening another resident. On the other hand, unfortunately Brian decided to quit the rehabilitation program, so he was unable to complete the parenting program. This was a different type of session today: firstly, we had to run it after lunch due to meetings at the centre in the morning; secondly, we used the downstairs room, which contained lounge chairs; and consequently the men were perhaps a little too relaxed, particularly Dave. He was clearly testing out the limits and seeing what he could get away with today. I felt a little undermined at times. This may have been a defence against his anger (the subject of today). And a largely positive

response at the end of the relaxation session became a little more negative, perhaps due in part to Mick's fairly hopeless and helpless situation.

Understanding anger

I started by asking them how they defined anger. Dave gave a good kettle analogy to start the conversation. We then discussed some of their more common trigger points, and the responses included lies/deceit (three of the four men mentioned this one), not being taken seriously (Mick), being treated unfairly (Dave), not being trusted, and being called a 'brown nose' for looking after a caseworker's kid (Dave again). As each of the men either completed or were completing an anger management course, they were pretty good at recognising their triggers and weak points.

Dealing with anger

We identified a couple of issues that required making a decision on how to respond: (i) rising anger and explosive anger; and (ii) when to communicate (e.g. if there is a miscommunication), and when not to do so (e.g. if you sense that someone is deliberately trying to upset you). We went through the steps on 'The anger manager', and the first one was to stop and look around – the social aspect of anger. There was general agreement that no one could get them angry like their ex-partners could, or in one case (Mick), the new partner of his ex, who had been his best mate. I asked them what they most needed to help them with their anger. The responses were patience, support and trust. We looked at the ways of calming anger, and the means of expressing it. There were some good suggestions for physical expressions of releasing anger. Dave made the comment that self-awareness helped him in managing his anger. I also gave the example of how humour can help us when we are angry (or perhaps when someone is angry with us).

Their children's anger

I then brought in the parenting aspect of dealing with their children's anger in the second half of the session. Dave was not taking it seriously at times, and I felt that he was almost trying to derail the conversation (perhaps misusing some of the strategies that we

had discussed). Gary gave a radical example of a mate of his cutting toys in half if his children refused to share. Dave also shared a drastic example in which he said that his 9-year-old son held a knife to his mother during an argument. Dave blamed this (at least in part) on his son's being allowed to watch violent computer games. He admitted that during his addiction times he would rather just 'throw him in front of the TV'.

Following this some tension arose, as Sam commented how damaging TV can be in excess for children. He said that he would much rather have his sons do something physical, even if he went off to get himself a drink. Dave replied to Sam: "That's where we differ, I guess. My addiction was about me" (meaning that he knew that Sam had said previously that the trigger for his addiction was his relationship with his ex-wife). Sam replied "now it's coming back to bite you on the bum", implicitly blaming Dave for his son's poor behaviour. Gary added a story that he had already told in which his son was unable to clean himself up after going to the toilet, highlighting a dismissive text sent to him by his ex-partner, but this time adding a positive resolution to it (she clearly had later helped their son with this, although she didn't communicate this to him).

Helping your child to express and control anger

Dave was lamenting his poor relationship with his son, but Sam (supported by Gary) said that there was still time to repair the relationship. I endorsed this view, talking about my repairing of my relationship with my dad as an adult, encouraged by Steve Biddulph's book *Manhood*. Sam connected with this, saying that we need to be aware of how similar we really are to our fathers. The men also shared stories of their sons losing their tempers and storming off. Gary told a story of taking his 15-year-old son surfing: when his son's surfboard was hit and broken by an adult surfer, his son became furious, and even when he heard that the man didn't intend to do it, he did not calm down. This showed that there was clearly underlying anger in this case. Sam also gave an example in which his son lost his temper, but Sam was apparently able to hug him through his strong, angry resistance to the point that his son softened and began to cry in his dad's arms. It felt like Sam was seeking reassurance from the group at this point, which he

received to an extent, but was probably also using the story to show Dave another way of helping his son with anger.

Emotion-coaching anger

For the role-play, Dave volunteered to be the father and Mick the son. But Dave decided to over-dramatise the part by yelling in the first section, which was a bit of a shock, and I recoiled slightly. He noticed this and, after completing the role-play, commented about my reaction, which served to make me feel a little undermined, perhaps to empower himself. He did admit though that the son's expressed hurt at not going to the park (in the role-play) after his dad promised it really resonated with him, firstly because he knew how much his kids loved going to the park and how good it was for them, and secondly due to the fact that he had not always kept his word with his kids. There was another interesting interaction between Sam and Dave, in which Dave had asked me if I was used to being yelled at, and Sam said that with a voice like Dave's, anything he said would sound scary to a child or even an adult. Sam said that he would never yell at his kids, but Dave got him to back-track on that statement by getting him to allude to a former time in which he did yell at his kids. So just as there was some tension between two of the men in the first group during our session on anger, the same was happening to an extent here between Dave and Sam.

Once Sam admitted he had in fact yelled at his sons in the past, Dave stopped pressing him, but instead turned his attention to me and asked about my shoes. Sam said that it was a good session, but Dave added another cheeky and slightly insulting comment at the end. So while the topic of anxiety caused the men to look inward, discussing anger for both groups had the effect of creating an environment of what appeared to be jostling for position. After all, if anger is around (and you feel safe enough), you would prefer someone else to be feeling it.

Session 6a (Catch-up) – 'This is how life is for me right now'

General

This session was required for two of the men because they had missed a few sessions: Mick missed the initial interview and the first three sessions, while Dave missed the second to fifth sessions. I experienced a little trepidation heading into this session, because these two men – especially Dave – had not taken the previous session completely seriously. However, it turned out to be a worthwhile session, since they were both very open about their circumstances, their feelings, their relationships with their families, and their understanding of how they normally respond to others.

My attitudes to emotions and my life

We looked at the issue of meta-emotion, since both men missed this topic in session 2. When I first asked the question (how they respond to their own feelings) early in the session, both men were pretty quick at replying: Dave with 'passive-aggressive', and Mick with 'arrogant-assertive'. And while I did refer to messages we get from our families of origin and especially fathers (as discussed in session 2 of both groups), today both men in this session concentrated their answers much more on their present circumstances. Dave's responses showed some ambivalence between dismissing his children's sensitivity (especially that of his sons), and trying to be mindful of them. He relayed a story in which his father gave him a 'clip' for complaining while he was playing T-ball, but then he hit a home run. Perhaps the message he was giving me here was that you need to do this in order to bring out the best in your boys (at least), though he did admit that he had been a bit of a 'bully' at times to his older son. For him the virtue to be sought after was 'courage' in his son, perhaps even at the expense of his other feelings.

Looking back on a previous session I realised that Mick argued that one's attitude to one's feelings can be more important than just emotional awareness, since he seemed to be quite aware of his own feelings. Like Dave, Mick said that you can be used by others if you are too sensitive, and that one of the few advantages of having spent some time in jail was to get "in touch with me hard side again". Mick also observed that he had a

different agenda to many others in the program, in that he wasn't so keen to change himself like the other men the first time he came into rehabilitation. He was at a very low point as he discussed his decision-making process following his best mate's affair with Mick's wife. His most poignant comment was "I love my kids…[but]…I will move on; I will have another family…but there will always be a bit of emptiness in me knowing that'll happen". His actions towards his former best mate who was now with Mick's former partner landed him in jail as well as making it untenable to be even in the same area as his partner and kids. In fact, he made some pretty honourable statements, including: "I don't want to be perceived as the good one; I want both of [my children] to be" and "my wants second and their needs first".

Dave, who had also spent some time in jail, made a similar statement: "Well I don't need [them to] get high hopes that we may get back together. If we do, we'll do it the right way, [but] for now that'll play havoc with their heads". He added that his 9-year-old son's life had been full of his dad going "back and forth" after walking out on the family when his son was 7 months old, so he felt compelled to give a full commitment once he was going to be able to do that.

Another similarity between the two men was that both said that they respected their dads for the morals they instilled in them, but implied that they did not feel loved by them. Mick reflected, "My dad's a good man – a lot of good strong moral values – but as a role model for life, he's not my role model". Both reacted quite positively to the short scene from a film, in which the father stopped his son from retaliating against other boys who had hit him. They were able to see that the father understood his son's feelings but prevented him from acting on them. This small group session allowed both men to open up more than they had before. Mick's story was particularly sad. Having lost his relationship with his partner and his regular access to his young children, he described his process of re-evaluation of his life and his values and lamented: "I probably have trust issues now", claiming that in going through this process, he even lost his sense of identity, at least for a time. Unfortunately Mick, in responding to his own rage in the way he did, may have lost the ability (at least for the time being) to reflect on his anger

before acting the next time. It sounded like he was searching for a way to justify his actions, which was probably prolonging his distress.

Session 7 'Thanks for the sessions – now actions speak louder than words'

General

This final session provided a relatively brief but, I felt, quite effective wrap-up of the program: the meditation was well received as always; the men related quite well to the discussion about the progress of their goals; some good thoughts were offered in the final practice examples; and some positive feedback was given at the end. This session, like some of the others, did threaten to get derailed by one of the men's stories, though. Sam spoke of his difficult weekend with his younger son, who was now suffering from acute anxiety at times. He said that he almost didn't attend our last session so that he could look after his son. I indicated to him that I was thankful that he had done so, however. I got a sense from the men's feedback in this session that while there had certainly not been resolution of their children's (or their own) issues, there had been progress, particularly in their relationships with their children, with one notable exception: Mick.

Re-visiting the group goals

As I said in this session, the composition of the group had changed since the start of the program, but these goals proved useful as a benchmark nonetheless. The goals essentially fell into four categories: improving their relationships with their children; improving their relationships with their partner; being a better role model; and helping their children to solve problems better. Sam and Gary agreed that they had improved their relationships with their children, and together with Dave, had been working hard on becoming better role models for their children. But Dave said that he wouldn't know how he had progressed with these goals until he got the opportunity to 'try them out', and Gary agreed, stating: 'actions speak louder than words'.

Mick replied that nothing had changed for him, while Sam said that he related to each of the goals, even if he felt that he had only made limited progress. On the other hand, Gary

was pretty positive about his relationships with his younger children, especially now that he had a new partner, his fiancée. He even appeared to hold out some hope that his relationship would improve with his two older children. Sam said that he was quite worried about his son's anxiety levels – he wanted to encourage him to take up more physical exercise, and he reported trying to convince him that, contrary to his son's claims about himself, he didn't have an addiction (to cigarettes).

Practising Emotion-Coaching

We started by re-capping the steps in EC. The men between them showed that they understood most of the steps – thanks in large part to Mick, who had now completed three parenting courses. Even so, they did not actually articulate the step of viewing this as an opportunity for more closeness or, to a lesser extent, to solve a problem. The responses to the example in which the child in the bath said that dolly was sad raised the topic of absence and presence. This was a particularly significant issue for Mick (who said that he was intending to be there *less* often from then on), and Dave, who observed that his children would not believe him if he were to tell them he would not be going away, because of his track record.

The next example concerned a situation in which parents of a child had the opportunity to go out together, but the child refused to go to a friend's place to be looked after so that his parents could go out. This promoted quite a bit of debate: one man said that it would be self-indulgent for the parents to expect a child to have to go to a family friend's place just so they could have a fun evening together; another said that the child might be scared of a person (or animal) at the other house (which was what the example was trying to get at); a third said that it depended on the age of the child and what the parents were proposing to do (as to whether one should emotion-coach them and what one might say); and still another said that kids were just stubborn sometimes. This led to Gary's story about his step-daughter, describing how difficult it was to handle her, as she had ADHD and acute anxiety problems. In this case, we agreed that the emotions were probably too high to do emotion coaching, and other calming strategies were more likely to be useful.

Feedback

As we finished the program, I gave the men the opportunity to give some feedback. Sam replied that he felt that he had a lot more patience now, but wished that he had done the program when his children were 2 or 3 (they were now 13 and 15); Mick said it increased his awareness about good and poor parenting even though he had done other parenting programs; Gary offered that he felt positive and was pleased that we had covered what he needed; while Dave added that most problems can just be solved through mutual respect.

General re-cap on the program: Group 2 and comparison of groups

This was another very interesting group. It was quite a different experience from the first group for a few reasons: firstly, there were more participants who appeared to have more in common with each other as well as some notable differences, and hence there was more stimulating debate on issues. That said, while I interviewed 10 participants and there were still seven in the first session, this dwindled to five in the second and third sessions, and thereafter to four. I had to include one man who wasn't there for the initial interview or first three sessions, and another who missed four sessions in the middle. I provided a catch-up session for them, however, which proved useful.

Secondly, I was able to change some of the things that didn't work so well the first time (e.g. the discussion topics in the anxiety session). Thirdly, the grounds of the second centre were much larger than the first, and so gathering the men together each day was challenging. Fourthly, related to the last issue, I sensed an air of egotism in this facility (listening to the plenary session, and experiencing the struggle to move the time of my session away from that of the anger management session). This last issue impacted the group in a couple of ways, as well as having other effects, maybe even to the point of Travis and Brian leaving the rehabilitation program of their own accord, quite frustrated at the way it was being run, apparently. Sam, Mick, Dave and Gary (the four who completed the parenting program) brought in their anger towards the rehabilitation centre management into a couple of the sessions. Also, the combination of the unpredictability of the men's availability and the strict rules on being sent home, together necessitated the 'catch-up' session.

Various issues were peculiar to the second group. These included complaints about the school system and the children's mothers, which boiled down to frustration about not being able to parent their children as they would have wanted to themselves, leading to a sense of helplessness (but also perhaps wanting to shift the blame for their children's behaviour problems). A second issue was the phenomenon of playing one parent off against another: A couple of the men blamed their own children for this, even though they admitted to having done it themselves growing up. In the second group I encouraged the men to add more of their own suggestions to the 'Emotional Strategies' table. Also, the men in this group were keen on reciting the serenity prayer at the end of each session, which despite some of the frivolity, indicated to me that they took these discussions seriously.

This second group was particularly transfixed on the subject of ex-partners. While this was also an issue in the first group (five of the six men who started in that group were not in stable relationships, at least for the duration of the first parenting program), it was easier in that group to shift the conversation to parenting, perhaps because Carl, who was the main contributor, had experienced some improvement in that relationship. The stories in the second group, by contrast, frequently related the difficulties involved in being a father (or step-father) back to their relationships with ex-partners. This was especially the case for Mick, who did jail time for beating up his ex-wife's partner (his former best mate), and Gary, who had a very poor relationship with his older children as a direct result of the poor relationship that he had with his ex-partner. And because neither Sam nor Dave were in stable relationships (although Dave spoke at times of getting back together with his children's mother), this topic of conversation was of interest to them as well.

Three useful components of the parenting program common to both of the groups were: the sharing of stories, which in both groups were more positively received than the scripted exercises; the stating and recapping of the men's goals (in the first and last sessions); and the last exercise on practising emotion-coaching, which proved challenging, but reinforced some of the skills learnt in the program.

Other elements common to the two groups included the difficulty younger men seemed to experience with the parenting program, for example Gavin and Ray in the first group, and Kevin in the second group. It may be that this program was pitched at a level too high for this age group, given that their addictions probably made them even less mature than other young men. This parenting program could be described as a developmental intervention, helping recovering men who often displayed limited capacity for empathy or sound emotion regulation to move towards being a father focused on his children as well as himself. So if young men, in particular, had been drinking since they were in their teens, they would have had even less opportunity than other men of a comparable age to be able to mature into confident fathers. Examples of this included one younger man in the first group, Ray, who said that he didn't really need to use these skills with his son, and Jim, who wished that he could do the program again, while Carl (in his forties) reported finding it quite helpful for him.

Concerning other issues in the second group, Mick said that while he got some new insights, he had already learnt a lot of the skills (and may not get much opportunity to use them in his current circumstances); Dave said that most problems can just be solved through 'mutual respect' (while no doubt true to a large extent, this comment served to question the usefulness of this program); and Sam said that he wished that he had learnt these skills when his children were much younger (implying that he felt that it might have been too late for him, particularly with regard to his relationship with his children's mother). Only Gary gave fairly uniformly positive feedback on his experience at the end of the parenting program. And so it was Carl and Gary who seemed most satisfied at the end, the commonality being that only these two men were now in good relationships with new partners. Interestingly, both stated that they intended to enrol into Psychology or Counselling courses. Finally, on listening again to the recordings of the men, I had the sense that Carl in particular was able to tell stories with an implicit empathic component: he tended to be more mature, and appeared to be feeling more content and less disempowered than the other fathers.

CHAPTER 6: STORIES OF CHANGE: A MIXED-METHOD EVALUATION OF PROGRAM OUTCOMES

Multiple Case Study Analysis

How did the parenting program, including the exercises and discussions, impact the seven men's views of themselves and their parenting skills, as well as their health and capacity for empathy, if at all? This question will be considered first by examining the men's questionnaire scores throughout the program, in which they obtained scores on the revised versions of the Fathers' Attachment to Children Questionnaire (FACQ-17), the Difficulties in Emotion Regulation Scale (DERS-26), and the Empathy Quotient (EQ-16), as well as the original General Health Questionnaire (GHQ-28), each on three occasions.

To assist in examining the participants' profiles, individual line graphs show changes in each of the four variables over time (Figures 6.1-6.7). These four variables are graphed separately in order to preserve the discrete nature of the measures; however, they are juxtaposed for presentation purposes. This enables comparative perusal of change scores and facilitates integrated analysis of each case. As a further point of comparison, separate data points show the scores for the Addiction and No Addiction groups. These group scores are shown at T1 – pre-program – since the scores of the general group of fathers were obtained without any parenting program. The following graphs are based on full-scale scores only. Please refer to Appendix E for full subscale data.

Group 1

Three fathers completed the parenting program as well as the initial and final interviews in this group: Carl, Ray and Jim. These men first completed their questionnaires at their initial interview, then at the end of the parenting program, and finally at a follow-up interview three months later.

Carl

As discussed in the previous chapters, Carl came into the parenting program as a very keen and loving father but, as a result of his upbringing and recent experiences that precipitated his alcohol addiction, had doubts about his value as a good father. He was also different from the other fathers in a number of ways, most notably the age at which

he both became a father and started his addiction (both around 40), and his professional experience. He was also closest of all the men to completing his rehabilitation program, and so his pre-program questionnaire scores were already low, meaning that there was generally less 'room for improvement' in his scores.

Carl's change scores

Carl's full-scale questionnaire scores throughout the program are shown in Figure 6.1 below.

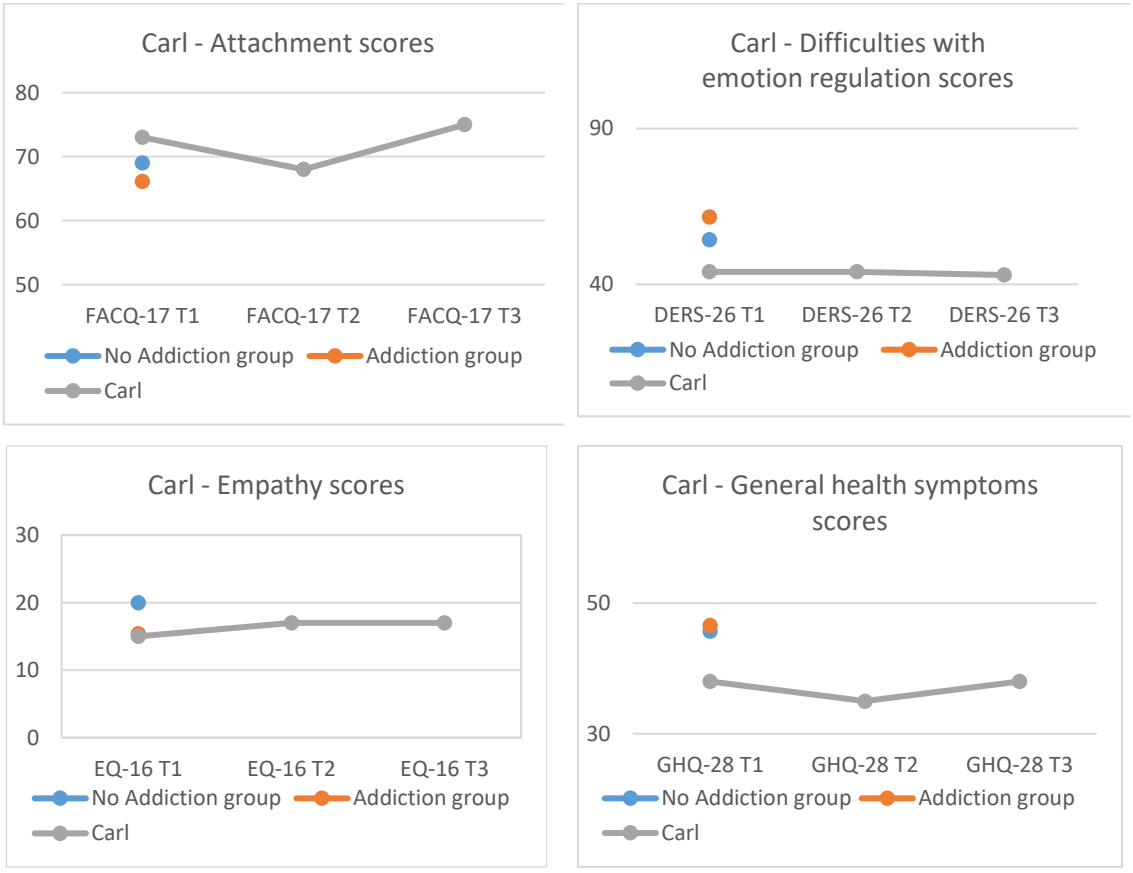

Figure 6.1: Full-scale scores for Carl throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)

- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = pre-program; T2 = post-program; T3 = follow-up (three months after fathering program)

Figure 6.1 above shows changes in Carl's scores from start of the program (T1) to follow-up (T3) with respect to his attachment, emotion regulation, general health symptoms and empathy. Starting from the top left, Carl's attachment scores between the start and finish (T1 to T2) of the parenting program actually showed a decrease. The most discernible difference between the T2 scores and those obtained at the other times was on the *Conflict* subscale of the FACQ-17. Thus, the reduced attachment score for Carl at this time was mostly due to conflict with his son (although there was an increase at the follow-up session). It should be noted that this was still during his residence in the rehabilitation program, whereas his follow-up interview was carried out once he had completed that program, at which time he started to spend more time with his son.

Running clockwise, the next graph indicates that Carl reported few difficulties in emotion regulation, with DERS-26 scores consistently lower than those of both groups. Concerning individual subscales, Carl's scores on the *Negative attitude to own emotions* subscale were, perhaps surprisingly, a little higher on the second and third sittings of the questionnaire. In fact, this topic was discussed during one of the parenting program group sessions, and Carl may have had higher expectations of himself once he was closer to completing his rehabilitation program. On the other hand, his scores improved slightly between the first and second sittings of the questionnaire on the *Concentration Difficulties* subscale. In any event, Carl's overall emotion regulation score remained low throughout the program.

Carl's general health scores were quite low throughout the program, with full-scale GHQ-28 scores remaining about 10 points lower than the average scores for both groups. The differences in Carl's subscale scores throughout the five months remained small, although his scores on the *Anxiety/Insomnia* subscale were actually higher on the second and third occasions than they were on the first. Nevertheless, these subscale scores also remained below the means of both groups.

On the *Severe Depression* subscale, Carl assessed himself at the minimum level (no symptoms of severe depression) each time. So although Carl was prepared to disclose some recent symptoms of anxiety, he did not admit to any such symptoms of depression; this may have been partly due to engaging in regular meditation practice, which he disclosed in one of the group sessions. It may also have indicated that, throughout all the obstacles and stresses that he had to face, his developing relationships with his son and his new partner had helped him maintain a hopeful and relatively positive focus in his life throughout that period.

Concerning empathy, Carl obtained a relatively low EQ-16 score of 15 (close to the average score of the Addiction group) the first time that he responded to it. However, as shown on the graph above, Carl's scores were a little higher on the latter two occasions, both at 17. This was mainly due to an increase in his score on the *Social Cues* subscale. But it was surprising that, while Carl's attachment to his child remained high, his empathy scores were, by comparison, quite low. Likewise, despite the relationship discussed previously between empathy and secure attachment (Gelb, 2002; Weinfield et al, 2008), a number of the fathers' empathy scores appeared at odds with their self-reported attachment to their children. The relationship between these two variables for these fathers will be further discussed in the following section in this chapter.

Carl's narrative: 'A boy needs his dad'

Throughout the parenting program the men were invited to share examples of their parenting and other stories about themselves or their children. On the topic of responding to his child's emotions, Carl expressed some regret in the story below in which he felt that he only considered his own needs, and did not properly consider his son's perspective.

> We were going home one day, shopping was done, housework was done, everything was done… and he said, 'Can we stop at the park?' I said, 'No, we'll go and get the shopping in', and that's the start. Got the shopping in; he gave me a hand with the shopping; then he wanted to go to the park and I said, 'No.' And all it was, I was a little bit tired; I just wanted to sit down and just chill for a while, and I could've done exactly that sitting down and chill by walking an extra 150 metres. He could've played on the

> swings as much as he liked, and I could've sat in the park and chilled. But it was my pig-headedness and I – just without thinking about it, without considering it – simply said 'no'.

The story above shows firstly a pattern into which Carl explained that he had become caught during his addiction, in which he handled fatigue and stress by withdrawing from others and focusing on his needs alone. On the other hand, the regret expressed in the telling of the story provided the start of a critique of his own parenting, based no doubt in part on some of the conversations that were being shared early in the parenting program. The overarching theme that Carl seemed to be conveying here was that he should not take for granted the precious time spent with his son. Clearly Carl had taken the chance to think about himself as a father and consider the kind of relationship he wanted with his son.

Another theme that surfaced in Carl's conversations was difference and belonging. Not only did he have quite a different story to tell from the other men, for whom stories of rebellion and early drinking and drug-taking were often present, but he explained that he felt quite different to the others. In addition, he questioned the motives of the other fathers in his group who undertook the parenting program, claiming that they had only decided to do so in order to gain access to their children, as they were not particularly responsive during the sessions. Indeed, during the session on managing anger, Carl became angry (albeit outwardly in jest) at Jim, who goaded Carl during that session by suggesting that he needed to practise some of the calming strategies himself. Carl responded with: **"**Yeah, what you don't realise… I use a lot of those things around you, son, but I use them on a regular basis. I suffer idiots not well." Carl may well have felt exposed and insulted by Jim's suggestion. After all, Carl did not see himself as similar to Jim or most of the others in the rehabilitation centre. This could be described as an example of Carl's emotion regulation skills being tested, as well perhaps as his prejudice towards those from a different background to his own. In the final interview, Carl expressed some of the discomfort that he felt in the rehabilitation community:

> The rehab – it's not a lifestyle I've ever had anything to do with. I've never even smoked pot. I started drinking a bit too much red wine. So I was exposed to a lot of people that had some pretty serious issues there at times; I found that a bit frustrating.

There was some evidence of a shift in Carl's attitude to others, however, which may explain the increase in his empathy scores. The following example suggested increased empathy from Carl in that he showed a willingness both to take on fellow resident Jim's perspective and to adopt one of the recommendations of the parenting program, which was physically getting down to one's child's level:

> But certainly I think the most valuable thing is that communication aspect of what we've been saying, because I know it's made me think about it; it certainly has made me think … and one of the things was that – and I got it from [Jim], where he talks about [how] he gets down at her level, so he doesn't seem like he's… intimidating or threatening. Getting down at her level, and the difference with you is fantastic. Even when we're in a rush, I could have argued with him the whole way, right? Because he wouldn't have wanted to do, or he would've had to do my way but would have resented having to do it, or I took just two minutes to sit down at his level and explain it, and have a perfectly happy child that understood this is what we had to get done, and it was quicker.

Carl's explanation was also consistent with one of the rationales given for emotion-coaching children (Havighurst et al, 2004), namely that such open discussions with one's children can short-circuit the need for arguments and poor behaviour. This vignette also suggests that Carl's attitude to fatherhood, his emotional control, and his communication skills were changing through his efforts to connect better with his son.

Carl was asked whether he felt that he had seen any changes in himself or in his relationship with his son in his follow-up interview; he made the following observations about himself:

> Whether I've made any progress? Probably emotional connection: I have found myself on outings and things like that where I've sort of stopped and explained a lot better, and I feel that he's actually appreciated it better [once] I've explained [it to him]. Sometimes I say, 'No, because we've got to do this', whereas I'll take the time to sit down and say, 'Listen: we have to do that because the supermarkets are going to close… rather than just say, 'No we've got to get to the supermarket'.

These were important changes. Moving from simply issuing directives to his son to involving him in the rationale for his decisions took humility and patience – again clear examples of improved emotion regulation as well as empathy. However, although Carl's narrative showed evidence of change, this was less evident in his questionnaire scores. This may have been reflective of a lingering doubt in his worthiness as a father, even

though he observed that this had improved throughout the rehabilitation program. At the follow-up interview, Carl was asked whether he noticed any changes in his life. His views on fatherhood, he said, were just as positive as they had always been, but he acknowledged change in his view of himself, as well as some changes in other parts of his life:

> Do I see myself differently? Yeah, probably – it's like a brand-new opportunity, if that makes any sense. I've been able to reassess… what I want to do. I've never had the opportunity to go to university; I've always wanted to. I am now going to go back to university part-time, because I have to work: I'm a working dad… I guess basically it's like a clean slate; it's a new start… I've moved away from [where I used to live]. I've… cemented a relationship, where we're actually starting to talk about – well not just starting, but we're talking about the future, our living arrangements, weddings, stuff like that.

So while Carl stated that he always had positive views of fatherhood, he appeared to show evidence that he now felt empowered to be a more empathic father and partner, as well as a more confident man generally. He also spoke of improvements in his mental health through the rehabilitation process, helping him to stop drinking (and craving) alcohol, and reducing his anxiety in a few key areas:

> Okay… twelve months ago… I felt like my very best prospect was living on the… disability pension… I didn't feel I was an overly good parent in any way, even though everyone used to say what a fantastic job I'd done. I think I felt a little bit hollow about that. The difference now is I certainly have a far more positive outlook on life… I feel like I've got the energy again to start doing things. Twelve months ago, I didn't have the confidence… [that] I could stop drinking at any time… And I didn't feel like I had the energy to start again. I think there's been quite a major shift, in taking the time to do the rehab program… it allowed me the time to reassess... Now I'll start university… In the meantime, I'm going to be working part-time. Housing is important… that's now organised. Secure access and routine for [my son]: that's organised… I couldn't have organised those things [before].

Carl's willingness to have his traditional views challenged was apparent in his description of some of the small changes that he had tried to make in his parenting. The implicit questioning of his sometimes authoritarian approach to parenting was in some ways simply a pragmatic choice: explaining his reasons for making decisions to his son both took the heat out of exchanges between them and permitted Carl to move onto the next activity more quickly. But it was also his improved emotional awareness and self-control that helped him see his son's perspective more clearly. This is consistent with the

findings of Buruck, Wendsche, Melzer, Strobel. & Dörfel (2014), which demonstrated that training in emotion regulation skills could improve people's capacity for empathy.

Carl also gave me permission to interview his fiancée, who said that his parenting had not changed in the 12 months that she had known him because he had "always been a fabulous father". She did, however, comment that he appeared to be less assertive – contrary to Carl's claim about himself – with his son's mother, since having been in rehabilitation and having depleted financial stocks. This difference in perspectives on this matter between Carl and his fiancée may have reflected their different expectations concerning the conditions and the amount of time that they could spend with his son. And indeed it may have been a function of Carl's greater empathy than that of his fiancée for the needs of the mother of his child.

Carl's relatively positive assessment of his emotionality and general health symptoms across time belied some of the mental health challenges that he discussed, although he explained that the most serious of these took place before the parenting program, during the early part of his rehabilitation. The relatively late onset of Carl's addiction meant that, although he told of a very difficult upbringing, his psychological development appeared not to have been as seriously impaired as those others whose addictions started mainly in their teenage years. It meant that Carl was able to position himself as the group leader. For Carl, a strong and positive masculinity was part of his personality, whereas for a number of the other men it appeared either unattainable or a barrier to better relationships with their children. It also meant that it was easier for Carl to learn and try out empathic parenting skills, and his daily functioning was not seriously hampered by depression or other major mental health conditions.

Ray

Ray re-started his rehabilitation in the same centre as Carl, after he described to the group how he had been bullied in the other centre. He was much younger than Carl, and although he remained fairly quiet throughout the group sessions – and difficult to draw out in the individual interviews – he kept his commitment to complete the program.

Ray's change scores

Like the other members of the first parenting group, Ray completed questionnaires at the start and finish of the parenting program, and was due to do so at a follow-up session three months after its completion. However, Ray stated that he was sick when asked to complete that questionnaire, and even though he was asked again and agreed to do so later, he did not complete it. It should be remembered that Ray needed me to read the questions to him on the previous occasions, so he may not have been keen to be reminded of his inability to read again. Ray's full-scale questionnaire scores throughout the program (with the third time showing as blank) are shown in Figure 6.2 below.

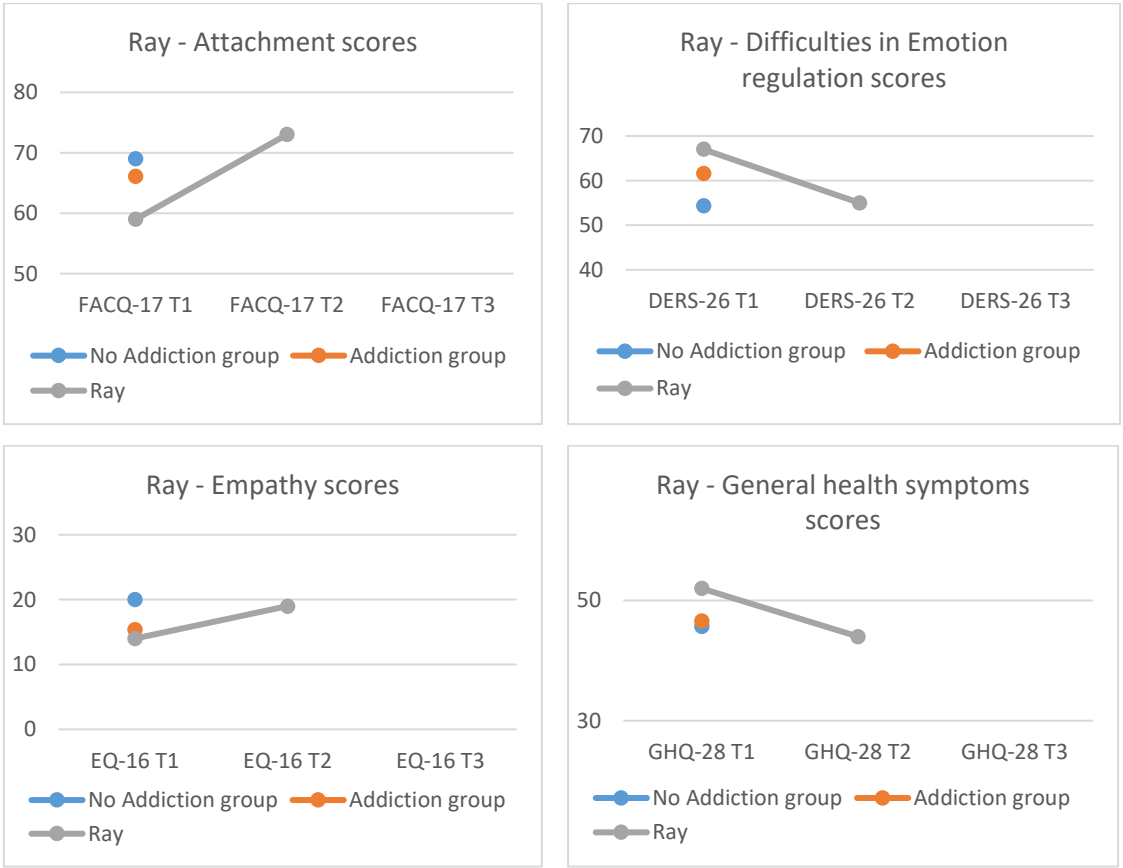

Figure 6.2: Full-scale scores for Ray throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)
- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = pre-program; T2 = post-program; T3 = follow-up (three months after fathering program). As indicated above, Ray did not complete the follow-up questionnaires.

The first feature that stands out is the significant improvement on each of the measures, particularly his attachment to his son. Ray improved from a score of 59 (below the average scores for both groups) to 73 (well above both scores). This increase in Ray's FACQ-17 scores occurred on all four subscales, largely due to the fact that he responded positively to most of the questions on which he had previously selected 'Not sure'. This is most likely attributable to the fact that Ray reported seeing his son more frequently and for longer periods once the parenting program started.

Like his attachment scores, his pre-program emotion regulation (DERS-26) scores were somewhat worse (higher) than the corresponding scores for the Addiction group, while his post-program score was close to that of the No Addiction group. The most notable improvements were on the *Lack of Control* and *Concentration Difficulties* subscales. Ray also reported an improvement over this time period in his general health symptoms. Specifically, his scores were substantially better the second time on each of the subscales *Anxiety/Insomnia*, *Social Dysfunction* and *Severe Depression*, mirroring the self-reported improvement in his emotional symptoms on the DERS-26. The one subscale that showed increased symptoms was *Somatic Complaints*, suggesting that Ray may have perceived some of his emotional symptoms as physical. In any event, the overall change that Ray reported in mental health symptoms was positive.

The change in Ray's reported empathy scores also tells a positive story, with Ray's post-program EQ-16 score being substantially above his pre-program score. The greatest change took place in the *Perception of Social Cues* subscale, but improvements were evident on both of the other subscales that also concerned relational (as distinct from cognitive) empathy. Ray may well have become more confident with his peers in the rehabilitation centre after being quite fearful at the start for the reasons described above.

Ray's narrative: 'I can be a good dad'

Ray assured me that he was committed to the recovery program, demanding as it did complete abstinence from addictive substances. He also demonstrated an understanding

that he needed to change for both his own and his son's sake. And Ray believed that he could improve his parenting skills, as he explained, "Well I've looked after my sister all her life, so I know how to look after someone – how to play with them and stuff like that".

However, Ray seemed to underestimate the need to acquire parenting skills, as he claimed during the final session, "I've got a few tools out of the program, [but] I haven't needed to use them, because my son's actually pretty good". This appeared to contradict his previous comments that his son had behaved in an "aggressive" manner in one of the sessions, and that Ray was "stressing out a lot about what happens if he gets uncontrollable". Ray also stated that he tried to deal with his son's behaviour by asking the support worker at one of his supervised visits if any red cordial was given to him, rather than considering an emotion-coaching approach, which may have been more difficult for him.

Nevertheless, consistent with his improved attachment and empathy scores, Ray reported that he made a real effort to connect better with his son. He said that he tried to get down to his son's level as recommended by the TIK program and discussed in our group sessions, but his son appeared not to want this. He continued,

> I was trying to do that because I didn't want him to feel like he was being stood over, and kept – every time I'd talk to him, I'd get down like this and be talking to him – and he's like, 'Stand up – stand up!', and I thought, 'Alright then, if that's what you want'.

Ray displayed a good deal of guilt and remorse for the effects that his drug use had had on his son:

> I had an instance the other day where me son just gets up now and he just leaves straight away, like as soon as I say, 'Pack up time', it's like he's like – it's like he's used to doing – like getting up and leaving … just, you know what I mean, like he says … and he's done it so many times now, and it really cut me down, and I felt really bad about the situation and… because of my using all these years, if I'd done things better, then he wouldn't be in the situation he's in. And I didn't really want him to go through those situations; I've had a pretty rough upbringing, and – but he is... So I feel really bad by it.

The quote above suggests the possibility that Ray's sense of regret may have been the beginning of some real empathy for his son, as Ray moved from a 'fog', in which he

could barely perceive his own emotions, let alone those of others, to a sense of unease that his actions had hurt his son, towards a possible renewed sense of care for him.

Ray had originally given me permission to talk to his partner about his parenting skills, but later withdrew this permission. In his post-program interview Ray reported some pleasing progress in his recovery from substance use and having fulfilled his aims for the parenting program. This included having his fortnightly visits to see his son increased to weekly, seeing a noticeable improvement in their relationship, and generally gaining more patience with his son. There appeared to be some hope for Ray in his aim to have a better relationship with his son.

Jim

Jim was also a younger of this group, with a traumatic history as described previously – though manifestly more aware of it than Ray was of his past. Jim also had to be prompted most times for contributions to discussions, but those that he made were usually dramatic, at times detailing devastating experiences for him and his family, albeit with an underlying message of hope and strength in the face of such trauma.

Jim's change scores

The change in Jim's questionnaire scores was also encouraging. As shown in Table 6.3 below, Jim reported improvements in each of the areas of attachment to his child, emotion regulation, general health symptoms and empathy.

Jim's total attachment score improved from 66 pre-program to 73 post-program, and it remained high at 72 at follow-up. This trend suggests that Jim may have progressively become more confident in his relationship with his daughter throughout the parenting program and as he made progress in his recovery from his addictions. A couple of features of his FACQ-17 scores are particularly noteworthy. Firstly, Jim's score on the *Pleasure in Relationship* subscale remained on the maximum 35 on each sitting of the questionnaire, consistent with his description of the joy that he derived from his relationships with each of his children. Secondly, Jim's scores on the *Mutual Trust* and *Conflict* subscales improved after the first time that he responded to the questionnaire,

suggesting a closer relationship with his daughter, including fewer arguments, as he became more confident as a parent, and perhaps as they both became more secure in their relationship.

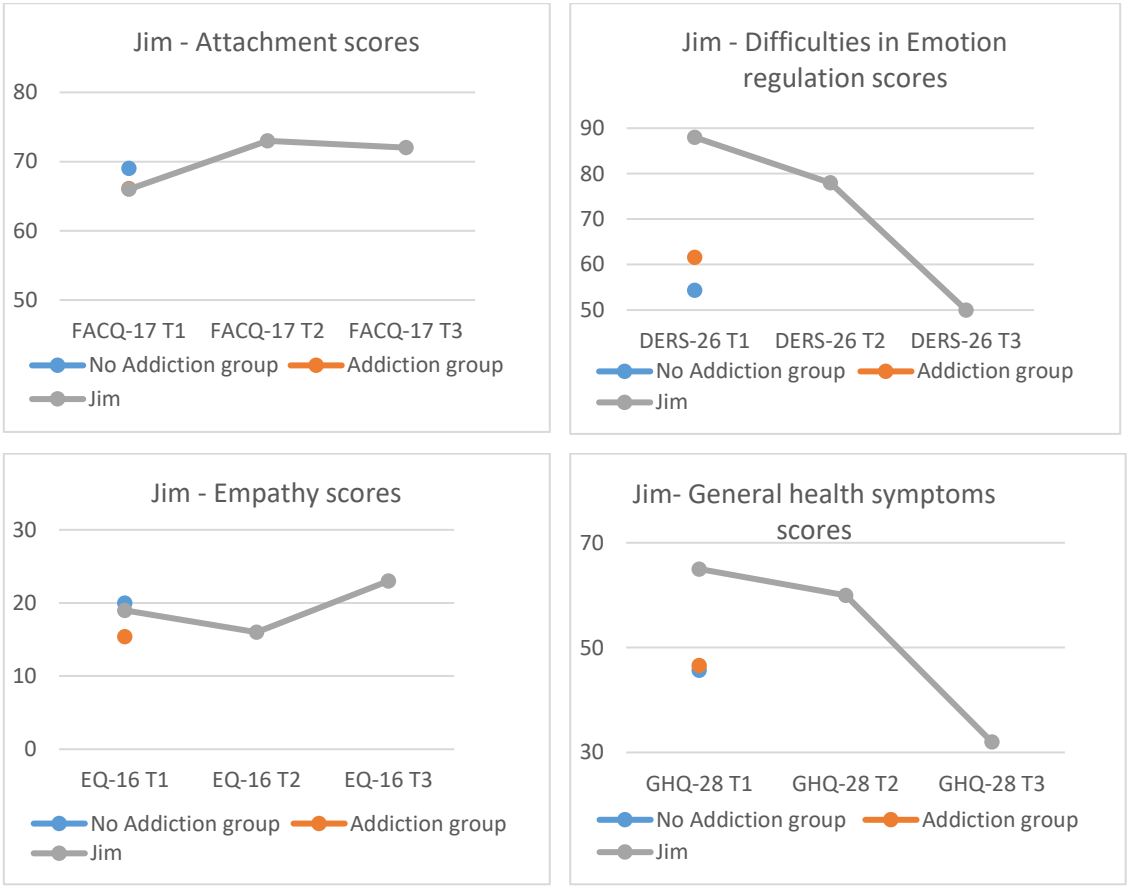

Figure 6.3: Full-scale scores for Jim throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)
- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = pre-program; T2 = post-program; T3 = follow-up (three months after fathering program)

Jim initially disclosed major problems handling his emotions; this was reflected in his pre-program DERS-26 score of 88, well above the mean for both the Addiction and No

Addiction groups. As the line graph shows, this score improved somewhat by the end of the parenting program, and was substantially lower at the follow-up interview. Regarding changes between the first and second sittings, most of the difference was due to a much lower score on the *Emotional Confusion* subscale the second time. Skills at handling strong emotions were discussed and practised during the parenting program, so this may have also contributed to his improved post-program score.

More difficult to interpret, however, is the change in Jim's scores between the second and third sittings of this questionnaire. A gradual improvement the first time became a very radical change the second time. In fact, the only responses that revealed any emotional difficulties were the five items on the *Negativity to Emotions* subscale. On all other 21 items Jim disagreed with any statement suggesting emotional difficulties and agreed with all positive statements about his emotions. Jim's rehabilitation and personal therapy may well have helped him become much more aware of, clearer about, and better able to constructively handle his emotions. But it is also quite possible that Jim underestimated his emotional difficulties on this questionnaire, as with the GHQ and EQ the third time (see below). He may have even believed that a very 'good' score on these questionnaires may have helped precipitate his departure from the rehabilitation centre, even though it was explained to the men that their scores would not be reported to anyone connected with the centre.

As with the DERS, Jim reported a moderate improvement in his general health symptoms throughout the period of the parenting program, but ostensibly a highly dramatic improvement during the three months afterwards. The difference between the first and second scores was mainly on the *Somatic Complaints* subscale. However, it was on the other subscales – *Anxiety/Insomnia*, *Social Dysfunction* and *Severe Depression* – that there was a major change in his responses between the second and third sittings of this questionnaire. In fact, Jim effectively denied that he was suffering from any adverse mental, social or emotional symptoms when answering the GHQ the third time. Given that Jim conceded during the follow-up interview that his stress levels were still high, it seemed unlikely that he was not actually experiencing any such symptoms. Instead, Jim

may have been saying through this part of his narrative (together with his responses on the DERS and EQ the third time) that he did not wish to admit to any emotional problems when he was so close to finishing his rehabilitation program, so that he could just get out and be with his children again. Alternatively, he may simply have been responding mostly according to how he hoped he had changed since the last time.

Regarding Jim's empathy levels, even though his full-scale score was a little lower on the second occasion, it was still above the mean score for those men in the Addiction group. On both the first and second sittings of the questionnaire Jim obtained relatively high scores on the *Cognitive Empathy* and *Perception of Social Cues* subscales. As discussed previously, Jim assessed himself as quite adept at understanding other people's perspectives and picking up on social indicators of others' potential intentions or behaviours. And it was also on these two subscales that Jim rated himself particularly high the third time that he responded to this questionnaire, scoring a combined 19 out of a possible 20 points on the questions that comprised these subscales.

Again, while Jim may have become more socially empathic in this time, he may have also wanted the reader of his responses to know that he was ready to leave rehabilitation and be with his family. Nevertheless, Jim did show some evidence of increased empathy in some of his statements towards the end of the parenting program and at his follow-up interview, as described in the next section.

Jim's narrative: 'My kids are my life'

Jim's parenting of his daughter – he also spoke of his twin sons with behavioural issues – was the subject of a number of his questions and stories. He told the group how she:

> …kept waking up with nightmares, screaming of a night…and it took me a very long time to learn…how to discipline her without scaring her…it took us [from when she was aged two] until seven to break her out of the whole trauma thing.

When asked how he was able to achieve this, Jim replied that the parenting program was one of the factors that helped him:

> I suppose it's most of the stuff we're doing here, like getting on my knee and talking to her nicely…and if she chucked a tantrum I'd let her go for a while [until] she cooled down…I'll pull up a seat, [offer her] milk and cookies, and sit down and have a yarn about why she couldn't do that.

Jim followed up this most moving description with another one concerning his influence on his children's moral development, no matter what they might do:

> I might not be able to keep [my children] from going to prisons or institutions or anything, but [I want to] just be there for them and guide them on the right path…and give them the life that I never had.

These words were spoken by a man in his twenties coming out of addiction, who had enough difficulty with his own mental health – given that he had earlier described his stress levels as "ten out of ten all the time" – let alone that of his children. Fortunately, as discussed previously, as well as the group rehabilitation program, Jim was having receiving individual therapy to help him with his mental health and presumably that of his children as well. In the follow-up interview Jim was reminded of his goal at the start of the parenting program, which was to connect better with his children. He reported progress in this area, as well as in his capacity to positively express his feelings in general:

> I'm pretty much nearly there now… I've still got to work on that, but otherwise I'm there more emotionally for them now that I've got off the drugs and alcohol, and spend as much time as I can with them, and it's really good. I'm just learning how to show emotions now, again. So yeah, it's a work in progress, but it's slowly getting better.

This quote shows that Jim may have been starting to be more positive about his own emotions than before. Jim's narrative of his transformation through his rehabilitation and the parenting program also displayed an increased capacity for empathy and sensitivity towards his children. Jim described the following simple but apparently effective technique in the final session in response to how to handle his children when they were having arguments with each other about sharing toys:

> …just gradually give them time to be ready to speak to you, but just gradually let them know that you're concerned initially and if there's anything you can do… and get down at eye level with them too, and to explain it to them and talk to them. It's like at eye contact, so they don't feel inferior. Or you're not giving [the toy] away – you're just letting them play with it – you can swap. For instance, if the kid's got… a toy, just swap for five minutes or 10 minutes and play with each other's toys.

Jim's empathy for his children may have also played a part in a decision about his relationship with his partner, which he spoke of during his final interview:

> We're not together anymore; we're just trying to make a friendship for our kids. And that's the best way to be, because… we've tried a fair few times to have a relationship and it's never worked out, so it's time to move on from that, you know.

Another example of Jim's emerging capacity for social empathy occurred during the final group session, when Jim commented favourably on Carl's description of his son; and when Carl spoke of being ridiculed by others for choosing a particular school for his son, Jim encouraged Carl to choose the school regardless of the opinions of the other men. This was all the more notable, since when Jim had goaded Carl the previous week during the session on anger, Carl had labelled him an "idiot". This is an example of Jim's improved emotion regulation and empathy, since he did not react negatively towards Carl, but instead showed some understanding for Carl in his supportive comments.

While Jim's transformation had some distance to go, there were some very hopeful signs. Jim reported spending more time with, and feeling closer to, his children. He confirmed that he was not drinking alcohol or using drugs, was soon to finish his rehabilitation, and was learning better how to display his emotions. As discussed above, Jim did admit to ongoing high stress levels in his post-program interview, but said that he was starting to deal better with that stress. This was another example of Jim's improved skills in emotion regulation. Jim's trauma-laden story conveyed his ability to parent his children with a remarkable degree of selflessness and commitment in the face of such chaos in his life.

Group 2

Four of the seven men who commenced this group – Gary, Sam, Dave and Mick – ultimately completed the individual interviews and group parenting program. While the troubled histories of the men in the first group involved varying levels of childhood trauma, for this group the trauma was more about the turbulent histories of their

relationships and marriages. This may have been because they had more time to reflect on the possible reasons for reduced attachment to their children, as this group completed their pre-program questionnaires approximately seven weeks before commencing the seven-week parenting program; this is represented as time T1 below. T2 represented the time of the pre-program interviews (just before the start of the group sessions); and T3 represented the time when questionnaires were completed during the final group session.

Gary

Like the other men, Gary's stresses were both past and current concerning the relationship with his ex-partner and their children. And while he came prepared to discuss one of his younger children (his four-year-old son, who was within the age of the children that the fathers were asked to nominate in completing their questionnaires), the conversation quickly turned to his broken relationship with his 15-year-old son, who had recently asked not to be contacted by Gary after apparently having a discussion with his mother about Gary's previous violence towards her.

Gary's change scores

Gary initially chose his relationship with his younger son (T1), but in subsequent sittings his responses concerned his older son (times T2 & T3). Gary's full-scale questionnaire scores throughout the program are shown in Figure 6.4 below. His attachment score was therefore very low at T2, just after this break in his relationship with his older son occurred, though it did improve by T3.

The line graph on the top left of Figure 6.4 below shows Gary's attachment scores as measured by the FACQ-17 throughout the parenting program. Since Gary chose to focus on his younger son at the first sitting of the questionnaire, that score is less relevant to the change in his scores. The progress of interest in Gary's case is shown by the slope of the line graph joining T2 and T3. And despite the fact that Gary stated at his final interview (approximately six weeks after the conclusion of his parenting program) "the relationships [with my ex-wife and our older children] are still the same", he rated his

overall attachment to his 15-year old son much better at the end of the parenting program than at the beginning.

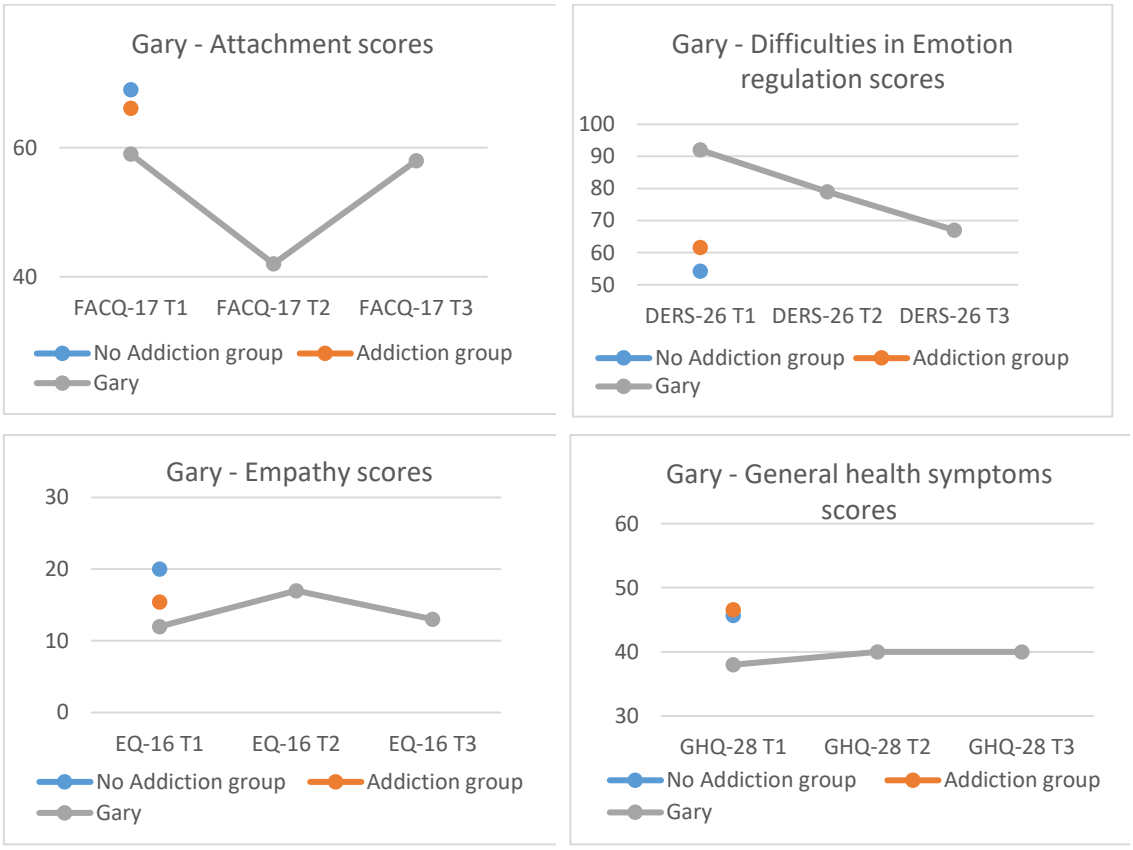

Figure 6.4: Full-scale scores for Gary throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)
- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = six weeks pre-program; T2 = pre-program; T3 = post-program
Note: Gary chose to focus his responses on his relationship with his 4-year-old son at T1 and his 15-year-old son at T2 & T3.

Gary's FACQ-17 scores improved during this period on the *Mutual Trust*, *Conflict*, and *Anxiety about Relationship* subscales. So although he reported that he was still only communicating by text messages to his older son, Gary was clearly reporting less

animosity at that time. That was a major change, given the poor relationship that he had described earlier.

The next graph shows Gary's progress in his capacity to regulate his emotions throughout the program via his DERS-26 scores. This time (as with the GHQ and EQ), all three results are relevant to his progress throughout the program. Gary's initial full-scale score was very high at 92 (indicating poor emotional control), but improved steadily throughout the ensuing three months, to 67 by the end of the parenting program. The two subscales on which there was the most substantial improvement were *Lack of Control* and *Concentration Difficulties*. As Gary was close to the end of his rehabilitation by the third time he responded to the questionnaire, it is clear that he had become calmer and more task-focused. Emotion regulation exercises, in which Gary willingly participated, were also included in the parenting program. In fact, during the one session at which he arrived late – missing the meditation exercise – he was clearly more emotionally reactive than he was during the other sessions in which he was able to participate in these exercises.

The graph on the bottom right shows Gary's reported general health symptoms throughout the parenting program, as measured by his GHQ-28 scores. Unlike his DERS-26 scores, these scores suggest relatively few mental health difficulties while Gary was attending the parenting group sessions, as these full-scale scores were consistently well below the average scores for both the Addiction and No Addiction groups. Thus, it may have been that while he had trouble controlling his emotions (especially at the start of the program), this did not necessarily translate into mental (or physical) health symptoms.

The graph on the bottom left shows the progress in Gary's level of empathy throughout the parenting program, as measured by his EQ-16 scores. His initial score was quite low at 12, but improved from below average for the empathy scores for the men in the Addiction group to above average by the time the parenting program started. However, another seven weeks later his score returned to close to where it was the first time. It is

difficult to interpret this fluctuation in Gary's empathy levels: they were not consistent with his emotion regulation scores or his attachment scores, both of which improved from the 2nd to the 3rd sitting of the questionnaires.

One particular area in which there was a decrease in Gary's score was on the *Cognitive Empathy* subscale over this time period. It may have been that Gary felt less confident understanding others (in the rehabilitation centre or in his family) at the end of the parenting program; for example, he stated in the second-last parenting group session that his ex-wife could be "vindictive" and that he was unable to calm down his older son when he became very angry. Gary himself may have found it very difficult to control his emotions after speaking to his ex-wife, and these questions on the EQ may have triggered a sense in him that he was not necessarily able to appreciate another person's perspective; this will be discussed further below.

Gary's narrative: 'I'm striving to be a better dad'

Gary's story of his relationship with his children could best be described as a journey from frustration and stagnation on the hand, to transformation and hope on the other, albeit not solely in one direction. At his initial interview, Gary lamented that he was not ready to be a father at just 18 years of age when his girlfriend at the time became pregnant; he described this upheaval in his life as a "shock". He remained 'on the scene' to support his partner and help parent their newborn son, but he did not speak proudly of his parenting in those early years. As described earlier in Gary's story, he experienced a great deal of stress in those first few years of fatherhood. By his own description of himself, he was a very different person then, with great challenges no doubt in the areas of mental health, emotion regulation and empathy. At the pre-program interview Gary was already several months into his rehabilitation program, and he reported that some positive changes in his behaviour had taken place over that time.

On speaking to Gary's ex-wife (with Gary's permission), I learnt that, while he remained in a good relationship with their two younger children (aged 8 and 4), the older two asked to break communication with him as a result of domestic violence which, she informed me, he committed against her over 12 months earlier while he was intoxicated.

While Gary did not refer specifically to this, he offered the following comment during the last group session:

> But you know it's being more aware of what did I do and – yeah – I think only time's going to change that one… I think your actions speak louder than words.

It may be that Gary developed more insight at this point in relation to the effects of his previous actions, and while he was positive about the changes in his emotions and behaviour, this increased awareness may have actually lowered his assessment of his own empathy levels at this stage.

However, Gary embarked on a quest of self-improvement: physically, mentally and spiritually. He trained for and completed a 1000-km bike ride to educate children against drugs; he also completed the rehabilitation program before the final interview, stating that he was feeling a sense of spiritual renewal, including more patience, which had been one of his goals in participating in the parenting program. This was also consistent with his changing self-assessment throughout the program of his capacity for emotion regulation through his improving DERS-26 scores.

Gary's renewed view of himself was corroborated by his fiancée when I spoke to her two months after the parenting program. She described how she was most thankful to those who ran the rehabilitation program for the significant changes that she observed in him over the 12 months that she had known him, stating that he had become quite a different person, including a more patient parent.

At the time of the last interview Gary stated that he was prepared to "put in the hard yards" with his four children and two step-children. Of his younger children, he said,

> I'm spending as much time with them as I can. Well now they're saying 'Well when can I see you next?' … I'm trying my best every day – I spend time with my fiancée's kids as well. I'm clean and sober, and I try to be the best role model I can be. We take the kids out, for example to the zoo, and put in the effort. We have four kids under 8.

Gary also reported greater self-confidence and a sense of purpose since completing his recovery program. He stated that he would be buying a new house with his fiancée, as

well as enrolling in a tertiary counselling course, similar to Carl (who graduated from the other recovery centre). Also like Carl, Gary's story spoke of a positive masculinity, one in which he aspired to be a "real man" and a caring father, as well as a positive role model. And while he accepted that there was some way to go in repairing some of his broken relationships, Gary was looking positively at the prospect of real healing taking place there as well, as he intended to put in the work that would be required. He reflected:

> I think in Australia the culture is when you turn 18 you become a man. I really just think that's just thrown way off context, but I think it takes a real man to be a real father, and that's something I'm working on and I'm aware of. So it's more a goal, is to really become a better man, or to be a man and be more compassionate… more loving towards the kids.

Gary's reference to becoming a "real man" is consistent with descriptions provided by Lamb (2010) and Levant (2011), in which positive masculinity is characterised by being caring and able to negotiate tasks alongside traditional attributes of strength and courage, but not dominance and imperviousness, which have frequently also been associated with masculinity.

Sam

Sam, like Carl, was older than the other members of his group, but with Sam this age difference may not have translated into greater maturity. Sam spoke of being a troubled child, but also of a chaotic marriage, in which he and his ex-wife both had addictions and had been violent towards each other.

Sam's change scores

Although Sam continually spoke negatively of his ex-wife, he remained very positive about his relationship with his children. He spoke of crises occurring at home while he was in rehabilitation, but he also showed progress in each of the areas assessed by the questionnaires, particularly emotion regulation and (mental) health. Sam's full-scale scores throughout the program are shown in Figure 6.5 below.

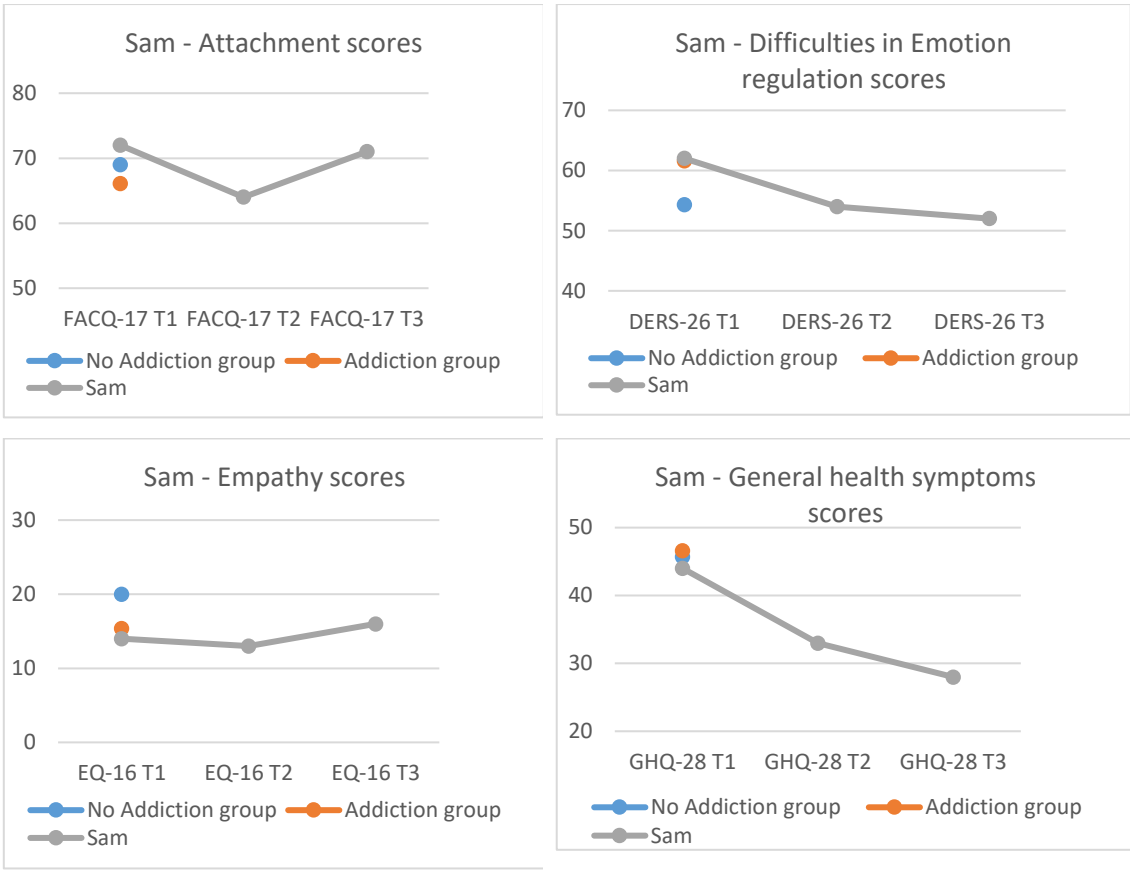

Figure 6.5: Full-scale scores for Sam throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)
- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = six weeks pre-program; T2 = pre-program; T3 = post-program

The graph on the top left of Figure 6.5 above shows Sam's attachment scores throughout the parenting program. Sam focused on his relationship with his 13-year-old son in responding to each of these questionnaires. As discussed in Chapter 4, there was a decrease in his attachment score at T2, suggesting less confidence in his relationship with his son at that time. However, at T3 Sam's FACQ-17 score returned to almost the same score as it was at T1. The two areas in which Sam rated his attachment to his son higher at the first and third sittings were on the *Pleasure in Relationship* and *Anxiety about Relationship* subscales (see Appendix E). This suggests that Sam may have been feeling more secure in his relationship with his son by the end of the parenting program.

Indeed, during the final group session Sam spoke very positively about their relationship at that time.

The graph on the top right suggests steady progress for Sam with his emotion regulation skills, showing a decrease throughout this period from 62 (T1) to 52 (T3), with the latter score even lower than the average DERS-26 score (indicating fewer difficulties) for the fathers in the No Addiction group. Specific areas of improvement were evident on the *Lack of Control*, *Emotional Awareness* and *Concentration Difficulties* subscales.

Consistent with his improvement in his emotion regulation scores, the graph on the bottom right shows a steady decrease in general health symptoms (GHQ-28 scores) from T1 to T3. This change is also likely to be reflective of the progress in Sam's recovery from alcohol and drug dependence. However, his score at T3 is most notable, because Sam rated himself at the lowest possible level on every question when he completed the GHQ at that time. While it is reasonable to assume that there was some improvement in his symptoms, it appears quite possible that Sam, like Jim, may have underrated the extent of such symptoms. To claim, for example, that he had no symptoms associated with anxiety would appear either overly optimistic or perhaps driven by another agenda, such as wanting the reader to know that he was 'well' and ready to see his children on a full-time basis. Alternatively, since Sam did not respond with such positivity on any of the other three questionnaires at this time, he may instead have simply been making a claim that the four weeks prior to that time, as indicated for the questions on the GHQ only – and during a time that there appeared to be less trouble at home – had been a much easier period for him.

The final graph shows the change in Sam's empathy levels as measured by his EQ-16 scores. The rise in the graph at T3 shows some evidence of an increased capacity for empathy for Sam throughout this time period. This is consistent with the decrease in his emotional and mental health symptoms, as well as an increase in his attachment to his son, thus providing further evidence of a more stable and positive disposition as a result of his rehabilitation. It is also possible that the increase in Sam's empathy scores

between T2 and T3 – before and after the parenting program – may have been influenced by some of the discussions and group exercises within that program. The main source of change over that time period occurred on the *Social Discomfort* subscale.

Sam's narrative: 'My kids are turning out OK, all things considered'

Much of Sam's story demonstrated chaos in his life, and the incident that he spoke of in the initial interview in which he gave his younger son some marijuana was one symptom of it. However, in one of the group sessions Sam used an example of his son's looking after his mother's marijuana plant to illustrate what he felt were improved parenting skills. He explained how, when he found a group of his son's peers smoking marijuana in their home (though not his son, he assured me), he managed to speak to his son on his own so as not to embarrass him in front of the other boys, and then, despite the late hour, invited his son to go down to the beach with him, which achieved the intended consequence of having his son's friends leave the house. Sam explained that he would have lost his temper with his son if this situation had occurred before he was in recovery from his addictions.

Sam shared a story of another situation in which he believed he had handled a parenting situation well. He described how his son had become very angry with him about an incident at home; Sam said that he did not give in to his son, but gave him a hug, which his son tried to resist; however, Sam explained that he continued to hold him, and described how his son then softened and cried in his father's arms. Nevertheless, when asked in the last session how helpful the parenting program had been for him, Sam replied that he wished he had done such a course when his children were "two or three", as they were now mainly "set in their ways". While Sam remained concerned and at times felt quite helpless about the situation at home, he said that he could continue with his recovery program because he trusted his sons, who encouraged him to complete it.

During the final group session Sam appeared quite satisfied with how his recovery was progressing, and also how he was tracking with his parenting group goals:

> I've pretty well – most of those goals, even if some of them aren't mine, I could relate to them, and [I'm] pretty much on track, I feel good about, just about every single one of them there, you know – which at the start was totally different.

Sam's positive demeanour during that session went some way to explaining his favourable self-assessments on his questionnaires. However, he did raise one issue of concern: his younger son confided in Sam that he had become addicted to cigarettes, which Sam initially dismissed. However, after talking it through and receiving feedback from other group members, Sam accepted that his son was also showing signs of high anxiety, which he linked to having smoked the marijuana a few months earlier. This time, unlike his minimising of the incident in the initial interview, Sam began to grapple with the implications of his actions and what he could do to help his son with his mental health.

In his post-program interview, Sam reported being recovered from his addictions and having shown some signs of better parenting skills over the six months since the start of his rehabilitation program. But again, all was not well at home, and this time Sam set the scene for our conversation as one full of drama. When asked what had happened in his life since the final group session, he responded:

> You really want to know?... At the moment I'm looking to get some legal advice [to] put a DOCS report in. She's so unmanageable; she's got my kids basically… emotional hostages.

During some of the group sessions as well as the individual interviews, Sam appeared to thrive on casting himself in the role of hero (Denzin, 2001). While he sometimes declared his shortcomings, he told a number of stories in which only he could look after his children properly despite being in rehabilitation. That said, Sam showed evidence of increased self-awareness during the post-program interview. One area that he knew had been a weak point for him was emotion regulation which, as discussed earlier, Sam rated as quite poor in his DERS-26 responses early in the program, but somewhat better by the end of the parenting program. Sam attributed this improvement to a spiritual renewal:

> My patience with things, in the past… some of my shortcomings… weren't great. Now with the grace of God he gives me strength in things where in other times I would've leapt first and thought later; now I tend to think first and see the scenario played out in

> my head before I actually do it and it seems to pay off, and I thank God for that because if it was my will I would've gone down the wrong [path]… I try to live by the rules that he's put out for us and they seem to work, and I'm more positive.

Sam also spoke of a new perspective on his relationships with his children, in which he showed evidence of starting to understand what it would mean for him to be more of an empathic parent:

> Yeah, I got some good things out of [the parenting program], and I'm more tuned in now to their emotions and [I'm] ready to use that for whatever situation… I won't try and not do anything negative [sic] to make them upset and walk away from me and feel frustrated that they didn't get the emotion that I needed to give them.

From his initial interview, in which he was somewhat defensive in his recounting of the incident in which he gave his son marijuana, Sam showed evidence in his final interview of having the capacity to focus more on his son. He appeared to understand more about what it meant to try to understand his children's emotional experience, and where their frustration might come from following interactions with him. Sam appeared to have progressed to the point at which he could perceive their emotions while keeping his own needs separate, a strong indicator of empathy (Martinotti et al, 2009).

Despite his apparently poor relationship with his children's mother, Sam gave me her phone number so that I could speak to her about his parenting if she was happy to speak to me. However, I was unable to speak to her: I left a couple of messages, but she did not return my calls. One possible explanation (of several) for this was that Sam's ex-partner was suspicious of my intentions in talking to her due to the lack of trust in their relationship. But while trust remained a barrier in Sam's relationship with his ex-wife, it was clear that he was making a real effort to understand his sons better and maintain their trust in him. Sam's more stable conception of himself as a father enabled that trust to be strengthened.

Dave

As discussed earlier, Dave presented as quite emotionally volatile, with a history of an austere upbringing, addiction to alcohol and drugs since his early teens, and some recent violence towards another man. He was even sent home during the course of the

parenting program for threatening another resident in the rehabilitation centre. However, he showed the ability to reflect on his actions and as a father remained at least emotionally committed to his relationships with his children.

Dave's change scores

Dave rated himself poorly (compared with the other fathers) on each of the dimensions. He did make some progress in by the end of the parenting program, particularly in relation to his symptoms of depression. Dave's full-scale questionnaire scores throughout the program (at T1, T2 and T3) are shown in Figure 6.6 below.

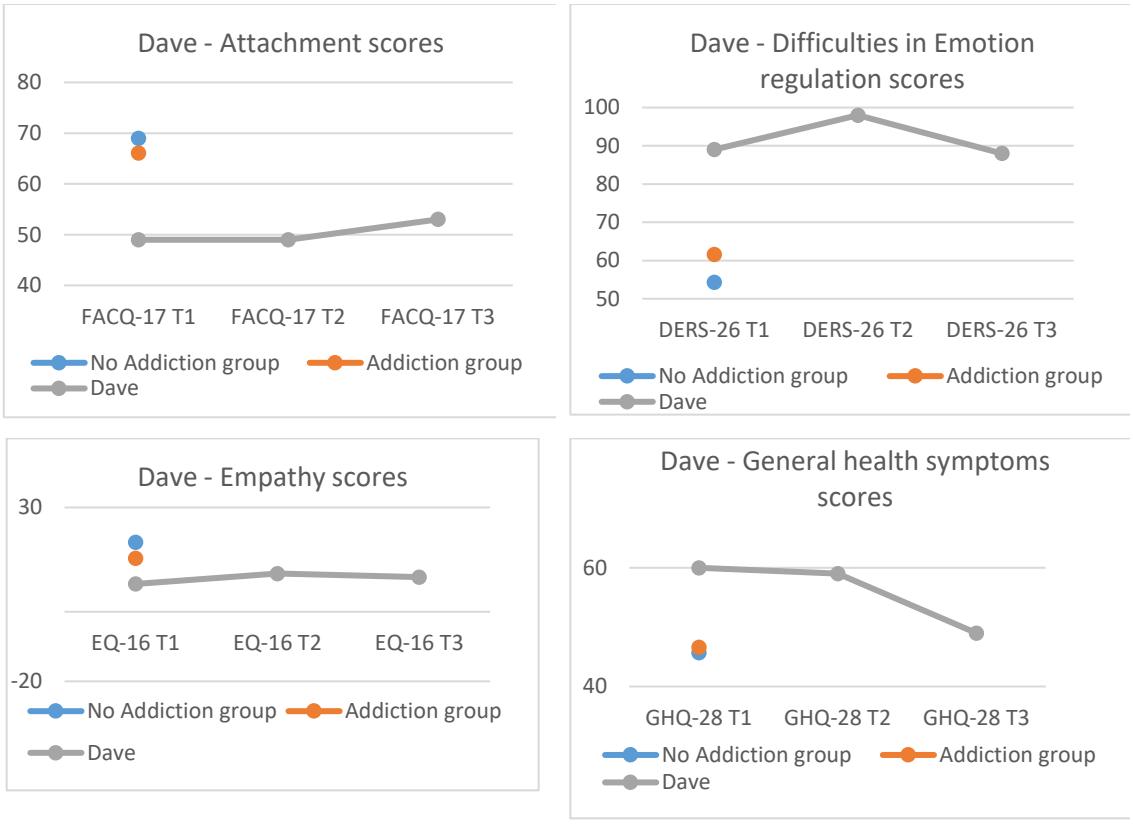

Figure 6.6: Full-scale scores for Dave throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)
- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = six weeks pre-program; T2 = pre-program; T3 = post-program

The graph at the top left of Figure 6.6 shows Dave's self-reported attachment to his nine-year-old son, as measured by his FACQ-17 scores throughout the parenting program. These scores remained quite low throughout the program, reflecting concerns that Dave continued to express about their relationship during that time. There was evidence of some improvement, however, as his score at T3 was a little higher than on the previous two occasions. The higher score at this time was the result of his changed responses on three of the four subscales: *Anxiety about Relationship, Conflict,* and *Mutual Trust*, especially the latter two subscales. But even by the end of the parenting program Dave stated that the relationship had a long way to go before he could feel content with his relationship with his son.

The graph on the top right shows Dave's DERS-26 scores throughout the parenting program, reflecting his difficulties handling his emotions throughout that period. These scores were well above the mean for the other fathers in the Addiction (and No Addiction) group, especially at T2, when Dave was quite emotional during his initial interview. At that time, Dave scored particularly high on the *Negativity to Emotions* and *Lack of Control* subscales. Dave's DERS-26 scores remained high throughout the program. Indeed, as indicated above, there was a period during the parenting program in which Dave was absent from the rehabilitation centre after being sent home for physically threatening another resident. And during the final interview Dave initially displayed some anger for having to remain at the rehabilitation centre for the interview rather than being permitted to leave the premises to speak at a high-school event about his recovery.

Dave's GHQ scores were also high – well above the average scores for both the Addiction and No Addiction groups – but again there was some improvement on the third questionnaire, which was completed during the final parenting group session. Dave particularly showed improvement on the *Severe Depression* subscale, on which he scored much lower than on the first sitting, rating himself as having no severely depressive symptoms the third (and second) time. But given the fact that a number of Dave's statements showed signs of poor self-esteem, he may have underestimated the

extent of his depressive symptoms. And Dave's scores on the other subscales, in particular the *Anxiety/Insomnia*, remained high compared to those of the other fathers in both groups. These scales, in part, reflected the agitated state in which Dave often presented, as well as the difficult relationships he appeared to have with a number of the other residents in the rehabilitation centre.

The graph on the bottom left shows Dave's empathy scores throughout the parenting program. Again, these scores were substantially different – in this case lower, indicating less empathy – from those of most of the other fathers, including those with addictions. While there was some improvement from the first time to the second and third times (his scores were 8, 11 and 10 respectively), the scores remained low, likely reflecting some of the same patterns as the results of Sam's other questionnaires. Indeed, Dave made it clear in the initial interview that he was only undertaking the rehabilitation program – instead of doing time in jail – for his children's sake, so empathy for people other than his children was unlikely to be a priority for him at that time. He also admitted in the second-last group session that the only reason he did not hit another resident who insulted him was because he didn't want to risk prolonging his rehabilitation process by being sent home again.

Dave's narrative: 'I want to be better for my kids' sake'

Although Dave continued to display volatility, he showed a degree of self-awareness at times during the parenting program. In his post-program interview, Dave was asked how he felt that he had progressed with his goals that he stated at the start of the program, including wanting to come out of his addiction and to become less angry. He replied, "I'm still an angry person, but I'm learning where that anger comes from". He also confirmed that he had not yielded to the temptation to use substances when the opportunity arose. Dave was especially keen to change himself so that he could return to his children and help guard them from heading in the same direction in which he had gone. Dave explained that he was increasingly finding inspiration in his faith, and wanted this to help guard his children from further spiritual harm: "I've got a…relationship with God [so I can] share that with my kids and show them the same path".

This theme of being determined to be a good role model for his son – particularly as seen through a religious lens – like the stories of some of the other fathers, could be considered as Dave's embracing of a positive masculinity (Furrow, 1998; Lamb, 2010; Levant, 2011). This was most clearly borne out in his determination, like Gary, to train for and complete a long bike ride so that he could convey an anti-drug message to children in various schools. On the other hand, Dave had expressed dissatisfaction in one of the earlier group sessions with the masculine role in which he felt that he was being placed (Levant, 1997), wherein he was frequently asked to be the disciplinarian after coming home from a long day at work. He lamented, "I just want to walk through the door and give him a hug; I don't want to walk through the door and dish out punishment", and later elaborated:

> I'd just like for my kids to be able to trust in me, so they can see that I am someone that they can come to with a problem… I didn't have that growing up, and that's one thing I think I really want to give my kids is, yeah, someone to talk to in times of good and bad, obviously – just yeah, for their trust, really.

Dave was able to give a fairly frank assessment of the manner in which he often related to others, describing his style as "passive-aggressive". Indeed, during the session on anger, Dave made a joke of some of the exercises and sought to undermine the stories of a couple of the other group members, claiming that one had more partners than he revealed, and manoeuvring another into admitting that he had indeed yelled at his children.

So while Dave was prepared to position himself as a flawed individual, he also played the role of prankster at times, which may have temporarily elevated his standing in relation to others, but may also have given him the opportunity to shift the focus from himself to others, thereby potentially slowing his recovery. It also emphasised the fact that although Dave said "my addiction is about me", it seemed that his recovery was not; instead it was more (albeit laudably at one level) about his children. Indeed he stated, "If I didn't have kids… I'd be happy to be doing the jail".

Dave provided another clear illustration of his rocky road to recovery in his final interview. He explained that he had just completed his anti-drug ride, which gave him

great pleasure, and he was able to spend the following weekend with his family, but it did not turn out quite as he had hoped it would, even though he said that he did not relapse:

> I sort of chucked a little bit of a tantrum… I couldn't handle coming off such a high, going to a caravan park with people drinking and smoking drugs… and I really wanted to be part of that because I sort of needed to reward myself for doing such a good job. But my reward was already there… with my kids [seeing] me do this massive thing that I've done… I didn't pick up, you know [although] I didn't handle it the best, but… that's a major part that I've had to learn to get my head around.

One hopeful sign for Dave was that he was able to articulate a changed view of fatherhood following the parenting program.

> The view of what I was, [which] wasn't a father, to what I can be, has changed; you know what I mean? But… that's always something that I was scared of, you know what I mean… that good father role model, you know. It's not something I'm scared of anymore; you know it's something… I'm looking forward to.

In his recounting of his experience of the weekend that he spent with his family, Dave appeared to demonstrate some genuine empathy for his children in the following two statements: "I don't need the kids to get high hopes that [their mother and I] may get back together. If we do, we'll do it the right way; for now, that'll play havoc on their heads" and "The…emotional torture that my elder boy has gone under because of me is unbelievable…I need to get back [home] to sort it out". This was a clear example that his children's pain was driving him, against all his emotional obstacles (such as feelings of rebellion against his father and a number of the men in the rehabilitation, including his case manager), to get well and be with his family again as a caring, responsible father.

Mick

As indicated previously, Mick joined the parenting program later than the other fathers, having been sent home, like Dave, for threatening violence towards another resident. While he did not suggest that he experienced any trauma growing up, his description of his recent history was full of violence, anger and despair. He had done jail time for assaulting his former best mate for having an affair with Mick's partner, resulting in the loss of access to his young children, about whom he spoke very fondly.

Mick's change scores

Although Mick was unable to spend much time initially with his children, his attachment to them remained high, as did his empathy scores, and perhaps even more surprisingly, his emotion regulation scores also improved. However, he did report a range of general health symptoms, particularly in relation to anxiety and insomnia. Since Mick was not present during the initial interviews he completed that set of questionnaires after he commenced the parenting program. He completed the third set of questionnaires at the same time as the other members of the second group. His questionnaire results are shown in Figure 6.7 below.

The graph at the top left of Figure 6.7 shows Mick's FACQ-17 scores throughout the parenting program, reflecting his attachment to his young son (aged 20 months when Mick responded to the first set of questionnaires). The graph shows that Mick reported a stable level of attachment to his son throughout the program, remaining close to the mean score for those fathers in the Addiction group.

Mick's attachment scores were lower on two subscales: as discussed in Chapter 4, the *Mutual Trust* scores were below both group means due to the age of Mick's child, as was the *Anxiety about Relationship* score, indicating that Mick expressed more anxiety about the security of their relationship since his son's mother and her new partner had full-time custody of the children. However, there was an increase in this score between times T2 and T3, suggesting a little more optimism about the relationship by the end of the parenting program.

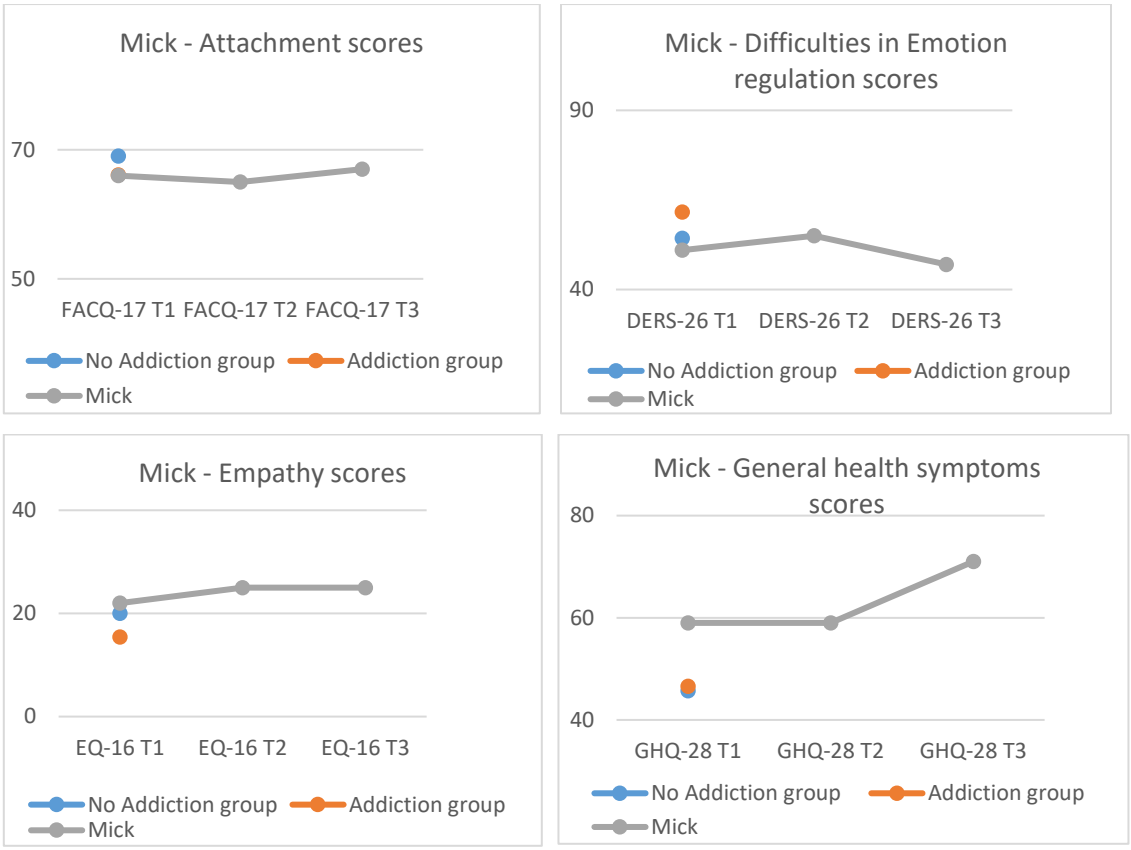

Figure 6.7: Full-scale scores for Mick throughout the program compared with mean questionnaire scores for Addiction and No Addiction groups. Graphs are (clockwise from top left):

- FACQ-17 – Fathers' Attachment to Children Questionnaire (17-item version)
- EQ-16 – Empathy Quotient (16-item version)
- GHQ-28 – General Health Questionnaire (28-item version)
- DERS-26 – Difficulties in Emotion Regulation Scale (26-item version)

Times: T1 = six weeks pre-program; T2 = pre-program; T3 = post-program

The graph on the top right of Figure 6.7 shows the progress in Mick's DERS-26 scores throughout the parenting program. These scores were quite low – at or below the average score for the fathers in the No Addiction group – from the start of the program. As discussed in Chapter 4, these were surprising results in the light of Mick's conviction of assault. Hence, with this in mind, one interpretation of this apparent contradiction is that Mick wanted the reader to know that he could generally be trusted to respond constructively to his emotions. Equally, along with his EQ-16 results, these scores might reflect enhanced self-awareness for Mick, and unlike the GHQ, which assesses recent

symptoms, the DERS and EQ ask the responder for typical attitudes or ways of responding to situations. So these results could just as easily reflect self-confidence as underreporting of difficulties. Indeed, Mick stated in a group session, **"**[I've] always been in touch with my feelings".

Regarding progress throughout the program, Mick's final DERS-26 score was especially low (47), indicating that, despite Mick's stories of great stress during that period, he was reporting that he had a good understanding and acceptance of his emotions. The subscales on which he obtained his best scores the third time were *Emotional Confusion*, *Emotional Awareness, Negativity to Emotions,* and *Concentration Difficulties*. The former two subscales indicated increased emotional clarity towards the end of the parenting program, suggesting good progress in his recovery, while the latter two were consistent with a more positive disposition, an interpretation which is also consistent with his improved score on the *Severe Depression* subscale of the GHQ (see below).

The graph on the bottom right shows the progress in Mick's GHQ-28 scores throughout the parenting program. It can be seen that, unlike his DERS-26 scores, this graph suggests a significant degree of difficulty with general and mental health problems for Mick throughout this period, especially at the end of the group sessions, when his score increased to 71, almost two standard deviations above the mean full-scale GHQ-28 score for the fathers in the Addiction group. In fact, Mick recorded substantial increases in his GHQ scores on three out of the four subscales (see Appendix E): he reported more symptoms associated with bodily complaints, anxiety and insomnia, and social problems, while only his *Severe Depression* score decreased.

If these subscale scores represent an accurate reflection of Mick's symptoms, then it is clear that Mick was suffering from a great deal of stress throughout the program (which was evident also through his discussion about his current life circumstances during the group sessions), particularly towards the end, when paradoxically his self-assessment of his depression levels actually improved. But while many of the questions on the GHQ are associated with acute stress, they do not necessarily imply hopelessness or poor self-

esteem, except on the *Severe Depression* subscale. In addition, the fathers in this study were not routinely asked about medication, so if Mick was on anti-depressant medication this could also have affected his perception of depression, anxiety or other emotional symptoms in unpredictable ways during this period.

Alternatively, although Mick's final score on the *Severe Depression* subscale (9) was still close to the mean score for those fathers in the Addiction group (9.55), the fact that Mick scored much lower on that subscale the third time may have reflected his attitude to disclosing depressive symptoms and his belief about the implications of doing so. If, after all, one wants to present as a worthy parent, it may be much more acceptable to disclose symptoms associated with stress or even anxiety than depression, which could be considered a potential sign of instability and risk around children. Likewise, it was unclear whether there was a protocol for responding to disclosure of depressive symptoms, so this may have also served to temper Mick's (and other men's) assessment of such symptoms. Even so, and despite his harrowing story, Mick did report feeling a little more at peace with himself in the follow-up interview (see below), so his improved score on the *Severe Depression* subscale may have reflected these sentiments.

The graph on the bottom left shows Mick's full-scale EQ-16 scores throughout the program. As discussed in Chapter 4, these scores, reflecting Mick's empathy levels, were high throughout the program, although no further increase in his overall score took place between the start and finish of the parenting program. However, being mindful of the fact that for Mick the time between T2 and T3 was reduced as he joined the program late, this is not surprising. His scores on the *Cognitive Empathy* subscale remained high, and actually increased slightly on his third completion of this questionnaire, when he responded positively to every question on that subscale for the first time. Mick appeared quite confident that he generally had a good understanding of other people's perspectives, although he did lament during the second-last group session that he had sometimes been too trusting of their intentions. This will be discussed further in the next section.

Mick's narrative: 'I've always been a good dad'

Mick presented paradoxically as both angry and reflective, and while undergoing tumultuous change in his life, his contributions to the parenting groups were very meaningful. He demonstrated quite a sound understanding of the principles of emotion coaching, and gave insightful suggestions to the group concerning what to say to one's children when their child had a tantrum. In addition, Mick relayed a number of relevant – if disturbing – stories of his situation, and received some support from other group members.

Mick also spoke about his previous 12 months and the effects that those experiences had had on his personality and ways of relating to others. Essentially, he felt that his trust had been violated to the core after his ex-partner had had an affair with Mick's best mate. After a harrowing year in which he spent time in prison before commencing his rehabilitation, Mick told of how he had to re-evaluate his life and was only just starting to see some hope:

> It's been hard: it's been a dilemma, but I'm past that now; I'm still just pushing along, a bit more reserved now. I do have barriers now, I probably have trust issues now, but they're good strengths and good qualities and I don't see why I should lose them. I lost touch with – I've now lost me home, me family, me missus, me kids, but more than that I lost touch with myself, I mean I lost my identity, [but] I've got that back now. … I was told I was too sensitive and that's a good quality… so I'm tired of other people using shit against me, so a part of me doesn't want to, but part of me wants to, [but] I'm not going to change that.

He told of his love for his young children, but rage at his ex-mate. In the second-last group session he described his situation as follows:

> I want to be around my kids and there's nothing more I want than to be with them… I never went in part-time; I have a strong moral connection to them, and I won't abandon them, but I just look at it at some stage where it was best for me… I'm not resentful; it's happened. It's a learning experience when all – the reality is I'll just have to – I love my kids – I was thinking about this last night – so I will move on. I will have another family… but there will always be a bit of emptiness in me knowing that'll happen, [not being] around me kids as much because if I go back there I won't respect her; I won't trust her, and it'll be purely just for the kids, and now I've got too much self-worth, and I can't do that…

Mick displayed concern for his children's mental health, showing signs that his love for them included empathy and a degree of unselfishness:

> I still struggle that I've missed parts of their babyhood; I can't get that time back no matter what I do. But… the only way I can get past it now is to just think, 'okay, well I don't get to be with them each day', but I'm sort of – I'm not really at peace with that but – I've just accepted it like it's the way it is. The kids need their mum, so for me to get full custody there… it's not really fair on them to – for their mum to – they don't really need to go to a full-time dad at the expense of their mother.

Mick also indicated that it could still have been advantageous for him to be skilled up as a parent, even if he could not see his children, at least at that time. He relayed an incident in which his 13-year-old nephew had been extremely rude to Mick's parents, and Mick spoke of how he was able to gently probe afterwards what was going on for the boy, allowing for some open communication. He felt that his knowledge from the parenting courses helped him in that difficult situation.

Mick told me that due to the AVO he was not permitted to give me his ex-wife's details. Instead, he gave me permission to interview his mother. When I interviewed her after the program, she confirmed that he had displayed a very bad temper on a number of occasions, and this continued to worry her, but he had consistently been an excellent father when he had the opportunity to look after his children. Her greatest concern was for his financial position. At his follow-up interview Mick informed me that his ex-wife was with a new partner who, among other shortcomings, he claimed, did not change the children's nappies. Mick remained upset about his situation, but was working on gaining strength from his religious faith and the tools that he had learnt in his rehabilitation program and parenting courses.

Mick's story was a stark mix of chaos and despair on the one hand (Frank, 2013), while on the other, he spoke of a very strong commitment to and love for his children. And he reported that he had developed a healthier self-esteem, reflecting that his "assertiveness" was sometimes seen by others as "arrogance". But the two realities seemed to co-exist in Mick: genuine, empathic love for his children, and an explosive potential for violence, though he was adamant that he had never hurt or threatened any of his partners or children. Mick also spoke of having "sage abilities" through which he believed that he

had a gift for better than normal intuition into people and potential events. And indeed Mick did speak like a sage at times, very confidently about life and human nature – about morals, about women, about children, about other men, and about himself. The challenge for Mick would be to integrate his sensitivity and insightful nature and his capacity for empathy into his relationships with other adults.

Synthesis of Case Studies

Having examined the individual case studies in depth, one can see the unique circumstances that contributed to the fathers' differing responses to the program, but there are also some patterns. In this section we explore the common themes that contributed to gains in several areas. The individual case studies have illuminated the change process for each father, as well as the benefits of the parenting program.

Experience of Fatherhood

Table 6.1 below outlines the central themes that arose during the interviews and parenting program. As previously discussed, the fathers in this study almost universally described the pleasure that they derived from spending time with their children, though most of them recognised that those relationships had not involved the level of closeness and trust that they wanted, due either to their actions or to those of other family members (often citing their children's mothers). The themes have been divided into various categories according to whether the men perceived the issues to be within their control, and whether the issue was pre-existing and explored within their addiction recovery program, or it arose as part of their goals in the parenting program.

Overall the men tended to assume that stressful issues were not within their control, and they had some difficulty framing their problems otherwise. Learning about control over issues and circumstances was also part of their rehabilitation program, and was expressed in the second group through the serenity prayer at the end of each session. This is the official prayer of Alcoholics Anonymous (AA), having been routinely used as part of rehabilitation programs with the aim of addressing the vexed issue of personal control (Roberts & Fitzgerald, 1991). For example, a difficult skill for a number of the

men was distinguishing between the stress of having to communicate with their ex-partner and how to handle such stress.

Table 6.1: Summary of results for RQ 2: Themes on the experience of fatherhood in addiction recovery as expressed by seven participants who completed the program

General Theme	Specific Issues
Experience of being a father	The joy of fatherhood Regret at not spending more time with their children The pain of separation from one's children and how to see them more often Noticing social/psychological problems in their children
Insight into their addictions	Addictions described as rebellion or coping with stress The work involved in being a responsible father coming out of addiction Regret at the effects of their addictions on their families Appreciation of their children's support in their recovery
Issues perceived as outside their control	Impoverished childhoods and experience of loss of parent and/or growing up with uncaring step-fathers Conflicted family relationships, often with former partners The many relational issues that lead to anger Having to go through their ex-partner to see their children Dissatisfaction with their children's mothers' parenting and their schools' education
Goals related to issues perceived (by some) as within their control	Wanting their children to have a better life than they had Becoming a better role model Accepting and managing their anger Wanting to break rigid masculine stereotypes
Goals arising from parenting group sessions	Developing a closer relationship with their children Helping their children work through strong emotions Handling stress and their own strong emotions Coping with the anxiety of having to go through their ex-partners to see their children

The issues that are directly relevant to the men's experiences of parenting have been further classified in Table 6.2 below, which summarises the concerns and desires of the seven fathers in the present study connected to their relationships with their children and families. It was clear, in speaking with the men – whether they were discussing their relationships with their children in terms of joy, pain or regret –that in almost every case they wanted more time with their children and a closer connection with them. This is undoubtedly an outcome of their recovery process, because their description of their experience of their children in the midst of addiction was almost universally more self-centred.

A number of the men also wanted to let the researcher know that they very much wanted their children to not have to go through what they themselves had experienced, and this was part of the motivation for wanting to become better role models for their children. On the other hand, a number of worries and resentments surfaced throughout the interviews and parenting program; these are shown in the sections of Table 6.2 relating to their concerns, which were broadly about two issues: acknowledgement that being a father is difficult, and frustrations with their present circumstances. These concerns included regrets about their behaviour during addiction, increased awareness of their role as parents and their worries in some cases about their children's mental health, and their frustration at being dependent on their children's mothers (with whom most of the men reported having poor relationships) in order to see their children. Some men also expressed their dissatisfaction at what they considered to be the poor standard of their child's schooling.

Table 6.2: Themes on fatherhood in addiction recovery expressed as desires and concerns

Desire	Issues related to desire	Concern	Issues related to concern
More quality time with their children	The joy of fatherhood	The difficulty of becoming a responsible father	Regret at the effects of their addictions on their families
	Regret at not spending more time with their children		Noticing social/psychological problems in their children
	The pain of separation from one's children and how to see them more often		The work involved in being a responsible father coming out of addiction
	Appreciation of their children's support in their recovery		
	Developing a closer relationship with their child		
Wanting life for their children to be better	Wanting their child to have a better life than they had	Current frustrations	Having to go through their ex-partner to see their children
	Helping their children work through strong emotions		Dissatisfaction with their child's mother's parenting and school
Wanting to be a better role model to their children	Becoming a better role model		
	Accepting and managing their anger		

It can be seen from Table 6.2 that the men who participated in the parenting program showed at times a great deal of vulnerability and altruistic desires in their responses, which included authentic emotional responses to their situations, an acknowledgement of their shortcomings and determination to do better, and an emphasis on the importance of their relationship with their children.

Indicators of Change

This chapter has also sought to answer the third research question (RQ 3), which contained two parts concerning the seven principal participants' perceptions of the effects of this parenting program: to what extent has it (i) helped them to reassess their capacities as fathers, and (ii) facilitated the development of empathy and wellbeing in them? Each father had a positive story to tell about his parenting by the end of the parenting program, and they all spoke of positive changes concerning their relationships with their children; the summary of these change stories is shown in Table 6.3 below.

Concerning the first part of RQ 3 overall, each man reported that he had been able to change in one or more of the following ways: becoming more patient with and a better role model for his child, becoming more involved in his child's activities, becoming more attuned to his child's needs and emotions, and/or starting to connect better emotionally with his child. These represented clear ways in which the men reassessed their fathering capacities. In considering these changes, it must be remembered that these fathers entered the parenting program at widely varying stages of recovery and levels of maturity. Therefore Carl's narrative, for example, is somewhat more advanced than Ray's in both the articulation of his goals and his self-reflections concerning his parenting skills.

Table 6.3: Summary of results for RQ 3(i): The men's reassessment of their capacities as fathers

Participant	Changes as a father
Carl	Described himself as more attuned to his son's needs, now stopping to explain decisions to him instead of expecting him to just accept what he was told. Also said that he vetted his new partner following group discussions about his child.
Ray	Reported trying out one of the recommended strategies from the parenting program, which was meeting his child at eye level. Said he was now enjoying access visits more with his child.
Jim	Reported that he was learning how to express his emotions and was gradually connecting better emotionally with his children, which was his main goal at the start of the parenting program.
Gary	Described himself as more involved in organising activities with his younger children, and more patient with them. Views on fatherhood changed in that he had started to see himself as a more positive role model.
Sam	Spoke of starting to see changes in his life through his sons' perspectives. Views on fatherhood changed in that he now described it as hard but rewarding, and said that he had now become more vigilant about what his children were feeling.
Dave	Appreciated more fully what needed to be done to help his son through his mental health problems and remained keen to complete rehab for his children's sake. Views on fatherhood changed in that he saw the need to be a more positive role model. Stated that he no longer feared becoming a responsible father.
Mick	Had come to accept that his children needed to live with their mother. Views on fatherhood changed in that he claimed to be more accepting of the reduced amount of time that he would be able to spend with his children.

The second part of RQ 3 asked to what extent the parenting program was able to encourage the development of empathy and wellbeing in these fathers. This part of the question implied quantitative as well as qualitative outcomes. In relation to the development of empathy, the qualitative aspects of RQ 3(ii) are implicit in most of the men's change narratives in Table 6.3. These included Carl's description of himself as more attuned to his son's needs; Ray's statement that he had tried meeting his son at eye

level; Jim's reflection that he was connecting more closely with his daughter; Gary's description of himself as more patient with his children; Sam's claim that he had started to see things more from his children's perspectives; Dave's comment that he had more appreciation of the need to help his son with his mental health problems; and Mick's acceptance of his children's need to be with their mother.

Empathy and wellbeing were also assessed quantitatively, through the relevant questionnaires. The men's full-scale pre-program and post-program scores, as well as their *Severe Depression* subscale scores (DEP), are summarised in Table 6.4 below, which shows improved results (in bold type) for six of the seven men in both their self-reported attachment levels (increased FACQ-17 scores) and their difficulties with emotion regulation (decreased DERS-26 scores). Carl was the exception in both cases, although his follow-up scores improved on both measures. The men's *Severe Depression* (DEP) scores have also been presented in bold type if they decreased or remained at the minimum level (7). By that definition, only Gary's depression score, which increased by just one point, did not improve. There was less uniform improvement in their overall scores for general (mental) health and empathy (full-scale GHQ-28 and EQ-16 scores). Nevertheless, in terms of improvements in well-being, two relevant scores (DERS-26 and DEP) suggest that the men largely reported greater capacity for regulating their emotions and reduced levels of depression between the start and finish of the parenting program.

Table 6.4: Summary of results for RQ 3(ii): Empathy and health outcome measures

	FACQ-17		DERS-26		GHQ-28		DEP		EQ-16	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Carl	73	68	44	44	38	**35**	**7**	**7**	15	**17**
Ray	59	**73**	67	**55**	52	**44**	**9**	**7**	14	**19**
Jim	66	**73**	88	**78**	65	**60**	**13**	**12**	19	16
Gary	42	**58**	79	**67**	40	40	7	8	17	13
Sam	64	**71**	54	**52**	33	**28**	**7**	**7**	13	**16**
Dave	49	**53**	98	**88**	59	**49**	**7**	**7**	11	10
Mick	65	**67**	55	**47**	59	71	**12**	**9**	25	25

Greater Empathic Connection to Children

The men's empathy levels did not necessarily improve, although it should be acknowledged that this questionnaire (the EQ) assessed general empathy rather than the fathers' specific empathy towards their children. Instead, the attachment questionnaire (FACQ) aimed to assess the men's perceptions of their relationships with their children. Moreover, as shown in Chapter 3 (Table 3.10), two of the subscales on that questionnaire – the *Anxiety about Relationship* (AAR) and *Mutual Trust* (MT) scores – correlated significantly with the men's EQ-16 scores. Therefore, these have been chosen as the closest measure of the men's capacity for empathy-related attachment (or 'empathic connection') in this study.

The theoretical rationale for this decision was based on Bowlby's (1969) attachment theory, in which Bowlby described trust as the core quality of a secure attachment relationship, with the threat of loss of that attachment security resulting in anxiety (for both the child and the parents). Therefore, if the father is secure in his relationship with his child, he would be low in attachment-related anxiety, thus more confident in his relationship with his child, and hence better able to consider his child's needs. Further, the second quality being assessed here is mutual trust, which requires the father to infer his child's trust in him as well, thereby implying a degree of cognitive empathy on the

father's part. And since both subscales were scored on the same scale with the same number of questions, the scores have simply been added to represent this combined variable. These scores are shown in Table 6.5 below. As these scores represent the sum of six items on a five-point Likert scale, the range of possible values is between 6 and 30, with higher scores representing closer attachment.

Table 6.5 shows the fathers' combined scores from the two subscales of the FACQ-17 described above, with improvements (in bold type) from the start to the finish of the parenting program for all participants except Carl, who once again obtained a higher score (23) at the follow-up interview three months later. These results are consistent with these fathers' descriptions of a closer connection with their children by the end of the parenting program, with the closeness being more child-focused, in keeping with the skills and experiences discussed in the parenting program. Overall, then, it can be concluded that these fathers responded more empathically to their children after the parenting program compared to before it. These results were consistent with their comments discussed earlier about their relationships with their children towards the end of the parenting program and at the final interviews.

In relation to the fathers' own wellbeing, as indicated previously, each of their emotion regulation scores improved throughout the parenting program, suggesting that they were having the experience of functioning emotionally in a healthier way during that time (or afterwards, in the case of Carl). And although there were no consistent changes in the men's general health (GHQ) scores, in each case their scores on the *Severe Depression* subscale had improved (in five of the seven cases), or had at least remained stable or below the mean score of the larger group of fathers with an addiction (for the other two men). Thus, in response to the third research question, the men who completed the parenting program generally showed evidence not only of reassessing their capacities as fathers, but also of improved wellbeing and a closer relationship with their nominated child in both their narratives and their questionnaire scores, including the capacity to respond more empathically to them.

Table 6.5: Sum of Anxiety about Relationship (AAR) and Mutual Trust (MT) pre- and post-program scores.

	AAR + MT	
	Pre	Post
Carl	23	22
Ray	16	**22**
Jim	15	**20**
Gary	9	**16**
Sam	19	**22**
Dave	12	**16**
Mick	14	**16**

Not all of the fathers were internally motivated to change: some showed evidence of being more driven by the possibility of being granted access to their children through having done the program, rather than through having been transformed by the group discussions or adopting the parenting skills. One father admitted that "the paperwork" was indeed his motivation. And while, no doubt, changes in these men would also have occurred as a result of their rehabilitation process, changed circumstances in their lives, or other factors independent of the parenting program, all of the men were at least able to articulate a change narrative concerning their relationships with their children, and they were not advised that this was in any way a requirement in order to gain a certificate of completion for the parenting program. In fact, they were only asked about any such changes in their final interviews, after they had received their certificates. In addition, all of the men were able to describe fatherhood in the language of the parenting program, namely in terms of their emotions, their children's emotions, and their connection with them.

Embedded Narratives

The ability to articulate a change narrative is a requirement in AA (Strobbe & Kurtz, 2012), having been considered to be a vital component of every addict's recovery

(Dunlop & Tracy, 2013; Andersen, 2015), and so it was within this context that these stories were situated. Therefore, although the stories differed according to each man's personality, his current and previous family circumstances, his stated reasons for taking up his addiction, and the role that he chose to give himself and others in his stories (Denzin, 2001), these seven narratives also shared important features. For example, since the rehabilitation program was run according to the twelve steps of AA (Anonymous, 1939) on an abstinence model and set within a religious philosophy, each man's story not only started with a form of chaos narrative Frank's (2013), but most moved into either a restitution narrative (Frank, 2013) or, more commonly, a redemption narrative (Furrow, 1998; Dunlop & Tracy, 2013), with the former more focused on illness and improved health, and the latter more focused on personal deficits and the Christian narrative of sin and the need for forgiveness.

Within the present study, Carl's story more closely followed the former type of narrative, as he resisted the religious momentum inherent in the recovery paradigm provided by the organisation used in this study to stay with a secular explanation of his changes, while the others to varying extents described transformation narratives that reflected the Christian redemption story, mirroring the philosophy of the rehabilitation program. The exception was Ray who, while he was able to articulate a change narrative, appeared unable go deeper, attributing changes in his emotional experience and relationship with his son to the rehabilitation program and the parenting program, without articulating the meaning of change for him. This was not surprising, given that he stated that he had been using drugs for almost half his life (from age 15 to 27, his current age), could not remember any specifics of his childhood, and still had some months to go in his rehabilitation program.

Religious narratives have not only been applied to the transformation process of addiction recovery, but also to the role of fathers (Furrow, 1998). Specifically, concepts that have been traditionally associated with the masculine leader, such as discipline, authority and being a good role model (Furrow, 1998), are likely to appeal to fathers who would already be feeling disempowered, are required (in most cases) to undergo a

very demanding and painful addiction rehabilitation, and are searching for a strong and meaningful identity.

This move from a state of chaos to one of conservative religious stability has previously been described by author and psychiatrist M. Scott Peck as a progression from Stage 1 ("chaotic/antisocial") to Stage 2 ("formal/institutional") spirituality (Peck, 1993, pp. 121-122), although the researcher does not endorse the word 'antisocial' here, in the sense that it could be routinely applied to people with addictions. Nevertheless, this theory describes quite effectively the psychological and spiritual journey of a number of people who enter this transformation in a state of despair and confusion. Peck (1993) formulated his stage theory based on his clinical experience, observing the therapeutic journeys of many of his patients over several years. Most of the fathers in this study, then, could be described as having moved from Peck's Stage 1 to Stage 2 level of spirituality, except Carl, whose questioning of the religious authority of the rehabilitation centre and his statement concerning an apparent contradiction between the behaviour and professed beliefs of many of the men would be more likely place him in Stage 3 ("skeptic/individual": Peck, 1993, p. 124).

Change processes

The recovery process, particularly for those with serious, long-term addictions, can be very powerful. It can include cognitive, behavioural, emotional, social, medical, spiritual, and even physical changes in the person (Dunlop & Tracy, 2013). Of particular interest to the present study are the social and emotional changes experienced by the seven fathers discussed in this chapter. Given that these men have claimed (and have been observed) to have undergone quite profound emotional changes, for example, how have such fundamental changes been able to take place?

From the literature reviewed in Chapter 1, a young child's capacity for emotion regulation is dependent on the attachment relationship with its primary caregiver (Bowlby, 1969; Schore, 2003; Siegel & Hartzell, 2004). Working with the assumption – as this thesis does – that addictions are attachment-based (Flores, 2001; Thorberg &

Lyvers, 2010), an essential part of the recovery process is the reconstruction of the self through the repair of the wounds caused by the relationships with one's 'attachment objects' (Winnicott, 1986; Schore, 2003), particularly in infancy (Flores, 2001) and adolescence (Rowe, 2012). This is why the rehabilitation process includes group-based interventions founded on the principles of family therapy (Rowe, 2012). In the case of men with addictions, whose addictive behaviour frequently starts in the teenage years, this includes helping the men to address their often unmet needs in adolescence to understand what it means to become a man (Pollack, 1999).

Moreover, the fathers' needs for stabilised emotion regulation received extra support by including an attachment-based intervention that centres on their relationships with their children. This means that the attachment reparation that occurs in the rehabilitation process based on the men's family of origin (Thompson, 2014) is further strengthened by the exploration of their attachment relationship with one or more of their children through the parenting program. In addition, the focus on emotional skills has the effect of reducing the fathers' tendency to attempt to compensate for deficits in their relationships with their children and other important attachment figures in their lives. Shaver & Mikulincer (2014) expressed this tendency as follows: "We conclude that people automatically search for internal representations of security-enhancing attachment figures during times of stress" (p. 240).

This increased capacity for emotion regulation, as found in the present study, then also has the effect of helping to improve their mental health (Ford & Russo, 2006; Azizi et al, 2010), as well as their capacity for empathy (Buruck et al, 2014), at least towards their children. Thus, to use a mechanical metaphor, emotion regulation is the driver, and attachment the underlying mechanism, for the overhaul in the men's wellbeing, including their individual mental health and their capacity for intimacy and empathy.

This chapter has sought to uncover both the meaning of fatherhood and the change processes for a group of fathers recovering from addictions. That meaning and that change can both be understood within the context of these men's attachment to their

children and their emotionality and motivation. The men's commitment to connect more closely to their children has provided the impetus to understand their children better and to start to put their children's needs before their own, as well as becoming more content in their newfound experience of closeness to their children.

CHAPTER 7: IMPLICATIONS AND CONCLUSIONS

Overview of Chapter

In this concluding chapter, the results obtained in this study will be synthesised and further illuminated by considering their meaning and implications for future studies. This research has focused on fathers recovering from addictions, and how they have responded to a parenting program provided for them in their rehabilitation centre. The results have been greatly encouraging, as a group of these fathers has opened up about their lives, past and current, and how it has been for them to be fathers, contrasting their relationships with their children during addiction with more recent interactions, as they emerged from addiction. They have also been broadly very receptive to the skills that concentrated on them (emotion regulation) and their children (emotion coaching). The strengths and limitations of the study will also be considered, and implications for further research and clinical practice with similar populations will be discussed. The central aim of the present study was to respond to three research questions concerning fathers in recovery from addictions and their relationships with their children. The results of these three questions are now discussed in turn.

Summary and Synthesis of Findings

Research Question 1: What distinguishes the relationships of fathers recovering from addictions with their children from those without addictions?

From the full sample of 169 fathers in this study, the first-phase analysis provided a number of comparisons between the group of fathers identified as being in recovery from various addictions and those who reported no addictions. As summarised in Table 3.24, the results of the three hypotheses within the first research question were mostly in accordance with the predictions. Firstly, the fathers in recovery from addictions indeed reported greater emotional difficulties than those fathers who did not disclose any addiction, as well as obtaining lower overall empathy scores. While significant differences were not found between the addiction and non-addiction groups in relation to their symptoms of general/mental ill health, these differences did become significant when narrowed down to symptoms of depression (the only subscale on the GHQ that uniquely assessed *mental* health).

Contrary to one of the predictions in the first hypothesis, the reported levels of attachment did not differ significantly between the two groups: the men in the recovery centres reported close to the same attachment to their children as the other fathers. However, the second hypothesis, which predicted that the factors influencing the attachment levels of the two groups would be different, was shown to be correct, suggesting that the construction of the fathers' attachment to their children depended on the presence or otherwise of an addiction. Specifically, the factors found to influence the fathers' attachment to their children were empathy, emotion regulation and father's age for those disclosing addictions, while for the other fathers they were empathy and depressive symptoms (see Equations 3.1 and 3.2).

The third hypothesis predicted a path model showing the relative contributions of mental health and empathy to attachment levels. This was also confirmed, with one pathway showing that the presence of addiction was one negative influence on the fathers' attachment to their children through the mediating variable empathy, with lower empathy predicting lower attachment. The other pathway showed an effect for depression (for fathers with or without addictions), in which recent depressive symptoms predicted emotional difficulties, which in turn predicted lower levels of attachment, either through the influence of reduced empathy, or directly from emotional difficulties to decreased attachment to their children. This is illustrated in Figure 3.1.

As previously discussed, addictions and depression have been frequently found to be associated with poor relationships, either through growing up in conflicted families or experiencing current relational difficulties or, most frequently, both. It is then unsurprising that these fathers, in the face of such troubled relationships, reported some difficulty with their relationships with their children, especially on the attachment subscale that assessed attachment anxiety. Insecure relationships frequently characterise the lives of addicted or depressed fathers.

Thus, the combination of an addiction and/or depressive symptoms, low empathy and poor emotional awareness and control proved to be detrimental to these men's attachment levels, and by implication, their relationships with their children. Conversely, as explained previously, merely having an addiction or being depressed did not necessarily condemn those fathers to having poor relationships with their children; the model suggested that having a relatively high degree of empathy and/or having good emotional self-regulation in the face of such mental health challenges may have served as a buffer against poor relationships with their children.

Another purpose of the first phase of the present study was to 'set the scene' for the individual interviews and group parenting sessions that occurred in the second phase. To this end, the resounding theme from these preliminary analyses was that empathy and sound emotionality were potentially highly influential for these fathers' attachment to their children. Consequently, if it were possible to help the men work on these areas of their psychological functioning, this could have very beneficial effects on their relationships with their children. This will be discussed further when considering the implications from the results of the third research question.

Research Question 2: What is life like for a father recovering from an addiction?

As discussed in Chapter 6, a number of themes emerged from the men's stories of their experiences of being a father in recovery from an addiction. A summary of these themes and the associated issues was provided in Table 6.1. One component of the rehabilitation program in which these men were situated involved inculcating a change narrative in their residents. Thus, it was clear that in formulating their goals for the parenting program, most of the men had already considered a number of the issues outlined in Table 6.1 within their rehabilitation program.

The issues that were specifically relevant to fatherhood were further summarised into five overarching themes: three desires and two concerns (see Table 6.2). The desires involved wanting to spend more quality time with their children, wanting their children's lives to be better than their own, and aiming to be a better role model for their children.

The concerns were generally about the difficulty of becoming a responsible father, and (in most cases) how they could have good relationships with their children when they had poor relationships with their children's mothers.

The parenting program afforded the men an opportunity to form more goals, either directly related to their parenting skills or, more indirectly, to become better fathers through improved emotional health and self-management. Goals arising from the desires outlined above included: how to see their children more often; how to handle stress and anger; how to form a closer relationship with their children; and becoming better at helping their children work through strong emotions. The implications of these goals to this research will be discussed in the final section.

Research Question 3: How has the parenting program helped these fathers?

This question was particularly concerned with the seven fathers who completed the interviews and parenting program, and asked: What changes were evident in their stories and their questionnaire scores between the start and finish of that program? The results associated with the third research question as articulated below have also been summarised in Table 6.3 (narratives) and Tables 6.4 and 6.5 (changed questionnaire scores).

The themes in the participants' change narratives as fathers as outlined in Table 6.3 ranged from appreciating more fully the need to be a good role model for their children, through being more attuned to their needs, to being more consultative and proactive in organising activities with their children. It was apparent that each of the seven men who completed the parenting program had engaged in some level of reflecting on, and in most cases re-evaluating, his capacity as a father.

The fathers' narratives also included reference to changes suggested by the second part of the third research question above, namely increased empathy and an improved sense of wellbeing. Examples of increased empathy towards their children included being more considerate of their children's feelings and being able to see their perspectives

more clearly. Stories of enhanced wellbeing were borne out through the fathers' reporting of having become better at expressing their emotions and enjoying more the connection with their children, as well as becoming more patient and self-controlled.

These change narratives were supported by improvements in the men's questionnaire scores on the relevant variables between the start and finish of the parenting program. The results in Table 6.4 demonstrated that overall, the seven fathers reported enhanced wellbeing through reduced depressive symptoms and improved emotion regulation. There was also evidence that these men, in their various ways, reported being able to connect better with their children by the end of the parenting program than previously; this was borne out in their final interviews, and demonstrated quantitatively by the results of their 'empathic connection' scores shown in Table 6.5, which measured the combination of attachment-related anxiety and mutual trust. Overall, the men claimed that they had become more confident about the quality of their relationships with their children through becoming less anxious and more trusting in those relationships, and being more likely to report that their children trusted *them*.

Discussion and Implications

Greater empathy?

Following the first-phase analysis, in which differences were found between the groups of fathers with and without addictions in the areas of empathy and emotion regulation, the results of the Phase 2 analysis showed that this training program was able to aid in achieving the goals in this study of helping the participants develop better emotion regulation skills and improved mental health, which the men reported through reduced depression scores. The fathers' narratives also included more positive self-assessments concerning their parenting skills and their relationships with their children. The one exception to this was in the area of general empathy, in that the fathers' EQ-16 scores did not show much evidence of change. Nevertheless, the improvement in the men's emotional skills but not their empathy levels makes sense from a number of perspectives. Firstly, whereas the men were trained in empathic parenting and emotion regulation skills within the parenting sessions, there was no such training in general

empathy, which in any event involves various components, and is affected by several factors. Indeed, emotion regulation has previously been described as just one component of empathy (Michalska, 2009).

In addition, empathy levels have been found to be influenced by individual and parental mental health (Koestner, Franz & Weinberger, 1990; Baron-Cohen & Wheelwright, 2004; Lawrence et al, 2004; Tong et al, 2012; Vilas-Sanz, Ludlow & Renier, 2016), as well as one's parents' empathy levels (Watt & Panksepp, 2016). People's capacity for empathy has also been found to vary according to their age and maturity (Muncer & Ling, 2005; Christov-Moore et al, 2014; Richaud de Minzi, Lemos & Oros, 2016), as well as their socio-economic status (Schieman & Turner, 2001). This latter point will be discussed in more detail in the next section. Furthermore, the empathy levels of the men in this study (when assessed by the 40-item EQ) were found to be lower than those in previous samples of men (Baron-Cohen & Wheelwright, 2004), including those with active addictions in addition to those in recovery (Martinotti et al, 2009). The participants' low baseline levels of empathy in this study are thus also likely to have rendered this aspect of their functioning more difficult to change.

One of the key aims of the parenting program in the present study was to help this population of fathers to improve their relationships with their children by responding more empathically – instead of punitively or dismissively – to their children's strong emotions when they arise (Havighurst et al, 2004). Moreover, the training in empathy within this study was very specific: the men were not educated in their attitudes towards different groups, nor were they trained in empathic responding to people other than their children. Therefore, "the development of empathy" referred to within RQ 3 is best understood as beginning with the men's response patterns towards their own children, given that the training program within the present study was designed with this in mind. The parenting program focused as much on the men's experiences as fathers as it did on parenting skills. This provided a practical basis for a focus on emotions and empathy, which were part of the men's stories that the men themselves identified as important, even if they did not actually use the word 'empathy'.

Centrality of emotion regulation

The results of this study also clearly amplified the value of the capacity for healthy emotion regulation for this population of fathers: improvements in the areas of emotional awareness and management were part of the recovery process for each of the fathers. What are the implications of paternal emotional dysregulation within their families? Firstly, the men's children (and partner, if present) are likely to feel threatened, particularly if they feel any of the anger directed at them; this is consistent with the findings of the study by Giallo et al (2014), referred to previously, in which mental health outcomes of adult children of depressed fathers depended on their fathers' earlier capacity for emotional self-control. Secondly, the men cannot attend to their children's emotions when they are highly aroused themselves. This issue was discussed in the parenting sessions in relation to choosing when to emotion-coach their children, as explained in the *Tuning in to Kids* manual (Havighurst & Harley, 2009). One of the many benefits for fathers recovering from addictions of being helped to connect better with their children is that this can give them the motivation that they need to manage their anger, as they experience the change in their relationships with them, as in the case of Dave and, to an extent, Sam and Gary.

Related to emotional reactivity is the theme of masculinity. Although there have been substantial changes in our society's attitudes towards male and female social roles over the past 50 years or so, there is still a strong tendency for many men – particularly in less affluent social strata – to identify with a traditional view of masculinity, partly because they are more likely to be feeling disempowered within broader society, and partly because there has been a simultaneous rise in the value placed on individualism, as discussed earlier. Two aspects of this type of masculinity are particularly relevant here. Firstly, the ideal of the good provider can have the effect of oppressing these men, because so often they cannot attain it, although it can also serve as an extra motivation to broaden their view of their role, including a renewed self-concept as someone who can support their child emotionally (Bryan, 2013) and prepare themselves better for employment. The other relevant feature of this type of masculinity is the tendency to aspire to be the leader in one's own social context. Within more disadvantaged groups in

particular, which includes most of the men in this study, this dynamic can play out quite strongly within their families and immediate social circle.

Reflecting on some of the men's stories in this study, it is apparent that when their view of themselves in this leadership role – which is often very difficult to sustain in a context of deprivation – is under threat, they can become enraged, and subsequently potentially dangerous to themselves and others, exacerbating the potential for these men to perpetrate family violence (Flood & Pease, 2006). Indeed, some of the fathers in this study disclosed such histories in their interviews. This potential for violence is another reason that this research is so important. So, two questions to ask are: to what extent are such men willing to reframe their relationships with their children so that they can become open to listening to them and responding to their emotional experience; and can training these men in emotional self-awareness and empathic parenting help address this issue of emotional volatility and even help reduce the potential to commit domestic and family violence?

Despite somewhat conservative views on masculinity and the role of fathers for many of the men in this program, there was generally a willingness to accept the legitimacy of male expressions of emotions other than anger, at least their own, their children's, and those of other men in the group sessions. So to answer the first question, these fathers recognised the value of their own emotional reality and that of their children, at least in the context of a parenting group. This increases the likelihood that these men will translate this openness into their day-to-day interactions with their children, especially if they experience improved relationships with them as a result of this renewed acceptance of their children's emotions.

To answer the second question, provided that these and other fathers in similar contexts have been assessed as suitable for these types of groups, and they have the necessary social support (for most of them, that will include other men), the evidence from the results of the present study suggests that these fathering groups can indeed be a very useful source of support for these men in responding positively to their own emotions in

addition to those of their children. Other recent studies have corroborated this finding, with emerging evidence showing that fathering programs for appropriately screened fathers can help them to monitor their own emotional reactivity more effectively, or become more aware of the effect of the violence on their children, and hence reduce the risk of reoffending against their partners or children (Scott & Lishak, 2012; Zanoni et al, 2014; Meyer, 2017).

A Return to the Importance of this Research

The research questions have now been addressed for the present study. In Chapter 1, the purposes of the study were also listed; these will now be revisited in turn. The two research purposes relating to the first research question were:

(i) Analyse the psychological factors that may influence a father's empathic connection with his children; and

(ii) Determine whether there is a relationship between a father's empathic connection with his children and the presence of an addiction

The assumptions underlying these first two research purposes were that the relationship between a father and his children is important because a good father-child relationship is deeply valued by both parties; it has also been well established that parental addictions adversely impact family relationships and health outcomes for the children. This research sought to examine whether an attachment-focused parenting program could be a further support to fathers recovering from addictions; for the reasons described in Chapter 6 it can be concluded that it has indeed provided such support to these fathers.

(iii) Understand better the perspectives of fathers, including the plights that many of these men face as parents, particularly those with addictions; and

(iv) Explore the social context of the fathers in this study; add to the theory base in this area; and increase public awareness of the importance and value of helping these fathers with their parenting.

These two purposes were addressed in Phase 2 by responding to the second research question. Through the 16 initial interviews and 12 follow-up interviews, as well as the 15 group parenting sessions, a number of themes emerged concerning fatherhood in the context of recovery from addictions. From these themes discussed in previous chapters,

one clear conclusion can be drawn: fatherhood is very significant for fathers recovering from addictions, because the restoration of their relationships with their children is one of the prime motivators for them to get well.

Concerning the specific statements in the third research purpose above, this study has amplified the perspectives of these recovering men, thereby allowing their voices to be heard. This has included themes of impoverished childhoods, reduced finances, a loss of respect within their families and society, and in many cases, being cut off from their families.

As discussed in Chapter 1, fathers with addictions are often characterised as absent fathers who have abrogated their responsibilities, but the fathers in this study, who have all been prepared to submit themselves to the recovery process, have demonstrated that they want to be back with their families, especially with their children. And if fathers recovering from addictions can be (and want to be) helped with their parenting skills, this has profoundly positive social implications for the next generation of children in our society.

(v) *Help make life better for fathers, particularly this population of fathers, and their families, if possible; and*

(vi) *Examine the notion that if a father can (re-)connect with his child, he can find more of a sense of purpose himself and perhaps even a reduction in his own anxiety and addictive behaviour if there is any.*

These two purposes were addressed in Phase 2 through the third research question. Concerning the fifth research purpose above, the parenting program aimed to help the fathers as well as (indirectly) their children; on the evidence presented in Chapter 6 the program has achieved this. The overwhelming message expressed by the fathers who completed the parenting program in this study is that their relationship with their children is the most important of all aspects of their lives – more important to them than any other relationships or their finances and employment status. And as discussed in the previous section, fathering programs that include men can with addictions be central to reducing the risk of domestic and family violence.

In relation to the sixth research purpose above, the final interviews with each of the fathers provided the researcher with the opportunity to explore the men's perspectives concerning their renewed sense of identity and purpose. Listening to the fathers in those final interviews I could hear a clear sense of purpose for some of them: for example, Carl, Gary and Sam. Carl told me that he enrolled into a psychology course so that he could work with recovering addicts; he was also very pleased to announce that he would be getting re-married, and that he considered that his fiancée would be a very good step-mother to his son. Gary, who was also engaged to be married, said in his post-program interview, "I have more goals and I have more purpose"; he stated that he was now committed to being the best role model that he could be, and (again similarly to Carl) would be enrolling into a counselling course to help others. Sam said, "I want to be a good dad for my kids and be the pillar of strength for them". To complete the rehabilitation program, Sam needed his sons' encouragement which, he said, he received.

The other four fathers, who were not quite as close to finishing their rehabilitation, were nevertheless able to articulate revised goals or talk about new achievements. Ray told me that he was able to do a presentation in front of the other fathers in the rehabilitation centre explaining the skills that he had learnt in the parenting program. Jim explained that he was just learning to show emotions at the time of the interview, and that he was very happy that he would be able to spend more time with his daughter. Dave reflected that he had recently achieved his greatest feat, which was completing the long bike ride to educate school children against using drugs. Speaking at schools was vital to his recovery, he said, and he reiterated his goal that he now wanted to become a responsible father and good role model. Finally, Mick shared with me that since he could only see his children once a week his new goal was to finish rehabilitation, get back to work, and start a new family. He also acknowledged that his children most needed ongoing contact with their mother.

Thus, the benefits for these fathers and their families of focusing their thoughts not only on their own recovery, but on their children's needs as well, can be seen through these

concluding statements. Three of the men (Carl, Gary and Mick) were resolved to make a fresh start with a new partner and potentially a new family. The other fathers, while they may not have been able (yet) to attain such a level of self-renewal, were nonetheless proud of a number of their achievements to date during their recovery. Those men's stories also showed that their children were proud of their fathers for the steps that they had taken in their recovery.

This aspect of the stories was very powerful for two reasons. Firstly, in becoming more attuned to their children's emotions through the parenting program, these fathers were able to take great encouragement themselves from their children's growing respect for them. Indeed, including a component of men's addiction recovery programs that specifically relates to fatherhood has shown evidence of being able to help in the recovery process (Williams, 2014). And secondly, the positive effect on these children's mental health in seeing their fathers recover could be quite profound for them. In this indirect sense, the parenting program within the recovery program could be considered as a form of early intervention for these children as these fathers, in all their brokenness, were still able to start to focus on their children's emotions and needs, even if sporadically.

Regarding the sixth research purpose, as discussed in Chapter 6, the fathers in this study assessed their mental health symptoms more positively after the parenting program than beforehand through fewer reported symptoms of severe depression. Also, as summarised in Table 6.5, the combination of the men's *Anxiety about Relationship* and *Mutual Trust* subscales on their attachment questionnaires improved throughout the parenting program. So it is fair to say that these fathers did show some evidence of reduced anxiety by the end of the parenting program, especially if they were able to gain more access to their children, as most of them were.

All of the fathers also confirmed that they were no longer abusing substances; while this was naturally a result of their rehabilitation, their awareness of the importance of their relationships with their children to them also provided a strong motivation to remain

sober. Moreover, the parenting program added a different dimension to these fathers' recovery experiences, as it focused on their strengths, new skills (emotion coaching of their children and emotion regulation exercises for themselves), and their goals for improving their relationships with their children, rather than concentrating on addiction as a disease, for which the twelve-step model has sometimes been criticised (Broekaert, Autrique, Vanderplasschen & Colpaert, 2010; McKay & Hiller-Sturmhöfel, 2011).

Limitations

The group sizes in this study were small, and were particularly so due to the attrition rate, which is common in rehabilitation centres. This may have compromised the statistical power in some of the statistical analyses, as well as the external validity. And while the sample size was assessed as sufficiently large to conduct factor analyses of the original scales, this also had the effect of making comparisons with previous studies that used the original scales more difficult. Other phase 1 limitations included the inability to match participants with controls recruited in a similar manner on key demographic variables, and the potential influence of the different data collection procedures on the results.

In relation to phase 2 of the study, one issue was that of admission into the parenting program. The original conditions for participation stipulated no severe mental health conditions or legal custody/access issues with their children, but exceptions were made to both of these conditions in order to accommodate more fathers into this program. That said, the participant with a severe mental health condition was still able to give some very valuable feedback in the group sessions, providing a striking example of how he was able to parent his children in the face of trauma. And the father who wanted the "paperwork" to help him gain access to his children also made very useful and at times poignant contributions to the group discussions.

The fairly wide age group of the fathers' children, from approximately 18 months to 15 years (instead of the recommended 2 to 12 years), again due to not excluding participants as far as possible, was not ideal, in that many discussions about parenting

were not relevant to all of the group members. The situational context of the parenting program also provided some significant challenges. On the one hand, it was helpful to have participants who were residents in rehabilitation centres so that they were less likely to miss sessions. However, the number of other activities taking place in each centre made it difficult to keep a consistent time or indeed have sufficient time for some of the sessions.

Another factor affecting the validity of any comparisons between pre-parenting program and post-program results was the stage of the participants in their rehabilitation program (Hibbert & Best, 2011). While all of the men had undergone a detoxification process, some were only a few weeks into the rehabilitation phase of their program, while others were almost finished, at least six months further into their rehabilitation program. The effectiveness of the parenting program appeared to depend to some extent on the fathers having a minimum level of recovery and maturity. The wide age range of the fathers (21-51) thus also presented a challenge. There was both a greater attrition rate and less in-session participation from the younger men in particular. This was especially likely to be the case for those young men who had started using substances early in life, as most of them had. Conversely, two of the more mature men, both aged over 45, seemed to respond at quite different levels from most of the others, and appeared to find a number of the exercises and group discussions less applicable to them, instead wanting to launch into longer stories themselves.

This study relied mostly on self-report in the form of the fathers' stories as well as their questionnaire responses. There was limited scope to obtain collateral report on the parenting and related behaviours of the fathers, although some interviews were conducted with partners or other people close to the men. Therefore these results need to be interpreted with some caution, depending on what underlying story the participants were wanting to tell, which may have been affected by their history, their motivation for both recovery and seeing their children, and their assumptions about the role and influence of the researcher. Studies that could complement self-report are discussed in the following section.

As discussed in Chapter 6, some of the stark differences among apparently similar measures for some individuals suggested particular agendas for some of the men's scores. And two of the men in particular were lacking in verbal skills, often unable to provide further explanations of some of their answers to the interview questions. Even so, the various forms of data – the fathers' stories individually and within the groups, feedback from others, the researcher's field notes, and the different quantitative measures – together served to create rich pictures of each of the seven main participants in this study.

Future Directions and Conclusion

This study has been predicated on the assumption that becoming a parent is difficult; fatherhood can be stressful for many men, and it is almost impossible to be a patient, empathic father in the throes of addiction. In relation to this, future studies could benefit from assessing masculine gender role stress and its effect on empathy, emotion regulation, attachment, and parenting. Moreover, it is axiomatic that children need emotional as well as physical security in order to grow and thrive. In vulnerable families, these essentials are certainly not guaranteed (Carlson & McLanahan, 2010). Despite their addictions and, in most cases, criminal histories, all of the fathers in this study articulated through their narratives that they loved their children. The missing component was whether these men were confident that their children felt loved by them. In fact, some of the men's narratives clearly indicated that they were not. This is another point at which this research is critical. There are many ways that parents can bridge this gap; one of the most powerful is through conveying empathy to their children.

How beneficial is it to train fathers recovering from addictions to be empathic parents? It is understood that empathy can be quite difficult to express or even experience for many parents, even out of addiction, particularly cognitive empathy for parents with developmental disorders (Baron-Cohen & Wheelwright, 2004) and affective empathy for parents with personality disorders (Seligman & Reichenberg, 2007). But, provided that they have not been assessed as unsafe (Zanoni et al, 2014), fathers (or mothers) with

such diagnoses can be helped to parent effectively (AAIDD, 2008; Newman, 2011; PASPD, 2015).

The other implication in this question is that parental empathy itself may or may not be helpful to the child, and may even be harmful to the parent. Regarding the first part of this objection to the use of parental empathy, there is little support for the belief that empathy can 'spoil' children, with the evidence showing instead that the judicious use of empathy by parents (for their children's feelings) is more likely to improve their children's behaviour (Havighurst et al, 2004). However, there is one caveat that should be mentioned concerning the limits of the value of paternal empathy. This can be a powerful gift to one's children, especially if they are not used to receiving it. But the value of empathy to the child lies in the feeling of being connected, understood and emotionally safe. In cases where the child or young person engages in harmful behaviour, empathy for their actions could be construed as collusion rather than understanding. Acceptance of the child's emotional experience thus needs to be clearly distinguished from defensive agreement with them on every issue.

In relation to the second part of the objection (questioning the value of parental empathy for the parents), the Manczak et al (2016) study referred to in Chapter 1 suggested that empathy is not always helpful to the provider of that empathy, and can even be harmful. Questions concerning the direct applicability of that study were made previously; the conclusion in relation to the present study is that there is insufficient evidence to mount a credible case against the positive effects of empathic parenting on both the parents and their children. Nevertheless, the authors' conclusion that there is a cost to providing empathy appears quite valid, which is not surprising, given that empathy is valuable, and valuable commodities are costly.

It is partly for this reason that the parenting program in the present study focused almost as much on the fathers' own emotional health as their parenting. One of the core assumptions of this research is that parents require stress reduction techniques and emotional support for the hard work that they do, particularly those with less developed

people skills and emotional resources, such as this population of fathers coming out of addictions. The question to ask here is not so much whether the current parenting program would be advisable to implement, but how, and in what context.

Following the positive results of this study, a reasonable conclusion to draw is that it would be beneficial to continue to run such programs for fathers in residential rehabilitation centres, which could likewise be incorporated into the rehabilitation programs in outpatient centres. To what extent should the consumer base of such a program be broadened; for example, how might this program be received by young fathers without addictions? And should such a program (or a similar parenting program) be mandated for fathers in recovery centres as part of their daily program?

On the last point, it is recommended that fathers be screened before participating in such a program. This of course applies to fathers with existing family-related criminal convictions, such as domestic violence or child abuse, until they have been assessed as safe to be with their children unsupervised or with limited supervision. It would also apply to other fathers who have been convicted of a serious criminal offence. As with parents with personality disorders, individual case work or therapy in addition to other relevant group programs should be carried out before enrolling these men into a parenting program such as this. But for fathers who state and show that they want to get well, and give an indication that they love their children (which of course is the overwhelming majority of fathers), this study has shown that an emotion-focused parenting program can be a great support.

In relation to the first point – broadening the program to young fathers without addictions – since one of the conclusions arising from this study was that the younger fathers seemed to not be as fully engaged as the fathers in their thirties and older, more research should be carried out before implementing this program in that context, as it may be that some of the concepts discussed are not as relevant to, or perhaps too sophisticated for, such a group. And the heavy focus on emotion regulation skills as employed in the present study may not be as well received by fathers with no history of

addiction. In addition, there are other programs and initiatives in place that are more specifically tailored to the needs of young fathers, including a recent technologically based initiative that supports them through the early months of their first child (AFRN, 2016), that respond to this need.

Nevertheless, the feedback provided by this particular population has generally indicated that there is support from these fathers for maintaining the focus on them as fathers as well as their children, and for including the emotion regulation exercises. And although parenting is of course carried out by mothers and fathers, the decision to include only fathers in this study remains a recommendation for future programs with such populations on two counts: the fathers related much more to the videos of other fathers interacting with their children than they did when the parents were mothers, and the focus on anger in particular permitted a frankness from the men that may have been more muted had they been discussing this in front of mothers.

Recommendations for Future Research

Following the outcomes of the present study, including the positive feedback received by the fathers, future research could include the following initiatives, in order to strengthen the gains experienced by recovering fathers concerning their relationships with their children. In addition, since another important theme arising from this research was the values of children's support and concern about their mental health, the program could be further broadened to include a program for the children themselves; see the second recommendation below:

- Delivery of the same parenting program at a nominated drug and alcohol rehabilitation centre together with 'refresher' group sessions both six and twelve months after completion of the parenting program, in order to assess for maintenance of positive change and to allow the fathers an opportunity to discuss their progress with their parenting skills and their relationships with their children. These results could be compared to a parallel group of fathers in addiction rehabilitation (controlled for stage of recovery, relationship status, and

father's level of access to his children) who had not undertaken the parenting program.

- This research could be extended to the children of fathers who had graduated from their rehabilitation programs and also completed the parenting program. These children could be given 'social skills' sessions within different age groups and could be assessed for some of the same variables as their fathers; they could also have the opportunity – depending on age and maturity – to discuss their experience of being children of fathers in recovery from addictions. Finally, the children's responses concerning their attachment to their fathers and their perception of their fathers' parenting could be compared with the relevant responses from the fathers, as a means of obtaining perspectives other than those of the fathers.

Concluding thoughts

While 'empathic connection' to one's child and 'addictive flight' are not entirely mutually exclusive, the men's comments throughout this program showed that they understood that they needed to work hard on their relationships with their children, and such work would only be compromised by their continual use of substances or otherwise resorting to their addictions. Help for young or struggling parents with parenting and communication skills with their children is rarely wasted. And the benefits to the community of providing parenting programs such as the one in the present study to fathers with addictions, who have so often been ignored in programs, having suffered from a deprived childhood and early adulthood, would far outweigh the costs.

It has been a greatly enlightening experience for me to have the privilege of interviewing and running parenting groups for these men. From my perspective, they have had to be prepared to give up much – their freedom, their dependency usually on drugs and alcohol, and their finances – in order to start to recover. It is not until they focus on their children that they realise how much there is for them to gain.

REFERENCES

Adinoff, B. (2004). Neurobiologic processes in drug reward and addiction. *Harvard Review of Psychiatry, 12(6),* 305-320.

Ainsworth, M.D., Blehar, M, Waters, E, & Wall, S. (1978) *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum.

Allen, S. & Daly, K. (2007). *The effects of father involvement: An updated research summary of the evidence.* Guelph, Ca: Centre for Families, Work & Well-Being, University of Guelph.

Amato, P.R and Dorius, C. (2010). Fathers, children and divorce. In M. Lamb, (Ed.), *The role of the father in child development* (5th ed., pp 177-200). Hoboken, NJ: Wiley.

Amato, P.R and Gilbreth, J.G. (1999). Non-resident fathers and children's well-being: A meta-analysis. *Journal of Marriage and Family, 61(3),* 557-573.

American Association of Intellectual and Developmental Disabilities (AAIDD). (2008). *Position statement: Parents with intellectual and developmental disabilities.* Retrieved from http://www.thearc.org/document.doc?id=3642

American Psychiatric Association (APA). (2013). *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). Washington, DC: Author.

Anda, R.F., Whitfield, C.L., Felitti, V J., Chapman, D., Edwards, V.J., Dube, S.R, & Williamson, D.F. (2002). Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services, 53,* 1001-1009.

Andersen, D. (2015). Stories of change in drug treatment: a narrative analysis of 'whats' and 'hows' in institutional storytelling. *Sociology of Health & Illness, 37(5),* 668–682

Anderson, A. M. (1994). The father-infant relationship: Becoming connected. *Dissertation Abstracts International.*

Andreas, J.B., O'Farrell, T.J & Fals-Stewart, W. (2006). Does individual treatment for alcoholic fathers benefit their children? A longitudinal assessment. *Journal of Consulting & Clinical Psychology, 74(1),* 191-198.

Anonymous (1939). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism.* World Services: A.A.

Applebaum, M. (2012). Phenomenological psychological research as science. *Journal of Phenomenological Psychology, 43,* 36-72.

Arenas, M.L and Greif, G.L. (2000). Short communication: Issues of fatherhood and recovery for VA substance abuse patients. *Journal of Psychoactive Drugs, 32(3),* 339-341.

Armsden, G. G. & Greenberg, M. T. (1983). The Inventory of Parent and Peer Attachment: Individual differences and their relationship to psychological well-being in adolescence. *Journal of Youth and Adolescence, 16(5),* 427-454.

Armstrong, J. (2008). Motivating Affect Self Control (MASC). Retrieved from: http://jlapsych.com.au/index.php/masc.

Australian Bureau of Statistics (ABS). (2008). Prevalence of mental disorders. Retrieved from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007?open

Australian Bureau of Statistics (ABS). (2011). Recorded Crime - Offenders, 2009-10. Retrieved from: http://www.abs.gov.au/ausstats/abs@.nsf/Products/9458935BB998B2EBCA257840000F31C9?opendocument

Australian Bureau of Statistics (ABS). (2015). Causes of Death, Australia, 2012. Catalogue No. 3303.0. Belconnen, ACT: Commonwealth of Australia. Retrieved from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0?OpenDocument

Australian Fatherhood Research Network (AFRN) (2016). SMS4dads. *Fatherhood Research Bulletin, 34,* 4-18.

Australian Institute of Health and Welfare (AIHW). (2011). Drugs in Australia 2010: tobacco, alcohol and other drugs. Drug statistics series no. 27. Cat. no. PHE 154. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW) (2016). Trends in alcohol availability, use and treatment 2003-04 to 2014-15. Drug treatment series no. 28. Cat. no. HSE 179. Canberra: AIHW.

Australian Research Alliance for Children and Youth (ARACY). (2015). Australian fatherhood research network: programs. Retrieved October 2015 from www.aracy.org.au/networks/australian-fatherhood-research-network

Australian Youth Mentoring Network (2017). Retrieved from www. http://aymn.org.au

Azizi, A., Borjali, A. & Golzari, M. (2010). The effectiveness of emotion regulation training and cognitive therapy on the emotional and addictional problems of substance abusers. *Iranian Journal of Psychiatry, 5(2),* 60-65.

Baker, J.K., Fenning, R.M & Crnic, K.A. (2011). Emotion socialization by mothers and fathers: Coherence among behaviors and associations with parent attitudes and children's social competence. *Social Development, 20(2),* 412-430.

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York: Freeman.

Barker, C. (2007). *The hearts of men.* Sydney: UNSW Press.

Barker, C. & Galasinski, D. (2003). *Cultural studies and discourse analysis.* London: Sage.

Barker, G. & Pawlak, P. (2011). Men, families, gender equality and care work. In Department of Economic and Social Affairs (DESA), *Men in families and family policy in a changing world* (pp. 9-45). Retrieved from: http://www.un.org/esa/socdev/ family/docs/men-in-families.pdf

Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guildford Press.

Baron-Cohen, S. & Wheelwright, S. (2004). The empathy quotient: An investigation of adults with Asperger syndrome or higher functioning autism, and normal sex differences. *Journal of Autism and Developmental Disorders*, *34,* 163-175.

Barnes, B.R. (2012). Using mixed methods in South African psychological research. *South African Journal of Psychology*, *42(4),* 463-475.

Bartholomew, T.T. & Brown, J.R. (2012). Mixed Methods, Culture, and Psychology: A Review of Mixed Methods in Culture-Specific Psychological Research. *International Perspectives in Psychology: Research, Practice, Consultation*, *1(3),* 177-190.

Baxter, J. (2011). Fathers' involvement in children's personal care activities. In *The Longitudinal Study of Australian Children (LSAC) Statistical Report 2011* (pp. 19-31). Melbourne, Vic: Australian Institute of Family Studies.

Baumrind, D. (1989). Rearing competent children. In W. Damon (Ed.), *Child development today and tomorrow* (pp. 349-378). San Francisco, CA: Jossey-Bass.

Bazeley, P. (2004). Issues in mixing qualitative and quantitative approaches in research. In R. Buber, J. Gadner, & L. Richards (Eds), *Applying qualitative methods to marketing management research* (pp 141-156). London: Palgrave Macmillan.

Bazeley, P. (2011). Integrative analysis strategies for mixed data sources. *American Behavioral Scientist*, *56(6),* 814-828.

Beaumont, S.L. & Pratt, M.M. (2011). Identity processing styles and psychosocial balance during early and middle adulthood: The role of identity in intimacy and generativity. *Journal of Adult Development*, *18*, 172-183.

Bernard van Leer Foundation (2014). Responsive parenting: a strategy to prevent violence. Retrieved from: http://www.bernardvanleer.org/Responsive-parenting-a-strategy-to-prevent-violence

Beyond Blue (2016). Beyondblue: the national depression initiative. Retrieved from http://www.beyondblue.org.au.

Biddulph, S. (2010). *The new manhood: the handbook for a new kind of man.* Sydney, NSW: Finch.

Bjorgo, T. (1998). *Recruitment and disengagement from extreme groups: The case of racist youth subcultures.* Paper presented at the 7th International Seminar on Environmental Criminology and Crime Analysis, 21-24 June, Barcelona.

Bottorff, J.L., Radsma, J., Kelly, M. & Oliffe, J.L. (2009). Fathers' narratives of reducing and quitting smoking. *Sociology of Health & Illness*, *31(2),* 185–200.

Bowlby, J. (1969). *Attachment. Volume 1: Attachment and loss.* London: Hogarth Press.

Bowlby, J. (1973). *Attachment and Loss. Volume 2: Separation: Anxiety and Anger.* New York: Basic Books.

Broekaert, E., Autrique, M., Vanderplasschen, W. & Colpaert, K. (2010). 'The Human Prerogative': A critical analysis of evidence-based and other paradigms of care in substance abuse treatment. *Psychiatric Quarterly, 81*, 227-238.

Brown, G.L., McBride, B.A., Shin, N. & Bost, K.K. (2007). Parenting predictors of father-child attachment security: interactive effects of father involvement and fathering quality. *Fathering, 5(3),* 197-219.

Bryan, D.M. (2013). To parent or provide? The effect of the provider role on low-income men's decisions about fatherhood and paternal engagement. *Fathering, 11(1),* 71-89.

Buckholdt, K.E., Parra, G.R., Anestis, M.D., Lavender, J.M., Jobe-Shields, L.E., Tull, M.T. & Gratz, K.L. (2015). Emotion regulation difficulties and maladaptive behaviors: Examination of deliberate self-harm, disordered eating, and substance misuse in two samples. *Cognitive Therapy Research, 39,* 140-152.

Bullying No Way (2016). Retrieved from www.bullyingnoway.gov.au.

Buruck, G., Wendsche, J., Melzer, M., Strobel, A. & Dörfel, D. (2014). Acute psychosocial stress and emotion regulation skills modulate empathic reactions to pain in others. Frontiers in Psychology, 5, 517. Doi: 10.3389/fpsyq2014.00517.

Buss, D. M. (2003). *The evolution of desire: Strategies of human mating* (Revised edition). New York: Basic Books.

Byrne, B.M. (2001). *Structural equation modelling with AMOS: basic concepts, applications and programming.* Mahwah, NJ: Lawrence Erlbaum Associations Inc.

Camic, P. M., Rhodes, J. E. & Yardley, L. (2003). Naming the stars: Integrating qualitative methods into psychological research. In Camic, Rhodes & Yardley (Eds.) *Qualitative research in psychology: expanding perspectives in methodology and design* (pp. 3-15). Washington, DC: American Psychological Association.

Carlson, M.J. and McLanahan, S.S. (2010). Fathers in fragile families. In M. Lamb (Ed.), *The role of the father in child development* (5th ed., pp 241-269). Hoboken, NJ: Wiley.

Castro, F.G., Kellison, J.G., Boyd, S.J. & Kopak, A. (2010). A methodology for conducting integrative mixed methods research and data analyses. *Journal of Mixed Methods Research, 4(4),* 432-360.

Chassin, L., Flora, D.B. & King, K.M. (2004). Trajectories of alcohol and drug use and dependence from adolescence to adulthood: The effects of familial alcoholism and personality. *Journal of Abnormal Psychology, 113,* 483-498.

Cherlin, A.J. (2010). *The marriage-go-round: The state of marriage and the family in America today.* New York: Knopf Doubleday Publishing group.

Christov-Moore, L., Simpson, L.A., Coude, G., Grigaityte, K., Miacoboni, M. & Ferrari. P.F. (2014). Empathy: Gender effects in brain and behaviour. *Neuroscience and Biobehavioral Reviews, 46,* 604–627.

Clandinin, D.J. & Connelly, F.M. (2000). Narrative inquiry: Experience and story in qualitative research. San Francisco, CA: Jossey-Bass.

Collins, C.C., Grella, C.E. & Hser, Y. (2003). Effects of gender and level of parental involvement among parents in drug treatment. *American Journal of Drug and Alcohol Abuse, 29(2),* 237-261.

Condon, J. (2015). *Paternal Postnatal Attachment Scale* [Measurement instrument]. Retrieved from http://hdl.handle.net/2328/35293.

Condon, J.T. & Corkindale, C.J. (1998). Assessment of parent-to-infant attachment: development of a self-report questionnaire instrument. *Journal of Reproductive and Infant Psychology, 16(1),* 57-76.

Condon, J.T., Corkindale, C.J. & Boyce, P. (2008). A longitudinal study of father-to-infant attachment: antecedents and correlates. *Journal of Reproductive and Infant Psychology, 26(3),* 195-210.

Condon, J.T., Corkindale, C.J, Boyce, P. & Gamble, E. (2013). Assessment of postnatal paternal-infant attachment: development of a questionnaire instrument. *Journal of Reproductive and Infant Psychology, 31(1),* 15-30.

Connell, R. W. (1987). *Gender and power: society, the person and sexual politics.* Cambridge: Polity Press.

Connell, R. W. (1995). *Masculinities.* Sydney: Allen & Unwin.

Connell, R. W. (2005). *Masculinities,* 2nd ed. Sydney: Allen & Unwin.

Coolican, H. (2014). Research methods and statistics in psychology (6th ed.). East Sussex: Psychology Press.

Cooper, M.L., Frone, M.R., Russell, M. & Mudar, P. (1995). Drinking to regulate positive and negative emotions: a motivational model of alcohol use. *Journal of Personality and Social Psychology, 6(5),* 990-1005.

Cozolino, L. (2006). *The neuroscience of human relationships: Attachment and the developing social brain.* New York: Norton & Company.

Creswell, J.W. (2014). Research design: Qualitative, quantitative, and mixed methods approaches (4th ed.). Los Angeles: Sage.

Currie, S.R., Patten, S.B., Williams, J.V.A., Wang, J., Beck, C.A., El-Guebaly, N. & Maxwell, C. (2005). Comorbidity of major depression with substance use disorders. *Canadian Journal of Psychiatry, 50(10),*660-666.

Daitch, C. (2007). Affect regulation toolbox: practical and effective interventions for the over-reactive client. New York: W.W. Norton.

Davidson, R.J., Putnam, K.M. & Larson, C.L. (2000). Dysfunction in the neural circuitry of emotion regulation – A possible prelude to violence. *Science, 289,* 591-594.

Dawe, S., Harnett, P.H., Rendalls, V. & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: the Parents Under Pressure programme. *Drug & Alcohol Review, 22,* 299-307.

de Botton, A. (2004). *Status anxiety*. New York: Vintage Books.

De Luccie, M.F. (1995). Mothers as gatekeepers: A model of maternal mediators of father involvement. *The Journal of Genetic Psychology; 156(1),* 115-131.

Deasy, C., Coughlan, B., Pironom, J., Jourdan, D. & Mannix-McNamara, P. (2014). Psychological distress and coping amongst higher education students: A mixed method enquiry. PLoS ONE 9(12): e115193. doi:10.1371/journal.pone.0115193.

Decety, J. (2010). The neurodevelopment of empathy in humans. *Developmental Neuroscience, 32(4),* 257-267.

Degenhardt, L., Larney, S., Chan, G., Dobbins, T., Weier, M., Roxburgh, A., Hall, W.D. & McKetin, R. (2016). Estimating the number of regular and dependent methamphetamine users in Australia, 2002–2014. *Medical Journal of Australia, 204(4),* 153.

Denzin, N.K. (2001). *Interpretive interactionism (2nd ed).* Thousand Oaks, CA: Sage Publications.

Depue, R.A. & Morrone-Strupinsky, J.V. (2005). A neurobehavioral model of affiliative bonding: Implications for conceptualizing a human trait of affiliation. *Behavioral and Brain Sciences, 28,* 313-395.

Devault, A., Milcent, M., Ouellet, F., Laurin, I., Jauron, M. & Lacharite, C. (2008). Life stories of young fathers in contexts of vulnerability. *Fathering, 6(3),* 226-248.

Dick, G.L. (2011). The changing role of fatherhood: The father as a provider of self-object functions. *Psychoanalytic Social Work, 18,* 107–125.

DiClemente, C.C. (2007). Mechanisms, determinants and processes of change in the modification of drinking behavior. *Alcoholism, Clinical and Experimental Research, 31*(10 Supplement), 13-20.

Dietz, L. (2003). *DBT Self-help.* Retrieved from www.dbtselfhelp.com.

Douglas, P. (1993). *Men = Violence. A pro-feminist perspective on dismantling the masculine equation.* Paper presented at Second National Conference on Violence convened by the Australian Institute of Criminology.

Drug and Alcohol Services South Australia (DASSA) (2008). Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician. Retrieved from http://www.ag.gov.au/cca. ISBN 1-74186-773-8.

Dube, S.R., Anda, R.F., Felitti, V.J., Edwards, V.J. & Croft, J.B. (2002). Adverse childhood experiences and personal alcohol abuse as an adult. *Addictive Behaviors, 27,* 713-725.

Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H. & Anda, R.F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics, 111,* 564-572.

Dubois-Comtois, K., Moss, E., Cyr, C. & Pascuzzo, K. (2013). Behavior problems in middle childhood: the predictive role of maternal distress, child attachment, and mother-child interactions. *Journal of Abnormal Psychology, 41,* 1311-1324.

Dunlop, W.L and Tracy, J.L. (2013). Sobering stories: Narratives of self-redemption predict behavioral change and improved health among recovering alcoholics. *Journal of Personality and Social Psychology, 104(3),* 576-590.

Dunn, O.J. (1961). Multiple comparisons among means. *Journal of the American Statistical Association, 56(293*), 52-64.

Eiden, R., Edwards, E. & Leonard, K. (2002). Mother-infant and father-infant attachment among alcoholic families. *Development and Psychopathology, 14(2),* 253-278.

Eisenberg, N. & Strayer, J. (Eds.) (1990). Empathy and its development. New York: Cambridge University Press.

El-Sheikh, M. & Buckhalt, J.A. (2003). Parental problem drinking and children's adjustment: Attachment and family functioning as moderators and mediators of risk. *Journal of Abnormal Child Psychology, 29,* 417-432.

Eldredge, J. (2001). *Wild at heart: Discovering the secret of a man's soul*. Nashville, Tenn: Thomas Nelson.

Enderstein, A.M. & Boonzaier, F. (2013). Narratives of young South African fathers: redefining masculinity through fatherhood. *Journal of Gender Studies*. DOI:10.1080/09589236.2013.856751.

Erikson, E.H. (1950). Eight ages of man. In *Childhood and society* (pp. 247-274). New York: W.W. Norton.

Esin, C. (2011). Narrative analysis approaches. In N. Frost (Ed.), *Qualitative research methods in psychology* (pp. 92-117). Berkshire: McGraw-Hill Education.

Everett, K. D., Bullock, L., Longo, D. R., Gage, J. & Madsen, R. (2007). Men's Tobacco and Alcohol Use During and After Pregnancy. *American Journal of Men's Health, 1(4),* 317-325.

Fabrigar, L.R., MacCallum, R.C., Wegener, D.T. & Strahan, E.J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods, 4(3),* 272-299.

Failde, I. & Ramos R. (2000). Comparison between the GHQ-28 and SF-36 (MH 1–5) for the assessment of the mental health in patients with ischaemic heart disease. *European Journal of Epidemiology, 16(4),* 311-316.

Fals-Stewart, W., Kelley, M.L., Fincham, F.D., Golden, J.C. & Logsdan, T. (2004). The emotional and behavioural problems of children living with drug-abusing fathers: Comparisons of children living with alcohol-abusing and non-substance-abusing fathers. *Journal of Family Psychology*, *18,* 319-330.

Feeney, G.F.X., Connor, J.P., Young, R.M., Tucker, J. & McPherson, A. (2004). Alcohol dependence: the impact of cognitive behaviour therapy with or without naltrexone on subjective health status. *Australian and New Zealand Journal of Psychiatry, 38(10),* 842-848.

Ferrari, V., Smeraldi, E., Bottero, G. & Politi, E. (2014). Addiction and empathy: a preliminary analysis. *Neurological Science*, *35,* 855–859. DOI 10.1007/s10072-013-1611-6

Fletcher, R. (2008). *The assessment and support of new fathers: Father-infant attachment as a basis for psychosocial assessment and support.* Saarbrucken: VDM Publishing.

Fletcher, R. (2011). *The dad factor*. Sydney: Finch Publishing.

Fletcher, R., Matthey, S. & Marley, C.G. (2006). Addressing depression and anxiety among new fathers. *Medical Journal of Australia*, *185(8),* 461-463.

Fletcher, R., May, C., St George, J., Stoker, L. & Oshan, M. (2014). Engaging fathers: Evidence review.
Canberra: Australian Research Alliance for Children and Youth (ARACY).

Flood, M. (2012). Separated fathers and the 'fathers' rights' movement. *Journal of Family Studies, 18(2-3),* 235–245.

Flood, M. & Pease, R. (2006). The factors influencing community attitudes in relation to violence against women: A critical review of the literature. Retrieved from: http://www.vichealth.vic.gov.au/~/media/ProgramsandProjects/DiscriminationandViolence/ViolenceAgainstWomen/CAS_Paper3_CriticalLiterature.ashx

Flores, P. J. (2001). Addiction as an attachment disorder: Implications for group therapy. *International Journal of Group Psychotherapy***,** *51(1),* 63-81.

Ford, J.D. & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: Trauma adaptive recovery group education and therapy (TARGET). *American Journal of Psychotherapy, 60(4),* 335-355.

Ford, J. J., Nalbone, D.P., Wetchler, J.L. & Sutton, P.M. (2008). Fatherhood: How differentiation and identity status affect attachment to children. *The American Journal of Family Therapy*, *36,* 284-299.

Forste, R., Bartkowski, J. & Jackson, R. (2009). "Just be there for them": Perceptions of fathering among single, low-income men. *Fathering, 7(1),* 49-69.

Foulds, J.A., Adamson, S.J., Boden, J.M. Williman, J.A. & Mulder, R.T. (2015). Depression in patients with alcohol use disorders: Systematic review and meta-analysis of outcomes for independent and substance-induced disorders. *Journal of Affective Disorders*, *185,* 47-59.

Fox, H.C., Axelrod, S.R., Paliwal, P., Sleeper, J. & Sinha, R. (2007). Difficulties in emotion regulation and impulse control during cocaine abstinence. *Drug and Alcohol Dependence, 89,* 298–301.

Fox, H.C., Hong, K.A. & Sinha, R. (2008). Difficulties in emotion regulation and impulse control in recently abstinent alcoholics compared with social drinkers. *Addictive Behaviors, 33(2),* 388-394.

Frank, A.W. (2013), 2nd ed. *The wounded storyteller – Body, illness and ethics.* Chicago: University of Chicago Press.

Frey, R. (2003). Fathers: Important, unique or uniquely important? In R. Sullivan (Ed.), *Focus on fathering* (pp. 55-71). Camberwell, Vic: ACER Press.

Furman, W. & Buhrmester, D. (2001). The parent-child relationship questionnaire. In J. Touliatsos, B.F. Perlmutter & M.A. Straus (Eds.) *Handbook of family measurement techniques* (pp. 285-289). California: Sage Publications.

Furrow, J.L. (1998). The ideal father: Religious narratives and the role of fatherhood. *Journal of Men's Studies, 7(1),* 1-17.

Furstenberg, F.F. (2011). Comment: How do low-income men and fathers matter for children and family life? *Annals of the American Academy of Political and Social Science, 635,* 131-137.

Gallant, W.A., Gorey, K.M., Gallant, M.D., Perry, J.L. & Ryan, P.K. (1998). The association of personality characteristics with parenting problems among alcoholic couples. *The American Journal of Drug and Alcohol Abuse, 24(1),* 119-129.

Gardener, E.K.T., Carr, A.T., MacGregor, A. & Felmingham, K.L. (2013). Sex Differences and Emotion Regulation: An Event-Related Potential Study. PLoS ONE 8(10): e73475. doi:10.1371/journal.pone.0073475.

Geary, D.C. (2000). Evolution and proximate expression of human paternal investment. *Psychological Bulletin, 126(1),* 55-77.

Geary, D. C. (2005). Evolution of paternal investment. In D.M. Buss (Ed.), *The Handbook of Evolutionary Psychology* (pp. 484-510). Hoboken, NJ: Wiley.

Gelb, C. M. (2002). The relationship between empathy and attachment in the adolescent population. *ETD Collection of Pace University.*

Gelkopf, M., Shabtai, L. & Bleich, A. (2002). An integration of three approaches to addiction and methadone maintenance treatment: The self-medication hypothesis, the disease model and social criticism. *The Israel Journal of Psychiatry and Related Sciences, 39(2),* 140-151.

Gettler, L.T., McDade, T.W., Agustin, S.S., Feranil, A.B. & Kuzawa, C.W. (2015). Longitudinal perspectives on fathers' residence status, time allocation, and testosterone in the Philippines. *Adaptive Human Behavior and Physiology, 1*(2), 124-149.

Giallo, R., Cooklin, A., Wade, C., D'Esposito, F. & Nicholson, J.M. (2014). Fathers' postnatal mental health and child well-being at age five: The mediating role of parenting behaviour. *Journal of Family Issues, 35(11),* 1543–1562.

Giancola, P. (2003). The moderating effects of dispositional empathy on alcohol-related aggression in men and women. *Journal of Abnormal Psychology, 112(2),* 275-281.

Gilbert, E., Ussher, J.M. & Perz, J. (2014). 'Not that I want to be thought of as a hero': Narrative analysis of performative masculinities and the experience of informal cancer caring. *Psychology & Health, 29(12),* 1442-1457.

Ginger, S. (2003). Female brains vs. male brains. *International Journal of Psychotherapy, 8(2),* 139-145.

Goldberg, D.P. (1978). Manual of the General Health Questionnaire. Windsor: NFER Nelson.

Goldberg, D.P. & Williams, P. (1988). A user's guide to the General Health Questionnaire. Windsor: NFER Nelson.

Golder, S., Gillmore, M., Spieker, S. & Morrison, D. (2005). Substance use, related problem behaviors and adult attachment in a sample of high risk older adolescent women. *Journal of Child & Family Studies, 14(2),* 181-193.

Gottman, J. M., Katz, L. F., & Hooven, C. (1997). *Meta-emotion: How families communicate emotionally*. Mahwah, NJ: Lawrence Erlbaum Assoc.

Gottman, J. M. (1998). Toward a process model of men in marriages and families. In A. Booth & A. C. Crouter (Eds.), *Men in families: When do they get involved? What difference does it make*? (pp. 144-186). Mahwah, NJ: Lawrence Erlbaum Associates.

Gottman, J. M. & de Claire, J. (1998). *Raising an emotionally intelligent child: the heart of parenting*. Sydney: Simon & Shuster.

Grace-Martin, K. (2008). *Can a regression model with a small R-squared be useful?* The analysis factor. Retrieved from http://www.theanalysisfactor.com/small-r-squared/

Grant, J. (2012). *Men and substance abuse: Narratives of addiction and recovery*. Boulder, Col: FirstForumPress.

Gratz, K.L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26(1),* 41-54.

Green, C. (1984). *Toddler taming.* Sydney: Doubleday.

Green, G., Emslie, C., O'Neill, D., Hunt, K. & Walker, S. (2010). Exploring the ambiguities of masculinity in accounts of emotional distress in the military among young ex-servicemen. *Social Science & Medicine, 71(8),* 1480-1488.

Grille, R. (2005). *Parenting for a peaceful world.* Sydney: Longueville Books.

Grossmann, K. Grossmann, K.E., Fremmer-Bombik, E., Kindler, H., Scheuerer-Englisch, H. & Zimmermann, P. (2002). The uniqueness of the child-father attachment relationship: Fathers' sensitive and challenging play as a pivotal variable in a 16-year longitudinal study. *Social Development, 11(3),* 301-337.

Guba, E.G. & Lincoln, Y.S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N.K. Denzin & Y.S. Lincoln (Eds.) *Handbook of qualitative research* (2nd ed.), pp.191-215. Thousand Oaks, Ca: Sage Publications.

Guzzo, K.B. (2011). New fathers' experiences with their own fathers and attitudes toward fathering. *Fathering, 9(3),* 268-290.

Hagerty, B.M., Williams, A. & Oe, H. (2002). Childhood antecedents of adult sense of belonging. *Journal of Clinical Psychology, 58(7),* 793–801.

Hall, W., Teesson, M., Lynskey, M. & Degenhart, L. (1999). The 12-month prevalence of substance use and ICD-10 substance use disorders in Australian adults: Findings from the National Survey of Mental Health and Well-Being. *Addiction, 94(10),* 1541-1550.

Hampton, T. (2006). Researchers tap into the male brain. *Journal of American Medical Association, 296(19),* 2301-2302.

Hanson, W.E., Creswell, J.W., Plano Clark, V.L., Petska, K.S. & Creswell, J.D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology, 52(2),* 224–235.

Hardré, P.L., Crowson, M. & Xie, K. (2012). Examining contexts-of-use for web-based and paper-based questionnaires. *Educational and Psychological Measurement, 72(6),* 1015-1038.

Hari, J. (2015). *Chasing the scream: The first and last days of the war on drugs.* London: Bloomsbury.

Havighurst, S. S., Duncombe, M., Frankling, E., Holland, K., Kehoe, C. & Stargatt, R. (2015). An Emotion-Focused Early Intervention for Children with Emerging Conduct Problems. *Journal of Abnormal Child Psychology, 43(4),* 749-760.

Havighurst, S. & Harley, A. (2009). *Tuning in to Kids Program Manual (2nd ed.).* Melbourne: University of Melbourne.

Havighurst, S., Harley, A. & Prior, M (2004). Building preschool children's emotional competence: A parenting program. *Early Education and Development, 15(4),* 423-447.

Havighurst, S. S., Wilson, K. R., Harley, A. E., Kehoe, C., Efron, D. & Prior, M. R. (2013). "Tuning into Kids": Reducing young children's behavior problems using an emotion coaching parenting program. *Child Psychiatry & Human Development, 44*(2), 247-264.

Havighurst, S., Wilson, K.R., Harley, A. & Prior, M. (2009). Tuning in to kids: An emotion-focused parenting program – initial findings from a community trial. *Journal of Community Psychology, 37(8),* 1008-1023.

Hazan, C. & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52(3),* 511-524.

Heerwegh, D. (2009). Mode differences between face-to-face and web surveys: An experimental investigation of data quality and social desirability effect. *International Journal of Public Opinion Research 21(1), 111-121*. DOI: 10.1093/ijpor/edn054.

Heiman, G.W. (2002). *Research Methods in Psychology* (3rd ed.). New York: Houghton Mifflin Company.

Henderson, C., Evans-Lacko, S., Flach, C. & Thornicroft, G. (2012). Responses to mental health stigma questions: the importance of social desirability and data collection method. *Canadian Journal of Psychiatry*, *57(3),* 152-60.

Henry, C. (2013). *The men's group manual.* Chula Vista, CA: Aventine Press.

Henson, R.K. & Roberts, J.K. (2006). Use of exploratory factor analysis in published research: Common errors and some comment on improved practice. *Educational and Psychological Measurement*, *66(3),* 393-416.

Hibbert, L. & Best, D. (2011). Assessing recovery and functioning in former problem drinkers at different stages of their recovery journeys. *Drug and Alcohol Review*, *30(1),* 12–20.

Hodgins, D.C., Peden, N. & Cassidy, E. (2005). The association between comorbidity and outcome in pathological gambling: a prospective follow-up of recent quitters. *Journal of Gambling Studies*, *21(3),* 255-271.

Hunter, S.V. (2009). Analysing and representing narrative data: The long and winding road. *Current Narratives*, *2*, 44-54. Retrieved from: http://ro.uow.edu.au/currentnarratives/vol1/iss2/5

Hunter, B. & Lubman, D.I. (2010). Substance misuse: Management in the older population. *Australian Family Physician*, *39*(10), 738–41.

IBM SPSS (Statistical Package for the Social Sciences) Inc. (2015). *SPSS 23.0 base user's guide*. Chicago: Author.

IBM SPSS AMOS 23 (2015). *AMOS 23.0 base user's guide*. Chicago: Author.

Jacob, T., Kahn, G.L. & Leonard, K. (1991). Parent-child interactions in families with alcoholic fathers. *Journal of Consulting & Clinical Psychology*, *59*, 176-181.

James, C.G. (2009). Mothers and fathers as parents and workers: family-friendly employment policies in an era of shifting identities. *Journal of Social Welfare & Family Law*, *31(3),* 271–283.

Johnson, L.N., Ketring, S.A. & Abshire, C. (2003). The revised inventory of parent attachment: Measuring attachment in families. *Contemporary Family Therapy*, *25(3),* 333-349.

Johnson, M.M. (1963). Sex role learning in the nuclear family. *Child Development*, *34(2),* 319-333.

Jokela, M., Kivimaki, M., Elovainio, M., & Keltikangas-Jarvinen, L. (2009). Personality and having children: A two-way relationship. *American Psychological Association, 96(1),* 218-230.

Jorm, A.F. (Ed). (1996). *Men and mental health.* Canberra, ACT: National health and medical research council.

Josselson, R. (2011). Narrative research. In Wertz, F.J., Charmaz, K., McMullen, L.M., Josselson, R., Anderson, R. & McSpadden, E. (Eds.), *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry.* New York, NY: Guilford Press.

Kahn, J.H. (2006). Factor analysis in counseling psychology research, training, and practice: Principles, advances, and applications. *The counseling psychologist, 34(5),* 684-718.

Kane, P. & Garber, J. (2004). The relations among depression in fathers, children's psychopathology, and father-child conflict: A meta-analysis. *Clinical Psychology Review, 24(3),* 339-360.

Kano, Y. & Harada, A. (2000). Stepwise variable selection in factor analysis. *Psychometrika, 65(1),* 7-22.

Kelley, M.L. & Fals-Stewart, W. (2007). Treating paternal alcoholism with learning sobriety together: effects on adolescents versus preadolescents. *Journal of Family Psychology, 21(3),* 435-444.

Kezelman, C., & Stavropoulos, P. (2012) *'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.* Kirribilli, Australia: Adults Surviving Child Abuse (ASCA).

Khantzian, E.J. (1985). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *American Journal of Psychiatry, 142(11),* 1259-1264.

Kidsmatter (2008). Kids Matter: Understanding and managing separation distress. Retrieved from: https://www.kidsmatter.edu.au/mental-health-matters/social-and-emotional-learning/positive-separations-understanding

Kidsmatter (2017). Kids Matter: Fathers connecting with their children. Retrieved from: https://www.kidsmatter.edu.au/mental-health-matters/dads-make-difference/fathers-connecting-their-children

King, A. (2005). The 'quiet revolution' amongst men: Developing the practice of working with men in family relationships. *Children Australia, 30(2),* 1-10.

Kirkman, M. (2002). What's the plot? Applying narrative theory to research in psychology. *Australian Psychologist* 37(1), 30-38.

Kleber, H.D., Weiss, R.D., George, T.P. et al (2007). Treatments of patients with substance use disorders, 2nd ed. *The American Journal of Psychiatry, 164(4),* 5-123.

Koestner, R., Franz, C., & Weinberger, J. (1990). The family origins of empathic concern: A 26-year longitudinal study. *Journal of Personality and Social Psychology, 58,* 709–717.

Krampe, M. (2003). The inner father. *Fathering, 1(2),* 131-148.

Kruijshaar, M.E., Barendreqt, J., Vos, T., de Graaf, R., Spijker, J. & Andrews, G. (2005). Lifetime prevalence estimates of major depression: an indirect estimation method and a quantification of recall bias. *European Journal of Epidemiology, 20(1),* 103-111.

Kun, B. & Demetrovics, Z. (2010). Emotional intelligence and addictions: A systematic review. *Substance use and misuse, 45(7-8),* 1131-1160.

Lamb, M.E. (2010). How do fathers influence children's development? Let me count the ways. In M. Lamb (Ed.), *The role of the father in child development* (5th ed., pp 1-26). Hoboken, NJ: John Wiley & Sons, Inc.

Lawler, S. (2002). Narrative in social research. In May, T. (Ed.), *Qualitative Research in Action.* London: Sage Publications.

Lawrence, E.J., Shaw, P., Baker, D. Baron-Cohen, S. & David, A.S. (2004). Measuring empathy: reliability and validity of the empathy quotient. Psychological Medicine, 34, 911-924.

Leahy, R.L., Tirch, D. and Napolitano, L.A. (2011). *Emotion regulation in psychotherapy: A practitioner's guide.* New York: Guilford Press.

Lembke, A. (2012). Time to abandon the self-medication hypothesis in patients with psychiatric disorders. *The American Journal of Drug and Alcohol Abuse, 38(6),* 524-529.

Lev-Ran, S., Roerecke, M., Le Foll, B., George, T.P., McKenzie, K., et al (2014). The association between cannabis use and depression: a systematic review and meta-analysis of longitudinal studies. *Psychological Medicine, 44(4),* 797-810.

Levant, R.F. (1997). The masculinity crisis. *The Journal of Men's Studies, 5(3),* 221-231.

Levant, R.F. (2011). Research in the psychology of men and masculinity using the gender role strain
paradigm as a framework. *The American Psychologist, 66(8),* 765-776.

Lewis-Beck, M.S. (1980). *Applied regression: An introduction.* London: Sage.

Lopez-Fernandez, O. & Molina-Azorin, J.F. (2011). The use of mixed methods research in the field of behavioural sciences. *Quality and Quantity; Dordrecht, 45(6),* 1459-1472.

Ludlow, L. & Klein, K. (2014). Suppressor variables: The difference between 'Is' versus 'Acting as'. *Journal of Statistics Education, 22(2),* 1-28.

Lutz, W. & Knox, S. (Eds). (2014). *Quantitative and qualitative methods in psychotherapy research.* Retrieved from http://www.eblib.com.

Macdonald, J.J. (2011). Building on the strengths of Australian males. *International Journal of Men's Health, 10(1),* pp. 82-96.

McCown, W. (1989). The relationship between impulsivity, empathy and involvement in twelve step self-help substance abuse treatment groups. *British Journal of Addiction*, *84,* 391-393.

McCown, W. (1990). The effect of impulsivity and empathy on abstinence of poly-substance abusers: a prospective study. *British Journal of Addiction*, *85,* 635-637.

McEwen, C. & Flouri, E. (2009). Fathers' parenting, adverse life events, and adolescents' emotional and eating disorder symptoms: the role of emotion regulation. *European Child & Adolescent Psychiatry*, *18(4),* 206-216.

McKay, J.R. & Hiller-Sturmhöfel, S. (2011). Treating alcoholism as a chronic disease: Approaches to long-term continuing care. *Alcohol Research and Health*, *33(4),* 356-370.

McMahon, T.J., Winkel, J.D. & Rounsaville, B.J. (2008). Drug abuse and responsible fathering: A comparative study of men enrolled in methadone maintenance treatment. *Addiction*, *103,* 269-283.

McMahon, T.J. (2013a). *Fathers too!* Building parenting interventions for substance-abusing men. In N. Suchman, M. Pajulo & L. Mayes (Eds.), *Parenting and substance abuse: Developmental approaches to intervention* (pp. 447-463). New York: Oxford University Press.

McMahon, T.J. (2013b). Substance-abusing fathers: A developmental perspective. In N. Suchman, M. Pajulo & L. Mayes (Eds.), *Parenting and substance abuse: Developmental approaches to intervention* (pp. 156-182). New York: Oxford University Press.

McMullen, L. (2011). Discourse Analysis. In F.J. Wertz, K. Charmaz, L.M. McMullen, R. Josselson, R. Anderson & E. McSpadden, (Eds.), *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. New York: Guilford Press.

Madsen, S.A. (2009). Men's mental health: Fatherhood and psychotherapy. *The Journal of Men's Studies*, *17(1),* 15-30.

Mahalik, J.R., Good, G.E. & Englar-Carlson, M. (2003). Masculinity scripts, presenting concerns, and help seeking: Implications for practice and training. *Professional Psychology: Research and Practice*, *34*(2), 123-131.

Mallers, M.H., Charles, S.T., Neupert, S.D. & Almeida, D.M. (2010). Perceptions of childhood relationships with mother and father: Daily emotional and stressor experiences in adulthood. *Developmental Psychology, 46(6),* 1651–1661.

Malmi, P. (2009). *Discrimination against men: appearance and causes in the context of a modern welfare state.* Lapland: Lapland University Press.

Maloney, E., Hutchinson, D., Burns, L. & Mattick, R. (2010). Prevalence and patterns of problematic alcohol use among Australian parents. *Australian and New Zealand Journal of Public Health, 34(5),* 495-501.

Manczak, E.M., De Longis, A. & Chen, E. (2016). Does empathy have a cost? Diverging psychological and physiological effects within families. *Health Psychology, 35(3),* 211-218.

Marlatt, G.A. & Gordon, J.R. (Eds.) (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford Press.

Martella, R.C. (2013). *Understanding and interpreting educational research.* New York: Guilford Press.

Martinotti, G., Di Nicola, M., Tedeschi, D., Cundari, S. & Janiri, L. (2009). Empathy ability is impaired in alcohol-dependent patients. *The American Journal on Addictions*, *18*, 157-161.

Matsunaga, M. (2007). Familywise error in multiple comparisons: Disentangling a knot through a critique of O'Keefe's arguments against alpha adjustment. *Communication Methods and Measures*, *1(4),* 243-265. DOI: 10.1080/19312450701641409.

Maul, A. (2013). Method effects and the meaning of measurement. *Frontiers in Psychology*, *4:* 169. DOI: 10.3389/fpsyg.2013.00169.

Meade, M. J. (1993). *Men and the water of life: Initiation and the tempering of men*. New York: Harper Collins.

Melrose, S. (2010). Paternal postpartum depression: How can nurses begin to help? *Contemporary Nurse*, *34(2),* 199–210.

Mennin, D. S. (2006). Emotion Regulation Therapy: An integrative approach to treatment-resistant anxiety disorders. *Journal of Contemporary Psychotherapy*, *36*, 95-105.

Mensline Australia (2014). Retrieved from: www.mensline.org.au.

Meyer, S. (2017). Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood. *Child & Family Social Work*, 1–8. https://doi.org/10.1111/cfs.12388

Michalska, K. (2009). Developmental changes in the neural circuits underlying the experience of empathy. *Dissertation Abstracts International.* University of Chicago (in press).

Mikulincer, M. & Shaver, P. R. (2008). Adult attachment and affect regulation. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 503-531). New York: Guildford Press.

Milfont, T.L & Fischer, R. (2010). Testing measurement invariance across groups: Applications in cross-cultural research. *International Journal of Psychological Research*, *3(1),* 111-121.

Millon, T., Grossman, S., Millon, C., Meagher, S. & Ramnath, R. (2004). *Personality disorders in modern life* (2nd ed.). Hoboken, NJ: Wiley.

Moller, M. (2007). Exploiting patterns: a critique of hegemonic masculinity. *Journal of Gender Studies*, *16(3),* 263-276.

Muncer, F.J & Ling, J. (2005). Psychometric analysis of the empathy quotient (EQ) scale. *Personality and Individual Differences*, *40(6),* 1111-1119.

Mvududu, N.H. & Sink, C.A. (2013). Factor analysis in counselling research and practice. *Counseling Outcome Research & Evaluation, 4,* 75-98.

Newman, I., Ridenour, C. S., Newman, C., & DeMarco, G. M. P., Jr. (2003). A typology of research purposes and its relationship to mixed methods. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 167–188). Thousand Oaks, CA: Sage.

Newman, L. (2011) *Parenting with Feeling.* Presentation delivered at the Australian Parenting Conference, Friday February 25, 2011, Convention Centre, Darling Harbour, NSW.

Nielsen, L. (2012). *Father-daughter relationships: contemporary research and issues.* New York: Taylor & Francis.

Noble, H. & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-based Nursing, 18(2),* 34.

O'Connor, P. (2015). Looking for 'likely' cause of addiction won't get you far. Retrieved from: www.rehabs.com/pro-talk/looking-for-the-likely-cause-of-addiction-wont-get-you-far.

Odyssey House (2014). Odyssey House residential rehabilitation. Retrieved from http://www.odysseyhouse.com.au/residential-rehabilitation/

Office of the children's e-safety commissioner (2016). e-safety. Retrieved from www.esafety.gov.au.

Oren, C. Z. & Oren, D. C. (2010). *Counseling fathers*. New York: Taylor & Francis Group.

Owen, K. (2003). Post-separation parenting and father's grief. In R. Sullivan (Ed.), *Focus on fathering* (pp. 73-91). Camberwell, Vic: ACER Press.

Padykula, N.L. & Conklin, P. (2010). The self-regulation model of attachment trauma and addiction. *Clinical Social Work Journal, 38(4),* 351-360.

Palaganas, E.C., Sanchez, M.C., Molintas, V.P. & Caricativo, R.D. (2017). Reflexivity in qualitative research: A journey of learning. *The Qualitative Report.* 22(2). *Academic OneFile*, http://link.galegroup.com/apps/doc/A489081430/AONE?u=uwsydney&sid=AONE&xid=dcc7f3d3.

Panfile, T.M. & Laible, D.J. (2012). Attachment Security and Child's Empathy: The Mediating Role of Emotion Regulation. *Merrill-Palmer Quarterly, 58(1),* 1-21.

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett. K. & Leckman, J.F. (2014). Practitioner Review: Engaging fathers – recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry, 55(11),* 1187–1212.

Parents beyond breakup (2017). Dads in distress. Retrieved from: https://parentsbeyondbreakup.com

Pathways Foundation (2017). Program: Pathways to Manhood. Retrieved from www.pathwaysfoundation.org,au

Peck, M.S. (1993). *Further along the road less traveled.* New York: Simon & Schuster.

Peled, E., Gavriel-Fried, B. & Katz, N. (2012). "I've fixed things up": Paternal identity of substance-dependent fathers. *Family Relations*, *61(4),* 893-908.

Peleg-Oren. N., Rahav, G. & Teichman, M. (2008). School-age children of fathers with substance use disorder: are they a high-risk population? *Journal of Alcohol and Drug Education*, *52(2),* 9-30.

Peters, H.E., Peterson, G.W., Steinmetz, S.K. & Day, R.D. (Eds.). (2014). *Fatherhood: Research, interventions and policies*. New York: Routledge.

Phares, V. (1996). *Fathers and developmental psychopathology*. New York: Wiley & Sons.

Plasse, B. R. (1995). Parenting groups for recovering addicts in a day treatment center. *National Association of Social Workers*, *40(1),* 65-74.

Pleck, J.H. (2010). Fatherhood and masculinity. In M. Lamb (Ed.), *The role of the father in child development* (5th ed., pp 27-57). Hoboken: Wiley.

Pollack, W. (1999). *Real boys*. New York: Henry Holt & Co.

Price-Robertson, R. (2015). Fatherhood and mental illness: A review of key issues. Retrieved from: https://www3.aifs.gov.au/cfca/publications/fatherhood-and-mental-illness.

Prochaska, J.O. & Norcross, J.C. (1994). *Systems of psychotherapy: A transtheoretical analysis.* Pacific Grove: Brooks/Cole.

Project Air Strategy for Personality Disorders (PASPD). (2015). *Parenting with personality disorder intervention: A manual by health professionals.* Wollongong: University of Wollongong: Illawarra Health and Medical Research Institute.

Putnam, P.H. (2006). *The song of father-son: Men in search of the blessing*. New York: iUniverse, Inc.

Qu, L. & Weston, R. (2014). Fathers' involvement in the lives of their children: Separated parents' preferences. In *LSAC Annual statistical report 2013* (pp. 151-166). Melbourne: Australian Institute of Family Studies.

Quadagno, D.M., Briscoe, R. & Quadagno, J.S. (1977). Effect of perinatal gonadal hormones on selected nonsexual behavior patterns: a critical assessment of the nonhuman and human literature. *Psychological Bulletin, 84(1),* 62-80.

Reio, T.G. & Shuck, B. (2015). Exploratory factor analysis: Implications for theory, research, and practice. *Advances in Developing Human Resources*, *17(1),* 12-25.

Rholes, W.S., Simpson, J.A., Kohn, J.L., Wilson, C.L., Martin, A.M., Tran, S. & Kashy, D.A. (2011). Attachment Orientations and Depression: A Longitudinal Study of New Parents. *Journal of Personality and Social Psychology, 100(4),* 567–586.

Richaud de Minzi, M.C., Lemos, V.N. & Oros, L.B. (2016). Empathy in children: Theory and assessment. In Watt, D.F. & Panksepp, J. (Eds.) *Psychology and neurobiology of empathy*. New York: Nova Science Publishers Inc.

Roemer, L., Lee, J.K., Salters-Pedneault, K., Erisman, S.M., Orsillo, S.M. & Mennin, D.S. (2009). Mindfulness and emotion regulation difficulties in generalized anxiety disorder: Preliminary evidence for independent and overlapping contribution. *Behavior Therapy, 40,* 142-154.

Rohner, R.P. & Veneziano, R.A., (2001). The Importance of Father Love: History and Contemporary Evidence. *Review of General Psychology, 5(4),* 382-405.

Richardson, M. L. (1995). Men's healing in connection: Toward mutually empathic fathercare. *Dissertation Abstracts International: The Sciences and Engineering, 55(11),* 5052.

Riessman, C.K. (2008). *Narrative methods for the human sciences.* Thousand Oaks, CA: Sage Publications.

Roberts, K.T. & Fitzgerald, L. (1991). Serenity: Caring with perspective. *Scholarly Inquiry for Nursing Practice, 5(2),* 127-142.

Roberts, W., Strayer, J. & Denham, S. (2014). Empathy, anger, guilt: Emotions and prosocial behaviour. *Canadian Journal of Behavioural Science, 46(4),* 465–474.

Rogers, C. (1967). *On becoming a person: a therapist's view of psychotherapy*. London: Constable.

Romanczuk-Seiferth, N., van den Brink, W. & Goudriaan, A.E. (2014). From symptoms to neurobiology: Pathological gambling in the light of the new classification in DSM-5. *Neuropsychobiology, 70,* 95-102. DOI: 10.1159/000362839.

Rowe, C.L. (2012). Family therapy for drug abuse: Review and updates 2003-2010. *Journal of Marital and Family Therapy, 38(1),* 59-81.

Roy, A.K. & Miller, M.M. (2012). The Medicalization of Addiction Treatment Professionals. *Journal of Psychoactive Drugs, 44(2),* 107–118.

Rueckert, L. & Naybar, N. (2008). Gender differences in empathy: The role of the right hemisphere. *Brain and Cognition, 67(2),* 162-167.

Sanders, M.R. (1999) Triple P – Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behaviour and emotional problems in children. *Clinical Child and Family Psychology Review, 2(2),* 72-90.

Sattmann-Frese, W.J. & Hill, S.B. (2007). *Psychology of ecological crises and eco-self transformation.* Morrisville, NC: Lulu.

Schieman, S. & Turner, H.A. (2001). "When feeling other people's pain hurts": The influence of psychosocial resources on the association between self-reported empathy and depressive symptoms. *Social Psychology Quarterly, 64(4),* 376-389.

Schindler, A., Thomasius, R., Sack, P.M., Gemeinhardt, B., Kustner, U. & Eckert, J. (2005). Attachment and substance use disorders: A review of the literature and a study in drug dependent adolescents. Attachment & Human Development, 7, 207-228.

Schore, A. (2003). *Affect regulation and the repair of the self*. New York: Norton.

Scollo, M.M. & Winstanley, M.H. (2015). Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria. Retrieved from www.TobaccoInAustralia.org.au.

Scott, K.L. & Lishak, V. (2012). Intervention for maltreating fathers: Statistically and clinically significant change. *Child Abuse and Neglect, 36(9),* 680-684.

Seligman, L. & Reichenberg, L.W. (2007). *Selecting effective treatments.* San Francisco: John Wiley.

Shapiro, E. (2012). Social construction of gender. In Banks, J.A. (Ed.), *Encyclopedia of diversity in education* (pp. 1979-1983). Los Angeles: Sage.

Shaver, P.R. & Mikulincer, M. (2014). Adult attachment and emotion regulation. In J.J. Gross (Ed.), *Handbook of emotion regulation* (2nd ed, pp. 237-250). New York: The Guilford Press.

Shipley, B. (2002). Start and stop rules for exploratory path analysis. *Structural Equation Modeling, 9(4),* 554-561.

Sibley, C.G., Fischer, R. & Liu, J.H. (2005). Reliability and validity of the Revised Experiences in Close Relationships (ECR-R) self-report measure of adult romantic attachment. *Personality and Social Psychology Bulletin, 31(11),* 1524-1536.

Siegel, D.J. & Hartzell, M. (2004). *Parenting from the inside out.* New York: Tarcher/Penguin.

Singer, T., Seymour, B., O'Doherty, J. P., Kaube, H., Dolan, R.J. & Frith, C.D. (2004). Empathy for pain involves the affective but not sensory components of pain. *Science, 303(5661),* 1157-1162.

Singer, T., Snozzi, R., Bird, G., Petrovic, P., Silani, G., Heinrichs, M. & Dolan, R.J. (2008). Effects of oxytocin and prosocial behavior on brain responses to direct and vicariously experienced pain. *Emotion, 8(6),* 781-791.

Smart, D. (2007). Tailoring parenting to fit the child. *AFRC Briefing, 4,* 1-9.

Soderstrom, K. & Skarderud, F. (2013). The good, the bad, and the invisible father: a phenomenological study of fatherhood in men with substance use disorder. *Fathering, 11(1),* 31-51.

Solomon, R.L. (1980). The opponent-process theory of acquired motivation: The costs of pleasure and the benefits of pain. *American Psychologist, 35(8),* 691-712.

Soper, D.S. (2015). A-priori sample size calculator for multiple regression [Software Online]. Retrieved from http://www.danielsoper.com/statcalc.

South Pacific Private (2014). South Pacific Private day programs. Retrieved from http://www.southpacificprivate.com.au/day-and-evening-programs.

Sroufe, L.A. (1997). *Emotional development: The organization of emotional life in the early years.* Cambridge: Cambridge University Press.

Stake, R.E. (2006). *Multiple case study analysis.* New York: Guilford Press.

Suchman, N., Mayes, L., Conti, J., Slade, A. & Rounsaville, B. (2004). Rethinking parenting interventions for drug-dependent mothers: From behavior management to fostering emotional bonds. *Journal of Substance Abuse Treatment, 27,* 179-185.

Stavropoulos, P. (2007). *Living under liberalism: The politics of depression.* Boca Raton: Universal Publishers.

Stephens, C. (2011). Narrative analysis in health psychology research: personal, dialogical and social stories of health. *Health Psychology Review, 5(1),* 62-78.

Stevens, A. (1999). *On Jung*. Princeton: Princeton University Press.

Streiner, D.L. (2005). Finding our way: An introduction to path analysis. *Canadian Journal of Psychiatry, 50(2),* 115-122.

Strobbe, S. & Kurtz, E. (2012). Narratives for Recovery: Personal Stories in the 'Big Book' of Alcoholics Anonymous. *Journal of Groups in Addiction & Recovery, 7(1),* 29-52, DOI: 10.1080/1556035X.2012.632320.

Sudraba, V., Rancans, E. & Millere, I. (2012). The emotional intelligence features of substance use disorders patients: Pilot research results. *International Journal of Collaborative Research on Internal Medicine & Public Health, 4(5),* 485-501.

Sullivan, R. (2003). Relationships between men and their children. In Sullivan, R. (Ed) *Focus on fathering.* Camberwell, Vic: ACER press.

Tacey, D. (1995). *Edge of the sacred: Transformation in Australia.* Sydney, NSW: Harper Collins.

Tarter, R.E., Schultz, K., Kirisci, L. & Dunn, M. (2001). Does living with a substance-abusing father increase substance abuse risk in male offspring? Impact on individual, family, school, and peer vulnerability factors. *Journal of Child and Adolescent Substance Abuse, 10,* 59-70.

Tavakol, M. & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2,* 53-55.

Taylor, C.J. (2014). Physiological stress response to loss of social influence and threats to masculinity. *Social Science & Medicine, 103,* 51-59.

Terry, D.J. & Hogg, M.A. (Eds.) (2000). *Attitudes, behaviour, and social context: the role of norms and group membership*. Mahwah, NJ: Lawrence Erlbaum Associates.

The Foundation for Young Australians (2017). Safe schools coalition Australia. Retrieved from http://www.safeschoolscoalition.org.au.

The Salvation Army (2017). Bridge program. Retrieved from https://salvos.org.au/need-help/addiction-services/about-the-bridge-program/

Thomas, A., Saugeres, L. & Moore, S. (2014). *The importance of where you come from: Exploring the impact of early life experiences on later gambling behaviour*. Paper presented at the 13th Australian Institute of Family Studies Conference, Melbourne, Vic.

Thompson, R.A. (2008). Early attachment and later development. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 348-365). New York: Guildford Press.

Thompson, R.A. (2014). Socialization of emotion and emotion regulation in the family. In J.J. Gross (Ed.), *Handbook of emotion regulation* (2nd ed, pp. 173-186). New York: The Guilford Press.

Thorberg, F. & Lyvers, M. (2010). Attachment in relation to affect regulation and interpersonal functioning among substance abuse disorder inpatients. *Addiction Research and Theory, 18(4),* 464-478.

Tong, L., Shinohara, R., Sugisawa, Y., Tanaka, Y., Yamakawa, N. & Anme, T. (2012). Early development of empathy in toddlers: Effects of daily parent-child interaction and home-rearing environment. *Journal of Applied Social Psychology, 42(10),* 2457-2478.

Toomela, A. (2011). Travel into a fairy land: a critique of modern qualitative and mixed methods psychologies. *Integrative psychological and behavioural science, 45(1),* 21-47.

Torres, M., Sng, R. & Deane, F.P. (2015). Establishing a parenting program for fathers in substance abuse treatment. *Australian and New Zealand Journal of Family Therapy, 36,* 273–288.

Tronnier, C.D. (2015). Harnessing attachment in addiction treatment: Regulation theory and the self-medication hypothesis. *Journal of Social Work Practice in the Addictions, 15(3),* 233-251.

Trumpeter, N., Watson, P., O'Leary B. & Weathington, B. (2008). Self-functioning and perceived parenting: relations of parental empathy and love inconsistency with narcissism, depression, and self-esteem. *Journal of Genetic Psychology, 169(1),* 51-71.

Tucker, D.M., Luu, P. & Derryberry, D. (2005). Love hurts: The evolution of empathic concern through the encephalization of nociceptive capacity. *Development and Psychopathology, 17,* 699-713.

Uniting Care ReGen (2015). Inspiring alcohol and other drugs treatment and education. Retrieved from www.regen.org.au.

van Dijk, S. (2012). *Calming the emotional storm: Using dialectical behaviour therapy skills to manage your emotions and balance your life.* Oakland, CA: New Harbinger Publications.

van Ijzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological Bulletin, 117(3),* 387-403.

Vigil, J.M. (2009). A socio-relational framework of sex differences in the expression of emotion. *Behavioral and Brain Sciences, 32,* 375-428.

Vilas Sanz, S.P., Ludlow, A. & Renier, R. (2016). Empathy dysfunction: Deconstructing social functioning in autism spectrum disorder and conduct disorder. In D.F Watt,. & J. Panksepp, (Eds.). *Psychology and neurobiology of empathy*. New York: Nova Science Publishers Inc.

Walker, J. (2007). Unresolved loss and trauma in parents and the implications in terms of child protection. *Journal of Social Work Practice, 21(1),* 77-87.

Waller, M. R. & Swisher, R. (2006). Fathers' risk factors in fragile families: Implications for "healthy" relationships and father involvement. *Social Problems, 53(3),* 392-420.

Watkins, L.E., O'Farrell, T.J., Suvak, M.K., Murphy, C.M. and Taft, C.T. (2009). Parenting satisfaction among fathers with alcoholism. *Addictive Behaviors, 34(6-7),* 610-612.

Watt, D.F. & Panksepp, J. (Eds) (2016). *Psychology and neurobiology of empathy*. New York: Nova Science Publishers Inc.

Wedekind, D., Bamdelow, B., Heitmann, S., Havemann-Reinecke, U., Engel, K.R. & Huether, G. (2013). Attachment style, anxiety coping, and personality styles in withdrawn alcohol-addicted inpatients. *Substance Abuse Treatment, Prevention and Policy, 8(1),* 1-7.

Weinfield, N. S., Sroufe, L. A., Egeland, B. & Carlson, E. (2008). Individual differences in infant–caregiver attachment: Conceptual and empirical aspects of security. In J. Cassidy, & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 78–101). New York: Guilford Press.

Werneke, U., Goldberg, D.P., Yalcin, I. & Ustun, B.T. (2000). The stability of the factor structure of the General Health Questionnaire. *Psychological Medicine, 30(4),* 823-829.

Weston, R. & Qu, L. (2014). Trends in family transitions, form and functioning: Essential issues for policy development and legislation. In A. Hayes & D. Higgins (Eds.), *Families, policy and the law: Selected essays on contemporary issues for Australia.* Melbourne, Vic: Australian Institute of Family Studies.

Williams, I.L. (2014). Desilencing fatherhood: Making the invisible visible within substance use disorder treatment. *Journal of Groups in Addiction & Recovery, 9,* 160-185.

Williams, B., Brown, T., & Onsman, A. (2012). Exploratory factor analysis: A five-step guide for novices. *Australasian Journal of Paramedicine, 8*(3). Retrieved from http://ro.ecu.edu.au/jephc/vol8/iss3/1.

Wilson, K.R., Havighurst, S.S. & Harley, A.E. (2014). Dads tuning in to kids: Piloting a new parenting program targeting fathers' emotion coaching skills. *Journal of Community Psychology, 42(2),* 162-168.

Winnicott, D. W. (1986). Essential papers in object relations. In P. Buckley (Ed.) *Essential papers in Psychoanalysis* (pp. 233-253). New York: New York University Press.

Yalom, I.D & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Yin, R. K. (2013). Validity and generalization in future case study evaluations. *Evaluation, 19(3)* 321–332.

Young, M., Markham, F. & Doran, B. (2012). Placing bets: Gambling venues and the distribution of harm. *Australian Geographer, 43(4),* 425-444.

Zainodin, H.J. & Yap, S.J. (2013). Overcoming multicollinearity in multiple regression using correlation coefficient. *AIP Conference Proceedings, 1557,* 416-419.

Zanoni, L., Warburton, W., Bussey, K. and McMaugh, A. (2013). Fathers as 'core business' in child welfare practice and research: An interdisciplinary review. *Children and Youth Services Review, 35,* 1055-1070.

Zanoni, L., Warburton, W., Bussey, K. and McMaugh, A. (2014). Are all fathers in child protection families uncommitted, uninvolved and unable to change? *Children and Youth Services Review, 41,* 83-94.

APPENDICES

Appendix A: Interview Questions

Semi-structured interviews were conducted to help the researcher establish the men's perceptions of their parenting capacity, their general emotional state and their coping skills. The interviews included the following questions.

QI (1) [pre-program] questions for all participating fathers:

- So you've got [number of] children. What's it like when you spend time with your children?
- How often do you spend time with your children?
- What do you think about the amount of time you spend with your children?
- What's your relationship with your kids like?
- What's it like for you to be a father?
- How was the change for you from before you were a father to now being a father?
- What do you enjoy most about being a father?
- What do you find most challenging or stressful?
- How do you handle the stress?
- I would like to know about your experiences with your own father: did you know your father?
  [If yes]: What was your father like? [If no]: Do you know what your father was like?
- How would you describe your relationship with your father?
- How are the things you do as a father similar to the things your father did? How are they different? How do you feel about this?
- If I was able to ask your children "what's your dad like?" what do you think they would say?
- If you could change something about the way you father your children what would you change? Why? Is there anything else you would like to change?
- What personal strengths do you/can you bring to your role as a father?
- Is there anything else you would like to say or know about being a father?

QI (2) [follow-up] questions for the fathers who completed the parenting program:

- How have you found parenting since the program finished?
- Have you noticed any difference in how you see your capacity as a father?
- Has your relationship with your children changed at all in the last six months?
- What about your relationship with your partner?
- How have your attempts to change certain aspects of your life gone?

QI (2) [follow-up] questions for the partners (or others nominated by program participants):

- Have there been any changes in your relationship with your husband/partner (/family member/friend) in the last six months?
- How would you describe his relationship with his children now?
- Have you noticed anything else of note in his behaviour (for example, change in coping mechanisms, emotional stability, substance use increase or decrease)?

Appendix B: Full Questionnaire

FATHERS AND THEIR RELATIONSHIPS WITH THEIR CHILDREN

The main aim of this questionnaire is to explore your experiences of parenting. It has 5 brief sections. On this page you are asked some basic information about yourself. The other four sections ask about your relationship with one of your children, your feelings, your health, and your interests. In the next sections there are no right or wrong answers. Please circle the letter or number corresponding to your chosen response (only a small number of questions require a written response).

1. Your age group:
   - A 18-24
   - B 25-34
   - C 35-44
   - D 45-54
   - E 55-64
   - F 65 or over

2. Number of children:_____

3. Ages of your children:_____

4. Marital status:
   - A Single
   - B Married
   - C Cohabiting
   - D Separated
   - E Divorced
   - F Widowed

5. Education level:
   - A School Certificate / Some schooling
   - B HSC (year 12)
   - C Trade or Diploma
   - D University (Bachelor or Grad Dip)
   - E University (Masters or PhD)
   - F Other (please specify):_____

6. Occupation level:
   - A Skilled labour
   - B Semiskilled/Unskilled labour
   - C Junior management
   - D Professional (manager)
   - E Professional (other)
   - F Unemployed (currently seeking work)
   - G Unemployed (not currently seeking work)
   - H Retired/volunteering/home duties
   - I Other (please specify):_____

[The following two questions were written for the online survey only]:

- Have you had any difficulties managing or controlling your use of alcohol or drugs recently?
- Have you had found it difficult to stop yourself from gambling or from other behaviours?

The following items are about your experience as a father. You are asked to read each item and indicate how much you agree or disagree with what it says.

You will need to think about one of your children * (see question in bold type below) aged between two and twelve years (2-12). If your children are all older than 12, please choose your youngest child. If your children are all younger than 2, please choose your oldest child. Please read each item and circle the answer that shows how much you agree or disagree with the statement.

How old is the child you have chosen for these questions?_____

1. I get frustrated with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

2. I am constantly yelling and fighting with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

3. My child trusts my judgement.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

4. I trust my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

5. My child respects my feelings.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

6. I feel angry with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

7. I get upset easily around my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

8. My child understands me.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

9. My child cares about my point of view.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

10. I don't like being around my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

11. When I am angry my child often understands.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

12. I don't get much attention or credit from my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

13. I feel my child is good.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

14. My child accepts me as I am.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

15. I often get the feeling that my child is deliberately being difficult or is trying to upset me.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

16. I often feel annoyed or irritable when I am with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

17. I often feel bored when I am with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

18. I often feel impatient when interacting with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

19. I usually enjoy time spent with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

20. I resent having to be so involved with my child with my busy lifestyle.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

21. I wish I could spend more time with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

22. I often feel resentful that I don't have enough time for myself.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

23. I often feel proud of my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

24. I feel close to my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

25. I often talk about my child's achievements to friends or others outside the family.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

26. I would like to be able to engage in more activities with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

27. I feel a great deal of affection for my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

28. I am in tune with my child's needs.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

29. I am concerned that I do not spend enough quality time with my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

30. I often worry that I will lose my child's admiration.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

31. It hurts me that my child may be closer to other family members than to me.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

32. My child only pays attention to me when I'm angry.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

33. I usually trust my own judgement when it comes to parenting my child.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

34. I am confident that my child sees me as a good father.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

The following items are about the way you feel in general and how you react to different feelings.
For each statement below please circle the answer that best describes how often the statement is true for you.

1. I am clear about my feelings.

Almost Never Sometimes About Half the time Most of the time Almost Always

2. I pay attention to how I feel.

Almost Never Sometimes About Half the time Most of the time Almost Always

3. I experience my emotions as overwhelming and out of control.

Almost Never Sometimes About Half the time Most of the time Almost Always

4. I have no idea how I'm feeling.

Almost Never Sometimes About Half the time Most of the time Almost Always

5. I have difficulty making sense of my feelings.

Almost Never Sometimes About Half the time Most of the time Almost Always

6. I am attentive to my feelings.

Almost Never Sometimes About Half the time Most of the time Almost Always

7. I know exactly how I'm feeling.

Almost Never Sometimes About Half the time Most of the time Almost Always

8. I care about what I'm feeling.

Almost Never Sometimes About Half the time Most of the time Almost Always

9. I am confused about how I feel.

Almost Never Sometimes About Half the time Most of the time Almost Always

10. When I'm upset, I acknowledge my emotions.

Almost Never Sometimes About Half the time Most of the time Almost Always

11. When I'm upset, I become angry with myself for feeling that way.

Almost Never Sometimes About Half the time Most of the time Almost Always

12. When I'm upset, I become embarrassed for feeling that way.

Almost Never Sometimes About Half the time Most of the time Almost Always

13. When I'm upset, I have difficulty getting work done.

Almost Never Sometimes About Half the time Most of the time Almost Always

14. When I'm upset, I become out of control.

Almost Never Sometimes About Half the time Most of the time Almost Always

15. When I'm upset, I believe that I will remain that way for a long time.

Almost Never Sometimes About Half the time Most of the time Almost Always

16. When I'm upset, I believe that I will end up feeling very depressed.

Almost Never Sometimes About Half the time Most of the time Almost Always

17. When I'm upset, I believe that my feelings are valid and important.

Almost Never Sometimes About Half the time Most of the time Almost Always

18. When I'm upset, I have difficulty focusing on other things.

Almost Never Sometimes About Half the time Most of the time Almost Always

19. When I'm upset, I feel out of control.

Almost Never Sometimes About Half the time Most of the time Almost Always

20. When I'm upset, I can still get things done.

Almost Never Sometimes About Half the time Most of the time Almost Always

21. When I'm upset, I feel ashamed of myself for feeling that way.

Almost Never Sometimes About Half the time Most of the time Almost Always

22. When I'm upset, I know that I can find a way to eventually feel better.

Almost Never Sometimes About Half the time Most of the time Almost Always

23. When I'm upset, I feel like I am weak.

Almost Never Sometimes About Half the time Most of the time Almost Always

24. When I'm upset, I feel like I can remain in control of my behaviours.

Almost Never Sometimes About Half the time Most of the time Almost Always

25. When I'm upset, I feel guilty for feeling that way.

Almost Never Sometimes About Half the time Most of the time Almost Always

26. When I'm upset, I have difficulty concentrating.

Almost Never Sometimes About Half the time Most of the time Almost Always

27. When I'm upset, I have difficulty controlling my behaviours.

Almost Never Sometimes About Half the time Most of the time Almost Always

28. When I'm upset, I believe that there is nothing I can do to make myself feel better.

Almost Never Sometimes About Half the time Most of the time Almost Always

29. When I'm upset, I become irritated with myself for feeling that way.

Almost Never Sometimes About Half the time Most of the time Almost Always

30. When I'm upset, I start to feel very bad about myself.

Almost Never Sometimes About Half the time Most of the time Almost Always

31. When I'm upset, I believe that wallowing in it is all I can do.

Almost Never Sometimes About Half the time Most of the time Almost Always

32. When I'm upset, I lose control over my behaviours.

Almost Never Sometimes About Half the time Most of the time Almost Always

33. When I'm upset, I have difficulty thinking about anything else.

Almost Never Sometimes About Half the time Most of the time Almost Always

34. When I'm upset, I take time to figure out what I'm really feeling.

Almost Never Sometimes About Half the time Most of the time Almost Always

35. When I'm upset, it takes me a long time to feel better.

Almost Never Sometimes About Half the time Most of the time Almost Always

36. When I'm upset, my emotions feel overwhelming.

Almost Never Sometimes About Half the time Most of the time Almost Always

Please answer ALL the questions on the following pages simply by circling the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past. It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently (in the last four weeks or so) –

Al been feeling perfectly well and in good health?

Better than usual Same as usual Worse than usual Much worse than usual

A2 been feeling in need of a good tonic?

Better than usual Same as usual Worse than usual Much worse than usual

A3	been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4	felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5	been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6	been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7	been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2	had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4	been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5	been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6	found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7	been feeling nervous and strung up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

C1	been managing to keep yourself busy and occupied?	More than than usual	Same	Rather less than usual	Much less than usual
C2	been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3	felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4	been satisfied with the way you've carried out your task?	More Satisfied than usual	About same as usual	Less satisfied than usual	Much less satisfied
C5	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

D1	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3	felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4	thought of the possibility that you might do away with yourself?	Definitely Not	I don't think so	Has crossed my mind	Definitely have
D5	found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual

D6	found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

This section is about your interests and things you enjoy doing.
Below is a list of statements. Please read each statement carefully and rate how strongly you agree or disagree with it by circling your answer. Please choose one answer for each question. If you are not sure, choose the answer that is mostly true for you. There are no right or wrong answers, or trick questions. For each question, choose from the following four responses:

1. I can easily tell if someone else wants to enter a conversation.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

2. I prefer animals to humans.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

3. I try to keep up with the current trends and fashions.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

4. I find it difficult to explain to others things I understand easily when they don't understand it first time.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

5. I dream most nights.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

6. I really enjoy caring for other people.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

7. I try to solve my own problems rather than discussing them with others.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

8. I find it hard to know what to do in a social situation.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

9. I am at my best first thing in the morning.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

10. People often tell me that I went too far driving my point home in a discussion.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

11. It doesn't bother me too much if I am late meeting a friend.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

12. Friendships and relationships are just too difficult, I tend not to bother with them.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

13. I would never break a law, no matter how minor.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

14. I often find it difficult to judge if something is rude or polite.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

15. In a conversation, I tend to focus on my own thoughts rather than on what my listener might be thinking.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

16. I prefer practical jokes to verbal humour.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

17. I live life for today rather than the future.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

18. When I was a child, I enjoyed cutting up worms to see what would happen.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

19. I can pick up quickly if someone says one thing but means another.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

20. I tend to have very strong opinions about morality.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

21. It is hard for me to see why some things upset some people so much.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

22. I find it easy to put myself in somebody else's shoes.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

23. I think that good manners are the most important thing a parent can teach a child.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

24. I like to do things on the spur of the moment.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

25. I am good at predicting how someone will feel.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

26. I am quick to spot when someone in a group is feeling awkward or uncomfortable.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

27. If I say something that someone else is offended by,
I think that's their problem, not mine.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

28. If anyone asked me if I liked their haircut,
I'd reply truthfully, even if I didn't like it.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

29. I could always see why someone should have felt offended by a remark.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

30. People often tell me that I'm very unpredictable.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

31. I enjoy being the centre of attention at any social gathering.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

32. Seeing people cry doesn't really upset me.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

33. I enjoy having discussions about politics.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

34. I am very blunt, which some people take to be rudeness, even though this is unintentional.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

35. I don't tend to find social situations confusing.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

36. Other people tell me I am good at understanding how they are feeling and what they are thinking.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

37. When I talk to people, I tend to talk about their experiences rather than my own.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

38. It upsets me to see an animal in pain.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

39. I am able to make decisions without being influenced by people's feelings.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

40. I can't relax until I have done everything I had planned to do that day.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

41. I can easily tell if someone else is interested or bored with what I am saying.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

42. I get upset if I see people suffering on news programmes.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

43. Friends usually talk to me about their problems as they say that I am very understanding.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

44. I can sense if I am intruding, even if the other person doesn't tell me.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

45. I often start new hobbies but quickly become bored with them and move onto something else.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

46. People sometimes tell me that I have gone too far with teasing.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

47. I would be too nervous to go on a big rollercoaster.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

48. Other people often say that I am insensitive, though I don't always see why.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

49. If I see a stranger in a group, I think that it is up to them to join in.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

50. I usually stay emotionally detached when watching a film.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

51. I like to be very organised in day-to-day life and often make lists of the chores I have to do.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

52. I can tune into how someone else feels rapidly and intuitively.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

53. I don't like to take risks.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

54. I can easily work out what another person might want to talk about.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

55. I can tell if someone is masking their true emotion.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

56. Before making a decision I always weigh up the pros and cons.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

57. I don't consciously work out the rules of social situations.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

58. I am good at predicting what someone will do.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

59. I tend to get emotionally involved with a friend's problems.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

60. I can usually appreciate the other person's viewpoint, even if I don't agree with it.

Strongly Agree slightly Agree slightly Disagree Strongly Disagree

Thank you for your time – it is most appreciated.

Appendix C: Development of Items on Fathers' Attachment to Children Questionnaire

Table C1: FACQ items that were revised from previous questionnaires

Original item	Q'naire	Revised item on FACQ
When I am caring for the baby I get feelings that the child is deliberately being difficult or trying to upset me	PPAS	I often get the feeling that my child is deliberately being difficult or is trying to upset me
When I am caring for the baby, I get feelings of annoyance or irritation	PPAS	I often feel annoyed or irritable when I am with my child
When I am with the baby I feel bored	PPAS	I often feel bored when I am with my child
Usually when I am with the baby: [responses] – I am (very impatient/ a bit impatient/ moderately patient/ extremely patient)	PPAS	I often feel impatient when interacting with my child
When I am with the baby: [responses] – I (always/ frequently/ occasionally/ very rarely) get a lot of enjoyment/satisfaction	PPAS	I usually enjoy time spent with my child
Regarding the things that we have had to give up because of the baby: [responses] – I find that I resent it (quite a lot/ a moderate amount/ a bit/ not at all)	PPAS	I resent having to be so involved with my child with my busy lifestyle
When I am with the baby: [responses] – I usually try to (prolong/ shorten/ neither) the time I spend with him/her	PPAS	I wish I could spend more time with my child
Over the past three months, I have felt that I do not have enough time for myself or to pursue my own interests	PPAS	I often feel resentful that I don't have enough time for myself
When I am with the baby and other people are present I feel proud of the baby	PPAS	I often feel proud of my child
When I have been away from the baby for a while and I am about to be with him/her again, I usually feel: [responses] – (intense pleasure/moderate pleasure/ mild pleasure/ no feelings at all/ negative feelings) at the idea	PPAS	I feel close to my child
I find myself talking to people (other than my partner) about the baby	PPAS	I often talk about my child's achievements to friends or others outside the family
I try to involve myself as much as possible in child care and looking after the baby	PPAS	I would like to be able to engage in more activities with my child
Over the last two weeks I would describe my feelings for the baby as: [responses] – (dislike/ no strong feelings towards the baby /slight affection/ moderate affection/ intense affection)	PPAS	I feel a great deal of affection for my child
I can understand what my baby needs or wants	PPAS	I am in tune with my child's needs
Regarding my overall level of interaction with the baby I believe I am: [responses] – (much more involved than/ somewhat more involved than/ involved to the same extent as/ somewhat less involved than/ much less involved than) most fathers in my position*	PPAS	I am concerned that I do not spend enough quality time with my child
How much does this child admire and respect you?	PCRQ	I often worry that I will lose my child's admiration
How much does this child admire and respect you?*	PCRQ	It hurts me that my child may be closer to other family members than to me
My partner only seems to notice me when I'm angry	ECR-R	My child only pays attention to me when I'm angry
My romantic partner makes me doubt myself*	ECR-R	I usually trust my own judgement when it comes to parenting my child
I worry that I won't measure up to other people*	ECR-R	I am confident that my child sees me as a good father

*These items were substantially changed to be more consistent with the appropriate subscale of the FACQ

Appendix D: Parenting Program for fathers in recovery from addictions –Session Content

Session 1

1. Background to program and facilitator
2. Group Agreement
3. Brainstorming Exercise (summary of men's responses to the three main questions I asked in the individual interviews: stress, dealing with it, change what about parenting)
4. Warm-up Exercise (break up into twos/threes to discuss 'getting-to-know-you' questions)
5. Group Goals
6. Relaxation Exercise
7. Developmental Milestones
8. Close

Session 2

1. Relaxation Exercise (incorporating feelings)
2. Emotion awareness exercise (Feeling Faces)
3. Attitudes to emotion ('meta-emotion') followed by scene from film
4. Dealing with emotions (more versus less useful strategies table) followed by classical piece
5. Close

Session 3

1. Guided relaxation, incorporating feelings
2. Dealing with emotions (strategies table – carried over from previous session)
3. Accepting one's own emotions
4. Re-cap on strategies for responding to your own emotions
5. Responding to your children's emotions: Emotion Tuning
6. Close

Session 4

1. Guided relaxation, incorporating feelings
2. Check-in
3. Introduction to Emotion Coaching
4. Developing empathy: the emotion detective
5. Being an Emotion Coach
6. Spot the Emotion Coaching Opportunity
7. Close

Session 5

1. Introduction/Check-in
2. Understanding anxiety
3. Anxiety Reduction Meditation
4. Dealing with anxiety
5. Your children's anxiety
6. Emotion Coaching anxiety
7. Close

Session 6

1. Introduction/Check-in
2. Progressive Muscle relaxation, incorporating anger/stress
3. Understanding anger
4. Dealing with anger
5. Your children's anger
6. Helping your child to express and control anger
7. Emotion Coaching anger
8. Close

Session 7

1. Introduction/Check-in
2. Meditation/ relaxation
3. Re-visiting your group goals
4. Practising Emotion-Coaching
5. Dealing with sadness and disappointment
6. Questionnaires
7. Close

'Catch-up' Session 6a *(required for two men in Group 2 who missed some of the previous sessions)*

1. Relaxation Exercise (incorporating feelings)
2. Responses to emotion followed by scene from film ('meta-emotion')
3. Dealing with emotions (more versus less useful strategies table)
4. Close (short break before final session).

Appendix E: Pre-Program and Post-Program Questionnaire Subscale Scores

Table E1: Subscale scores for phase 2 participants

Scale*	Sub-scale	Carl			Ray**		Jim			Gary			Sam			Dave			Mick		
		T1	T2	T3	T1	T2	T1	T2	T3	T1	T2	T3	T1	T2	T3	T1	T2	T3	T1	T2	T3
FACQ-17	PIR	34	33	35	27	34	35	35	35	28	25	26	33	29	33	29	27	25	34	31	32
	AAR	11	10	11	8	11	6	7	6	6	3	6	10	8	10	5	6	7	3	4	6
	CON	16	13	17	16	17	16	18	20	16	8	16	17	16	17	8	10	12	20	19	19
	MT	12	12	12	8	11	9	13	11	9	6	10	12	11	12	7	6	9	9	10	10
	LOC	6	5	5	11	7	7	11	5	18	12	13	12	12	9	20	21	18	8	9	11
DERS-26	EA	15	15	15	22	23	22	19	9	28	29	24	22	16	18	32	35	32	16	16	13
	NAE	8	10	10	12	10	25	25	25	19	15	13	10	10	10	8	16	12	9	10	8
	CD	9	8	9	14	9	21	18	6	20	15	12	12	10	10	17	18	20	12	14	10
	EC	6	6	4	8	6	13	5	5	7	8	5	6	6	5	12	8	6	6	6	5
GHQ-28	SC	9	8	10	10	17	16	12	11	10	10	10	11	7	7	12	18	10	15	11	17
	A/I	9	11	12	19	11	23	24	7	9	10	13	13	9	7	17	17	15	19	16	23
	SDY	13	9	9	14	9	13	12	7	11	13	9	10	10	7	17	17	17	15	20	22
	DEP	7	7	7	9	7	13	12	7	8	7	8	10	7	7	14	7	7	10	12	9
EQ-16	CE	3	4	3	4	4	6	6	9	4	6	3	3	4	4	1	3	2	6	8	9
	INS	3	2	3	3	4	2	0	2	3	3	2	3	3	3	0	1	1	3	5	4
	PSC	5	7	6	5	8	9	8	10	4	5	5	5	5	6	5	5	5	8	7	8
	SDI	4	4	5	2	3	2	2	2	1	3	3	2	1	3	2	2	2	5	5	4

*For full names of questionnaires and range of possible subscale scores, see Table 4.1.
**This participant did not complete the questionnaires at time T3.

Legend:

- FACQ-17 subscales – PIR Pleasure in Relationship; AAR Anxiety about Relationship; CON Conflict; MT Mutual Trust
- DERS-26 subscales – LOC Lack of Control; EA Emotional Awareness; NAE Negative Attitude to own Emotions; CD Concentration Difficulties; EC Emotional Confusion
- GHQ-28 – SC Semantic Complaints; A/I Anxiety/Insomnia; SDY Social Dysfunction; DEP Severe Depression
- EQ-16 – CE Cognitive Empathy; INS Insensitivity; PSC Perception of Social Cues; SDI Social Discomfort

Appendix F: Means and ANOVA Tables for FACQ-17 scores by Marital Status, Education and Occupation

Table F1: Attachment (FACQ-17) scores by Marital Status – Means

Attachment Scale

Marital Status	Mean	N	Std. Deviation
1 – Single	64.75	36	8.70
2 – Married	68.10	68	6.71
3 – Cohabiting	67.71	14	8.71
4 – Separated	67.20	20	7.07
5 – Divorced	68.18	22	8.56
6 – Widowed	66.33	3	3.21
Total	67.196	163	7.644

Table F2: Attachment (FACQ-17) scores by Marital Status – ANOVA Table

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * MStatus	Between Groups	(Combined)	61.61	32	1.93	.971	.520 (n.s.)
	Within Groups		257.86	130	1.98		
	Total		319.460	162			

Legend: n.s. = non-significant

Table F3: Attachment (FACQ-17) scores by Education level – Means

Attachment Scale

Education	Mean	N	Std. Deviation
1 – School Certificate / Some Schooling	66.10	49	7.54
2 – HSC (year 12)	66.22	18	9.57
3 – Trade or Diploma	68.31	36	5.21
4 – University (Bachelor or Grad Dip)	68.42	31	8.86
5 – University (Masters or PhD)	69.69	26	7.74
6 – Other	64.00	3	4.58
Total	67.196	163	7.644

Table F4: Attachment (FACQ-17) scores by Education level – ANOVA Table

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Education	Between Groups	(Combined)	53.61	32	1.68	.683	.895 (n.s.)
	Within Groups		318.86	130	2.45		
	Total		372.466	162			

Legend: n.s. = non-significant

Table F5: Attachment (FACQ-17) scores by Occupation level – Means

Attachment Scale

Occupation	Mean	N	Std. Deviation
1 – Skilled labour	68.04	23	6.86
2 – Semi-skilled/Unskilled labour	62.63	8	7.56
3 – Junior management	67.67	6	1.86
4 – Professional (manager)	68.61	28	7.26
5 – Professional (other)	67.83	54	7.99
6 – Unemployed (currently seeking work)	67.08	12	8.31
7 – Unemployed (not currently seeking work)	63.23	22	8.04
8 – Retired/volunteering/home duties	72.33	3	5.13
9 – Other	69.14	7	7.38
Total	67.196	156	7.644

Table F6: Attachment (FACQ-17) scores by Occupation level – ANOVA Table

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Occupation	Between Groups	(Combined)	155.45	32	4.86	1.146	.292 (n.s.)
	Within Groups		551.20	130	4.24		
	Total		706.650	162			

Legend: n.s. = non-significant

Appendix G: Plots of Means for dichotomous independent variables against Attachment (FACQ-17) scores

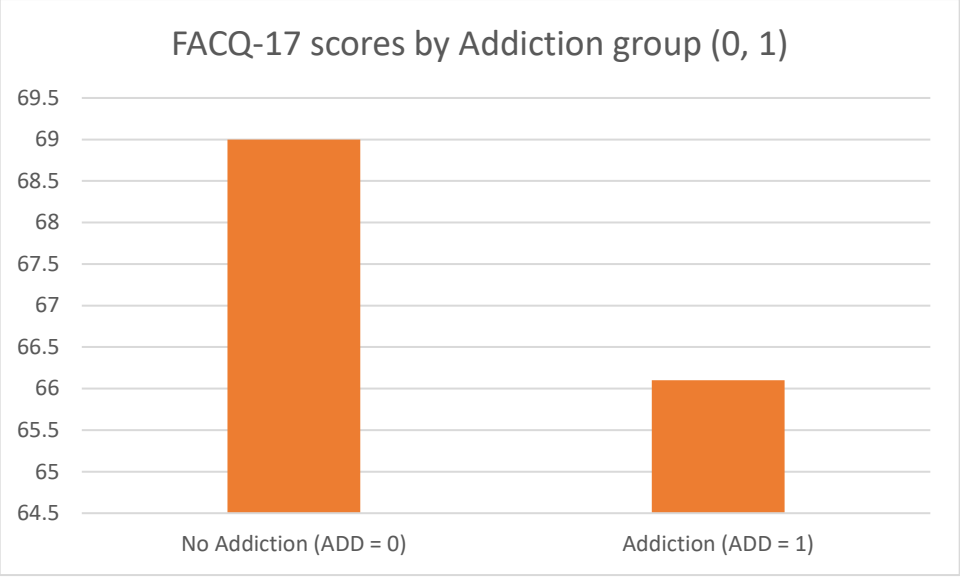

Figure G1: Attachment (FACQ-17) scores by Addiction group (ADD) – Means

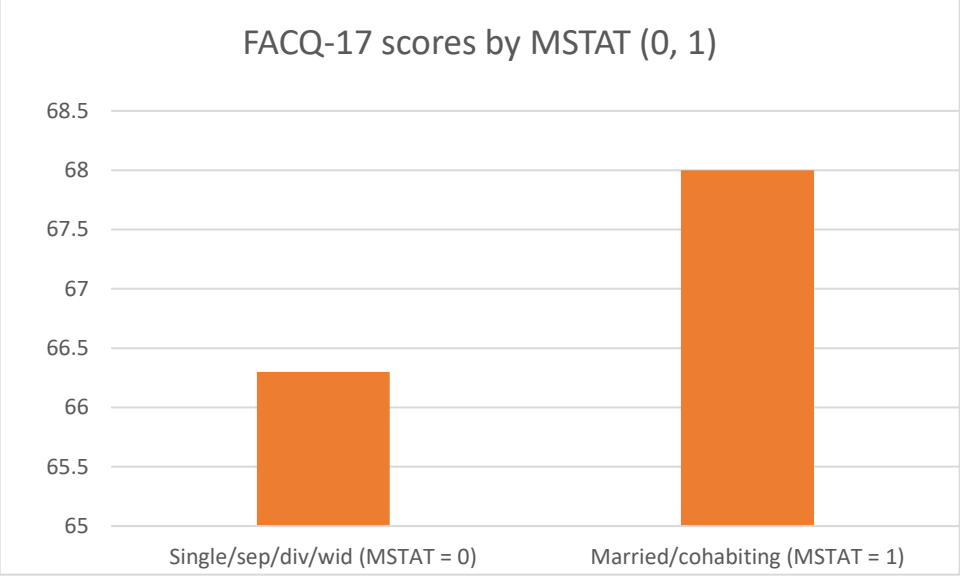

Figure G2: Attachment (FACQ-17) scores by Marital Status (MSTAT) – Means

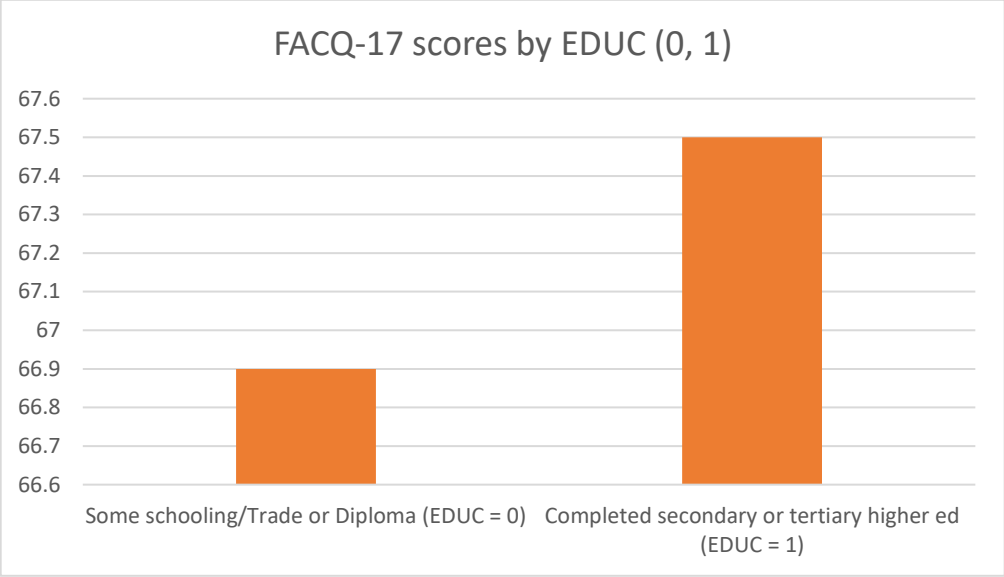

Figure G3: Attachment (FACQ-17) scores by Education (EDUC) – Means

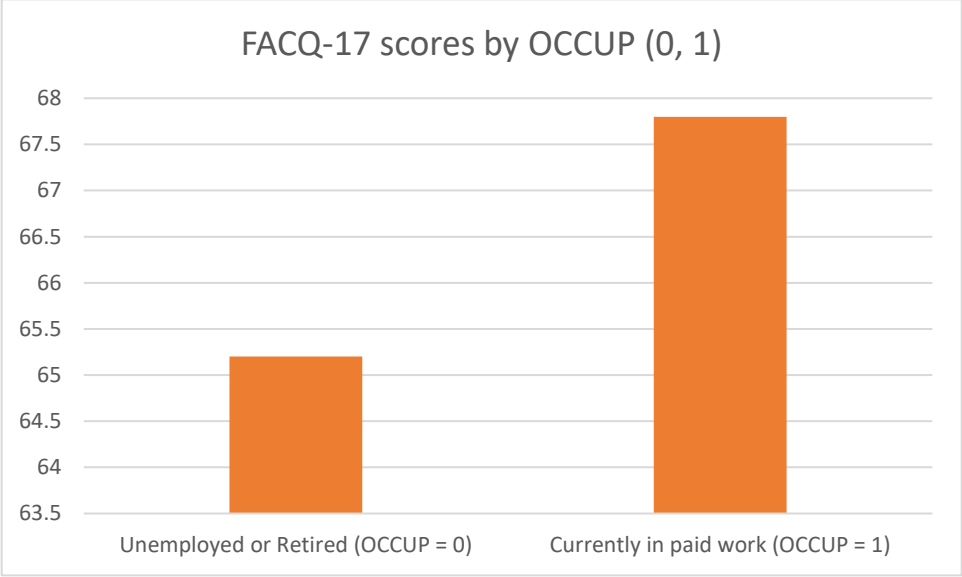

Figure G4: Attachment (FACQ-17) scores by Occupation (OCCUP) – Means

Appendix H: Scatterplots and tests for linearity for numerical independent variables against Attachment (FACQ-17) scores

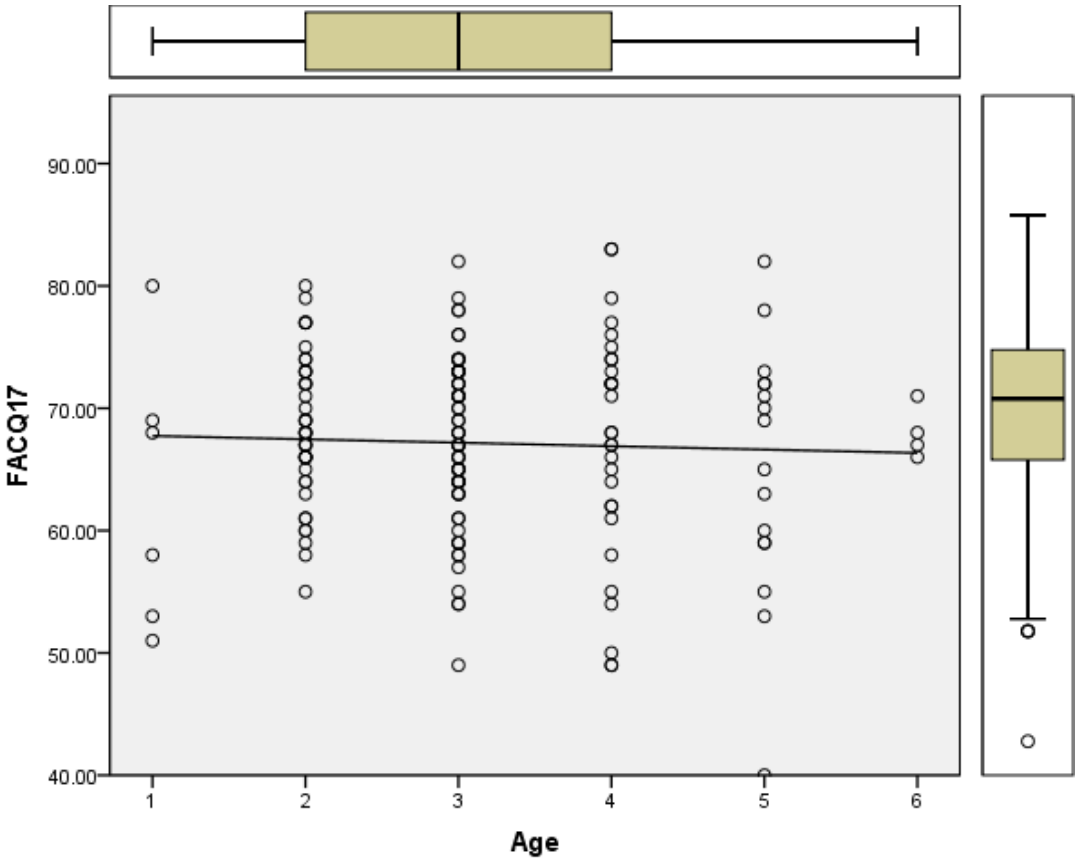

Figure H1: Attachment (FACQ-17) scores by Father's age group

Table H1: Attachment (FACQ-17) scores by Father's age group: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Age	Between Groups	(Combined)	224.82	5	44.94	.764	.577
		Linearity	15.05	1	15.05	.256	.614 (n.s.)
		Deviation from Linearity	209.68	4	52.42	.891	.471 (n.s.)
	Within Groups		9179.72	156	58.84		
	Total		9404.44	161			

Legend: n.s. = non-significant

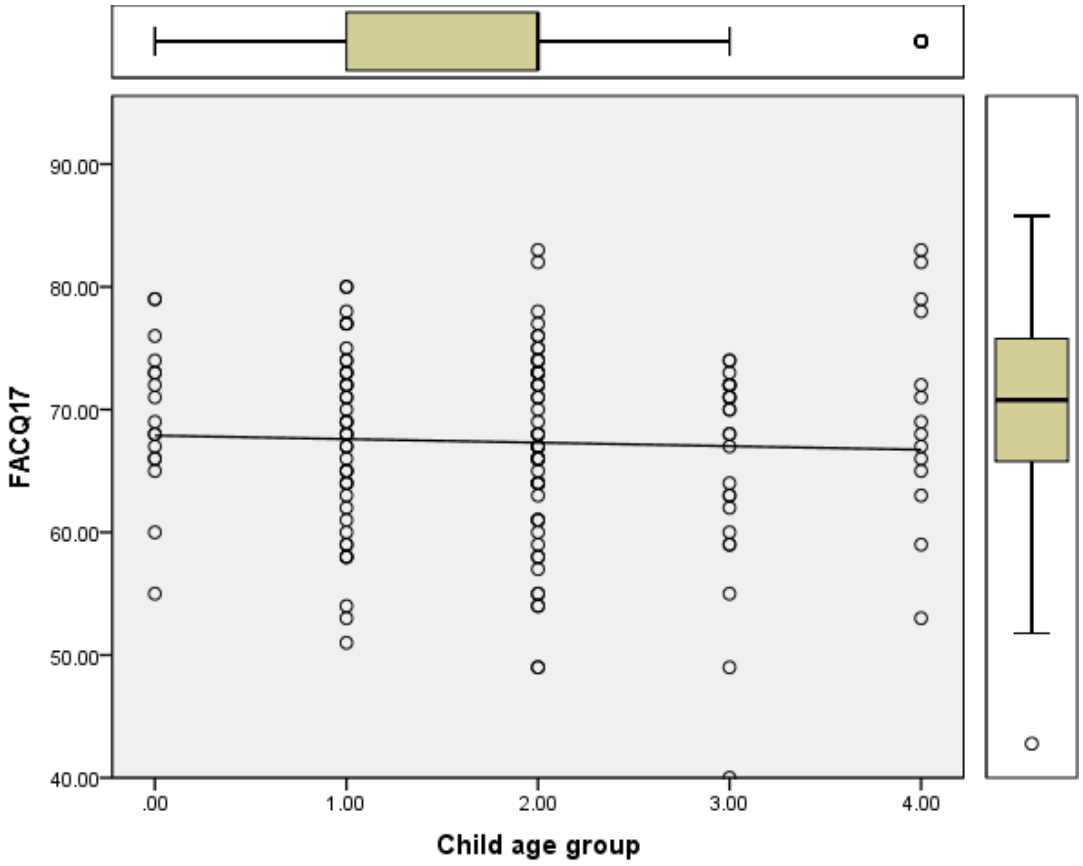

Figure H2: Attachment (FACQ-17) scores by Child's age

Table H2: Attachment (FACQ-17) scores by Child's age: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Child age group	Between Groups	(Combined)	241.18	4	60.29	1.039	.389
		Linearity	15.82	1	15.82	.273	.602 (n.s.)
		Deviation from Linearity	225.36	3	75.12	1.295	.278 (n.s.)
	Within Groups		8876.97	153	58.02		
	Total		9118.152	157			

Legend: n.s. = non-significant

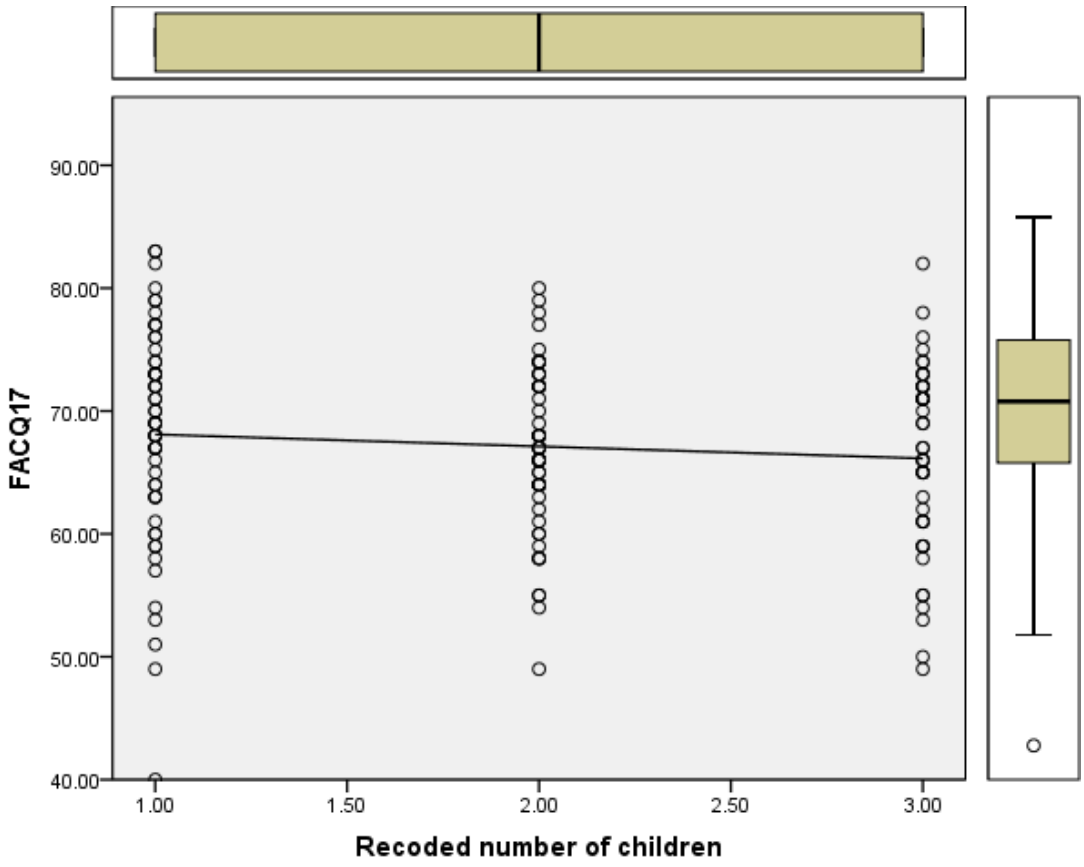

Figure H3: Attachment (FACQ-17) scores by Number of Children

Table H3: Attachment (FACQ-17) scores by Number of Children: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Recoded number of children	Between Groups	(Combined)	106.06	2	53.03	.901	.408
		Linearity	98.35	1	98.35	1.671	.198 (n.s.)
		Deviation from Linearity	7.71	1	7.71	.131	.718 (n.s.)
	Within Groups		9359.01	159	58.86		
	Total		9465.068	161			

Legend: n.s. = non-significant

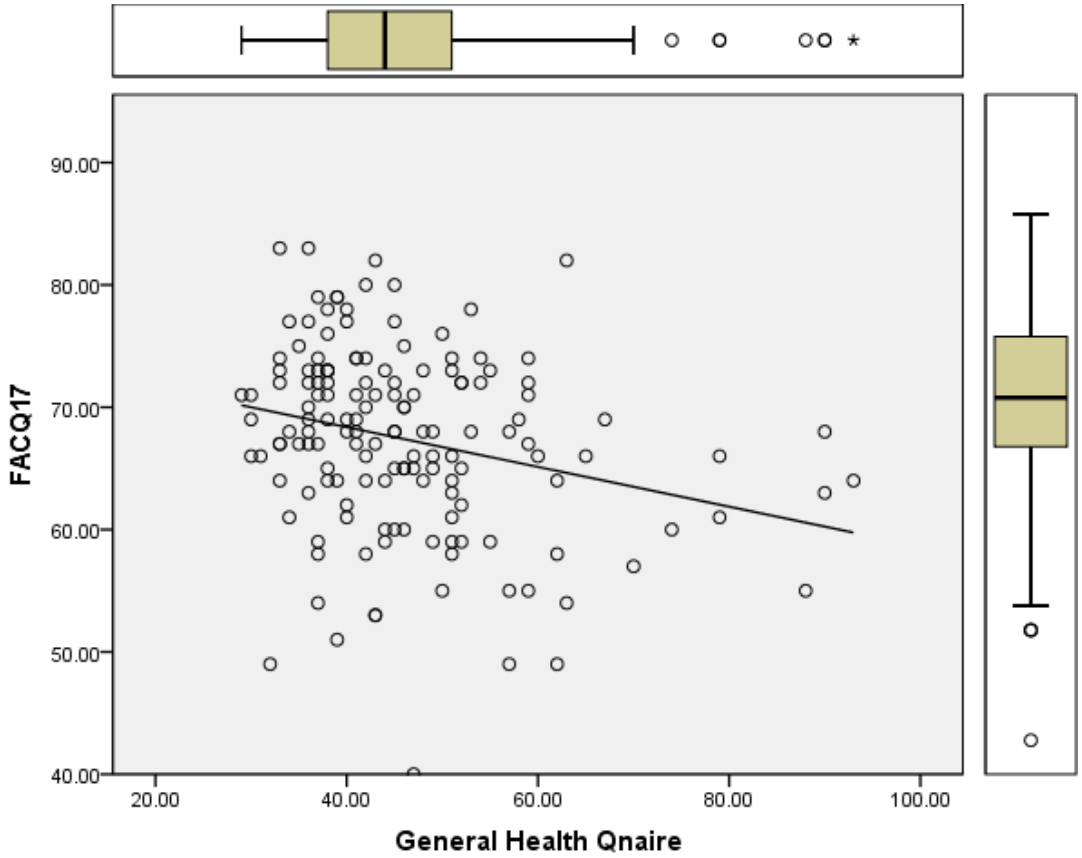

Figure H4: Attachment (FACQ-17) scores by GHQ-28 scores

Table H4: Attachment (FACQ-17) scores by GHQ-28 scores: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * General Health Qnaire	Between Groups	(Combined)	2466.23	40	61.66	1.083	.365
		Linearity	588.19	1	588.19	10.333	.002**
		Deviation from Linearity	1878.04	39	48.16	.846	.719 (n.s.)
	Within Groups		6147.92	108	56.93		
	Total		8614.148	148			

Legend: n.s. = non-significant; **Significant at p<.005

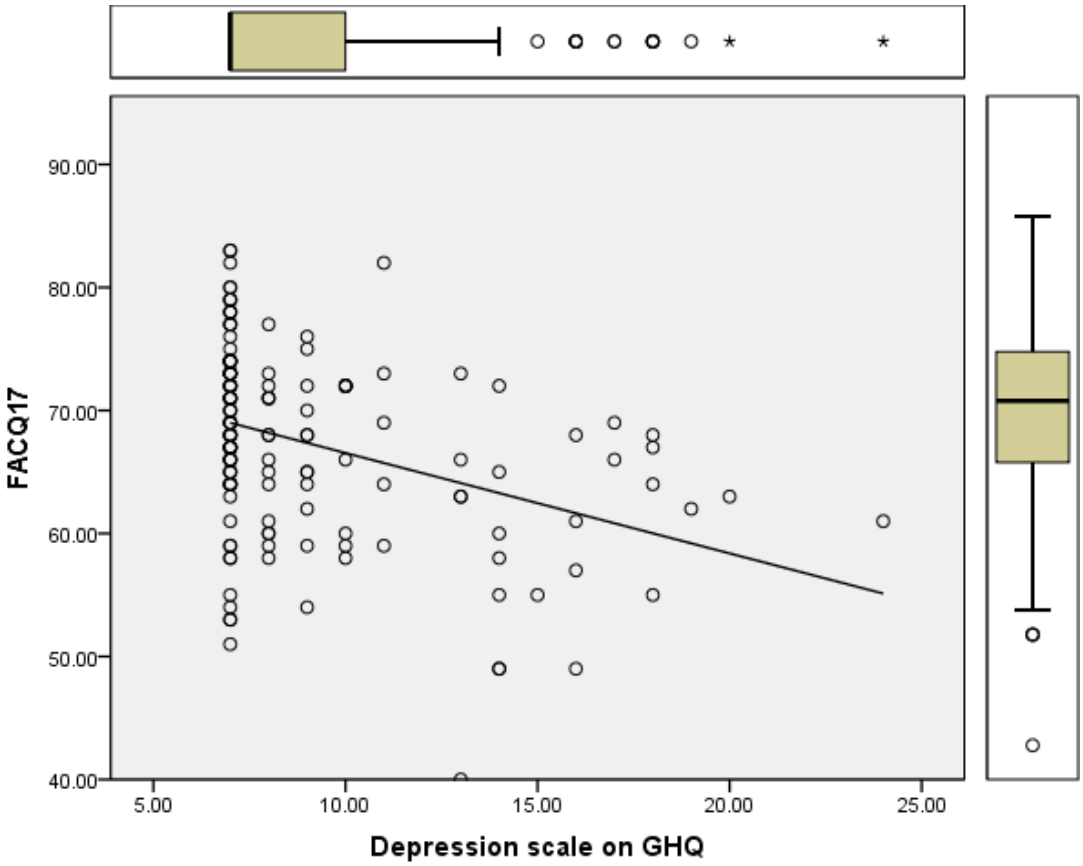

Figure H5: Attachment (FACQ-17) scores by DEP scores

Table H5: Attachment (FACQ-17) scores by DEP scores: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Depression scale on GHQ	Between Groups	(Combined)	1844.83	13	141.91	2.851	.001
		Linearity	1181.62	1	1181.62	23.739	.000***
		Deviation from Linearity	663.20	12	55.27	1.110	.357 (n.s.)
	Within Groups		26432.48	139	49.78		
	Total		32935.31	152			

Legend: n.s. = non-significant; ***Significant at p<.0005

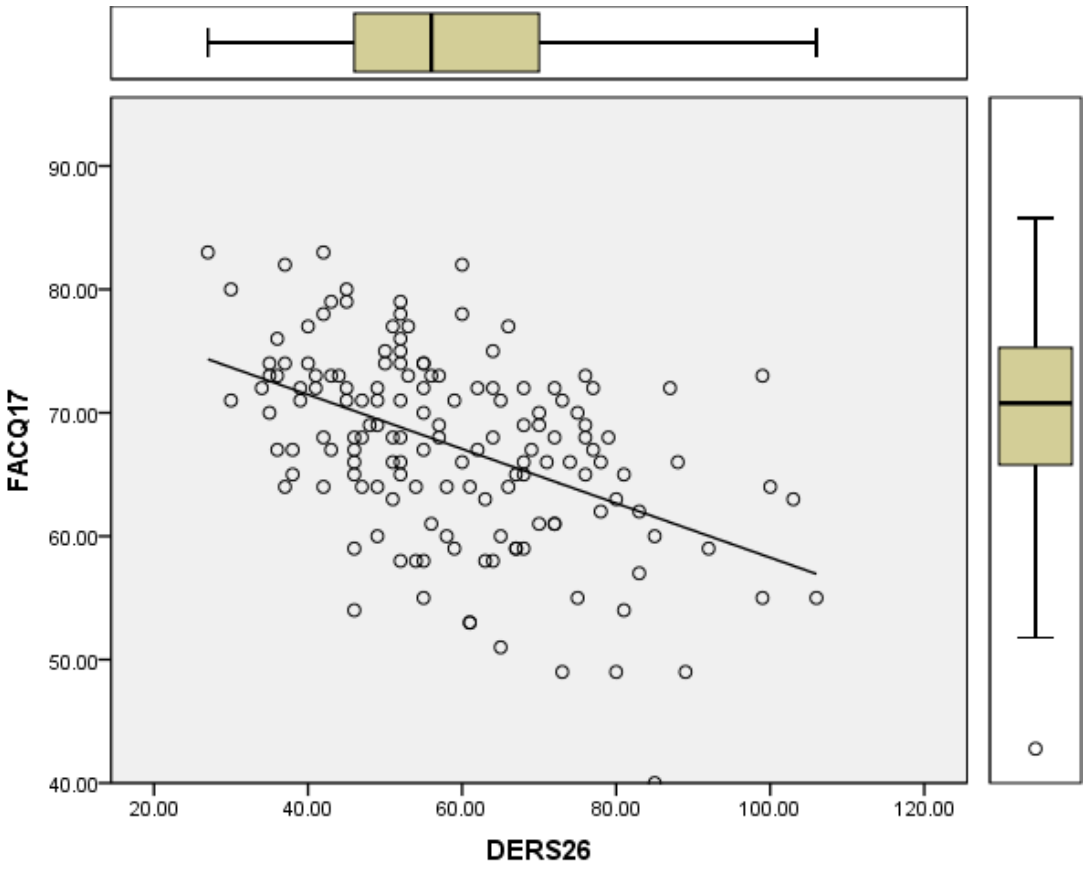

Figure H6: Attachment (FACQ-17) scores by Emotion Regulation (DERS-26) scores

Table H6: Attachment (FACQ-17) scores by DERS-26 scores: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Emotion Regulation Scale	Between Groups	(Combined)	4915.54	59	83.31	1.965	.002
		Linearity	1969.39	1	1969.39	46.438	.000**
		Deviation from Linearity	2946.15	58	50.80	1.198	.218 (n.s.)
	Within Groups		3859.21	91	42.41		
	Total		8774.742	150			

Legend: n.s. = non-significant; **Significant at p<.0005

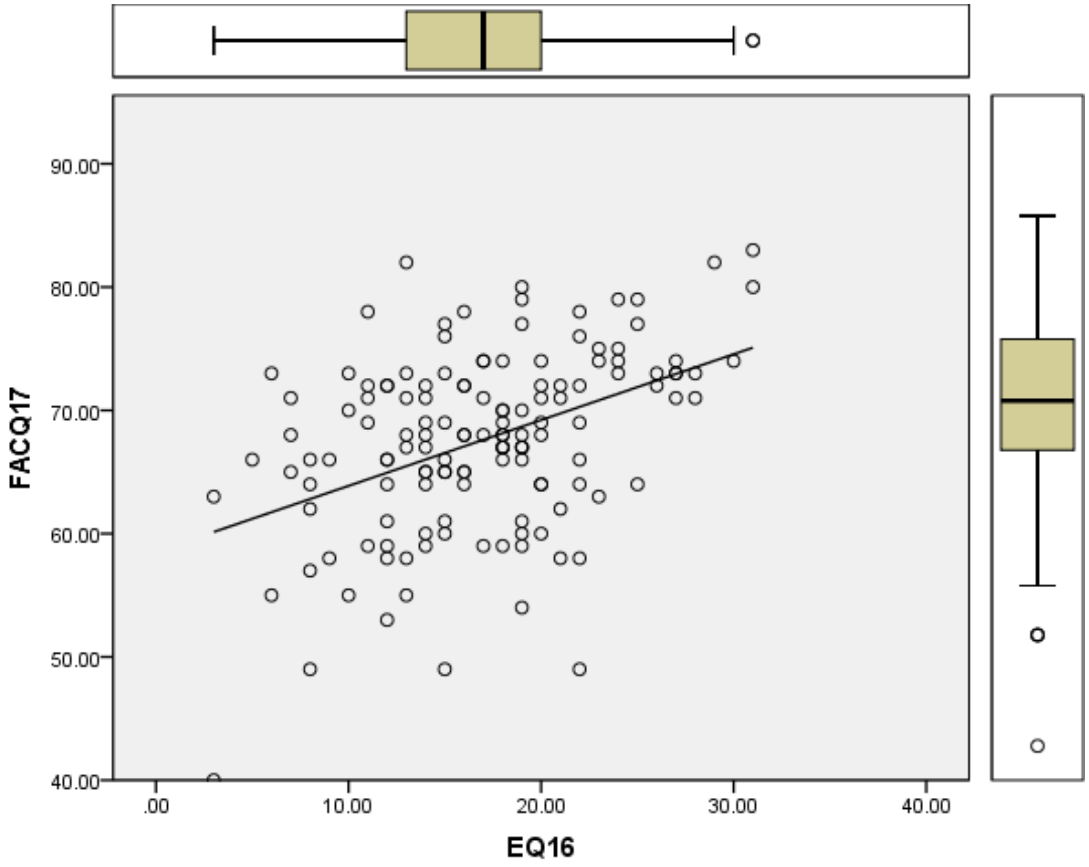

Figure H7: Attachment (FACQ-17) scores by Empathy (EQ-16) scores

Table H7: Attachment (FACQ-17) scores by EQ-16 scores: ANOVA and tests for linearity/non-linearity

ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Attachment Scale * Empathy Quotient	Between Groups	(Combined)	2407.15	27	89.15	1.945	.009
		Linearity	1373.09	1	1373.09	29.963	.000***
		Deviation from Linearity	1034.06	26	39.77	.868	.651 (n.s.)
	Within Groups		5040.89	110	45.83		
	Total		7448.036	137			

Legend: n.s. = non-significant; ***Significant at p<.0005

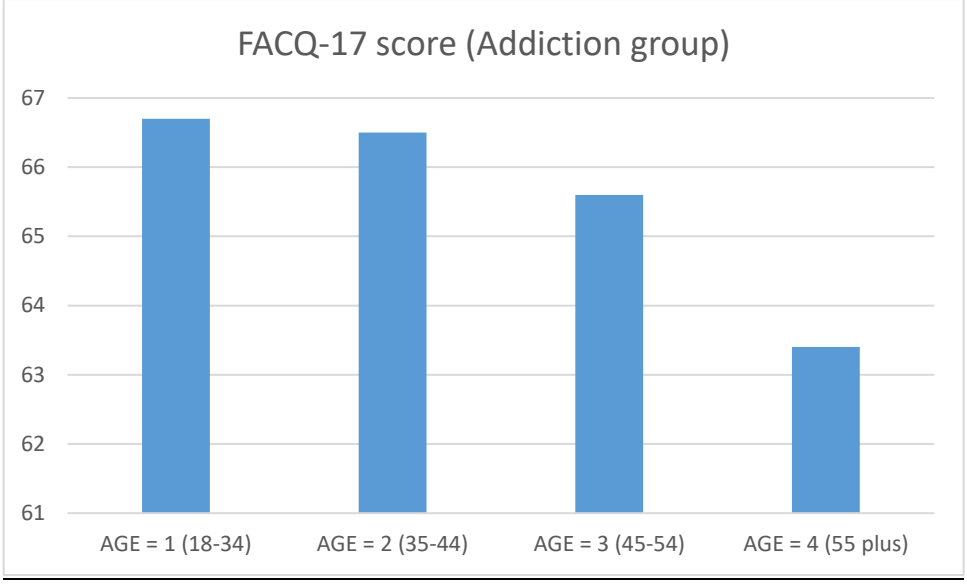

Figure H8: Attachment (FACQ-17) scores by fathers' age group (recoded into four categories) for fathers in the Addiction group

Appendix I: CFA models for FACQ-17, EQ-16 and DERS-26 scores

Table I1: Results of CFA statistics testing goodness of fit for various FACQ models

Model	Items	Factors	Method	Rotation	R^2	Global α	RMSEA	NFI	CFI
1*	34	4 / 7	PAF	Oblimin	51.4% (4) 62.5% (7)	0.91	.097	.55	.65
2	21	4	PAF	Oblimin	59.7%	0.87	.073	.78	.88
3	20	4	PCA	Oblimin	60.2%	0.86	.072	.79	.88
4	20	4	PAF	Oblimin	63.6%	0.86	.076	.78	.88
5	19	4	PAF	Oblimin	64.3%	0.85	.070	.805	.90
6	18	4	PAF	Oblimin	62.1%	0.84	.066	.82	.91
7	17	4	PAF	Oblimin	63.4%	0.82	.067	.83	.915
8	**17****	**4**	**PAF**	**Oblimin**	**63.4%**	**0.83**	**.061**	**.84**	**.93**
9	16	4	PAF	Oblimin	64.8%	0.815	.062	.845	.93
10	15	4	PAF	Oblimin	65.7%	0.795	.064	.85	.93

*Model 1 was validated first onto the present sample. **Item 4 (instead of item 10) was removed from FACQ-18 for the second (and final) 17-item version.

Table I2: Results of CFA statistics testing goodness of fit for various EQ models

Model	Items	Factors	Method	Rotation	R^2	Global α	RMSEA	NFI	CFI
1*	40 / 28	3	PCA	Varimax	41.4%	0.92	--	--	--
1a	40	5 / 11	PAF	Oblimin	35.2% (5) 63.6% (11)	0.88	.051	.56	.79
2	39	5	PAF	Oblimin	44.8%	0.88	.053	.56	.79
3	35	4	PAF	Oblimin	47.9%	0.885	.057	.59	.79
4	32	4	PAF	Oblimin	46.5%	0.884	.063	.61	.79
5	30	4	PAF	Oblimin	47.1%	0.877	.064	.62	.79
6	28	4	PAF	Oblimin	48.1%	0.87	.063	.64	.81
7	28	3	PAF	Oblimin	42.3%	0.87	.065	.63	.80
8	27	4	PAF	Oblimin	49.3%	0.87	.061	.665	.83
9	27	3	PAF	Oblimin	43.3%	0.87	.064	.65	.81
10	25	4	PAF	Oblimin	50.6%	0.86	.064	.68	.83
11	22	4	PAF	Oblimin	52.7%	0.86	.064	.71	.85
12	20	4	PAF	Oblimin	56.6%	0.86	.063	.75	.88
13	20	3	PCA	Oblimin	49.6%	0.86	.068	.745	.86
14	**16**	**4**	**PAF**	**Oblimin**	**60.0%**	**0.82**	**.054**	**.80**	**.92**
15	16	3	PAF	Oblimin	51.3%	0.82	.071	.74	.85
16	15	3	PAF	Oblimin	56.3%	0.825	.060	.81	.915
17	13	2	PAF	Oblimin	52.9%	0.83	.067	.83	.92
18	12	2	PAF	Oblimin	53.2%	0.81	.064	.85	.93

*Model 1 was validated by the original authors onto a mixed clinical and general sample (28 of the 40 items loaded onto the three factors). Model 1a is the application of the original instrument onto the present sample.

Table I3: Results of CFA statistics testing goodness of fit for various DERS models

Model	Items	Factors	Method	Rotation	R^2	Global α	RMSEA	NFI	CFI
1*	36	6	PAF	Promax	55.7%	0.93	----	--	--
1a	36	6	PAF	Oblimin	68.0%	0.95	.078	.73	.84
1b	36	6	PAF	Oblimin	68.0%	0.95	.073	.75	.86
2	29	6	PAF	Oblimin	69.1%	0.94	.063	.81	.91
3	28	5	PAF	Oblimin	66.3%	0.94	.062	.81	.91
4	34	5	PCA	Oblimin	64.0%	0.95	.078	.75	.85
5	34	6	PAF	Promax	68.1%	0.95	.071	.76	.85
6	32	6	PAF	Promax	68.5%	0.95	.068	.78	.89
7	31	6	PCA	Oblimin	68.4%	0.94	.073	.78	.88
8	30	6	PAF	Promax	69.8%	0.945	.068	.79	.89
9	27	4	PAF	Promax	62.0%	0.94	.085	.75	.84
10	24	4	PAF	Promax	63.7%	0.93	.083	.78	.865
11	30	5	PAF	Oblimin	65.9%	0.945	.065	.79	.90
12	29	5	PAF	Oblimin	66.1%	0.94	.065	.80	.90
13	27	5	PAF	Oblimin	66.9%	0.935	.060	.82	.92
14	**26**	**5**	**PAF**	**Oblimin**	**67.4%**	**0.93**	**.055**	**.84**	**.94**
15	25	5	PAF	Oblimin	68.9%	0.93	.059	.84	.93

*Model 1 was validated by the original authors; Model 1a is the application of the original instrument onto the present sample. Model 1b was generated by an EFA fixing 6 factors.

Appendix J: Residual plots for testing regression assumptions

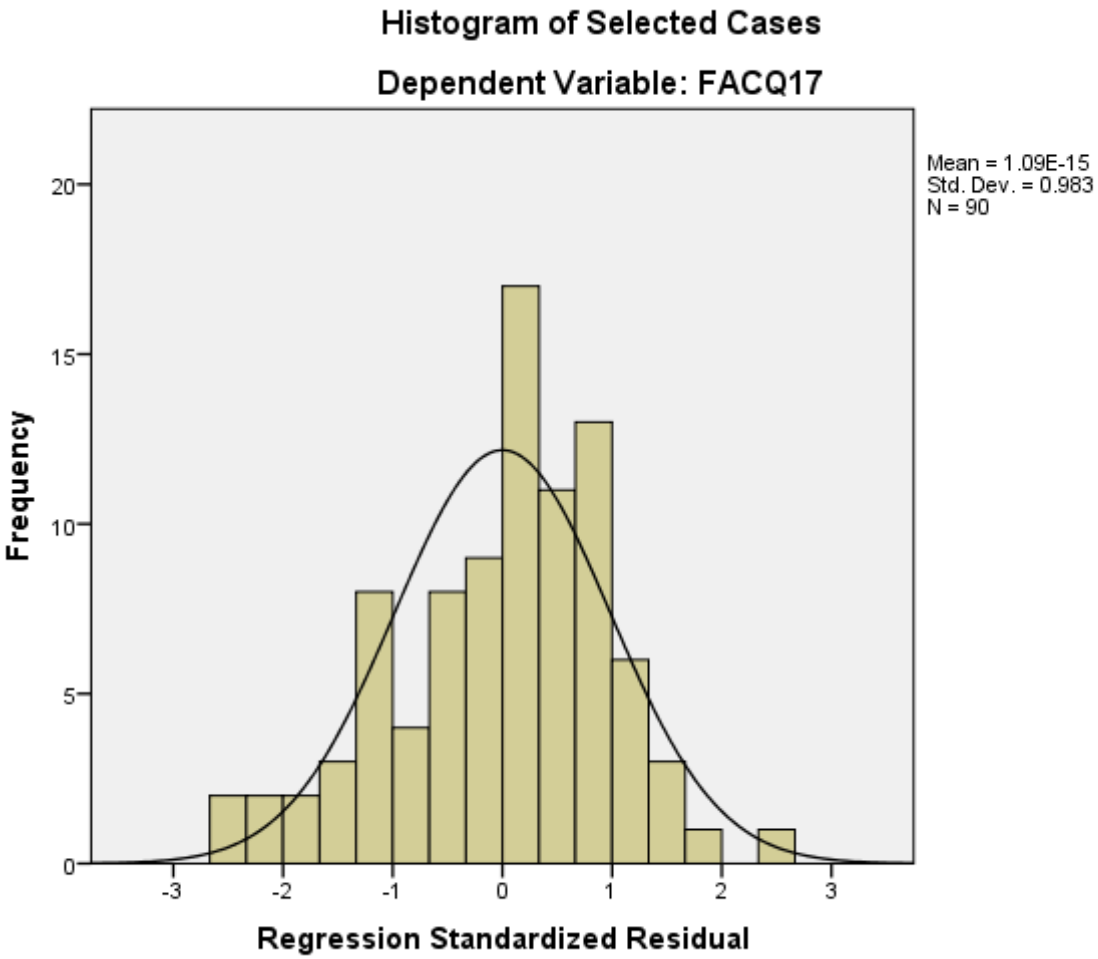

Figure J1: Histogram of standardised residuals for Attachment (FACQ-17) scores for fathers in the Addiction group, predicted from the regression in Table 3:14 (Equation 3.1)

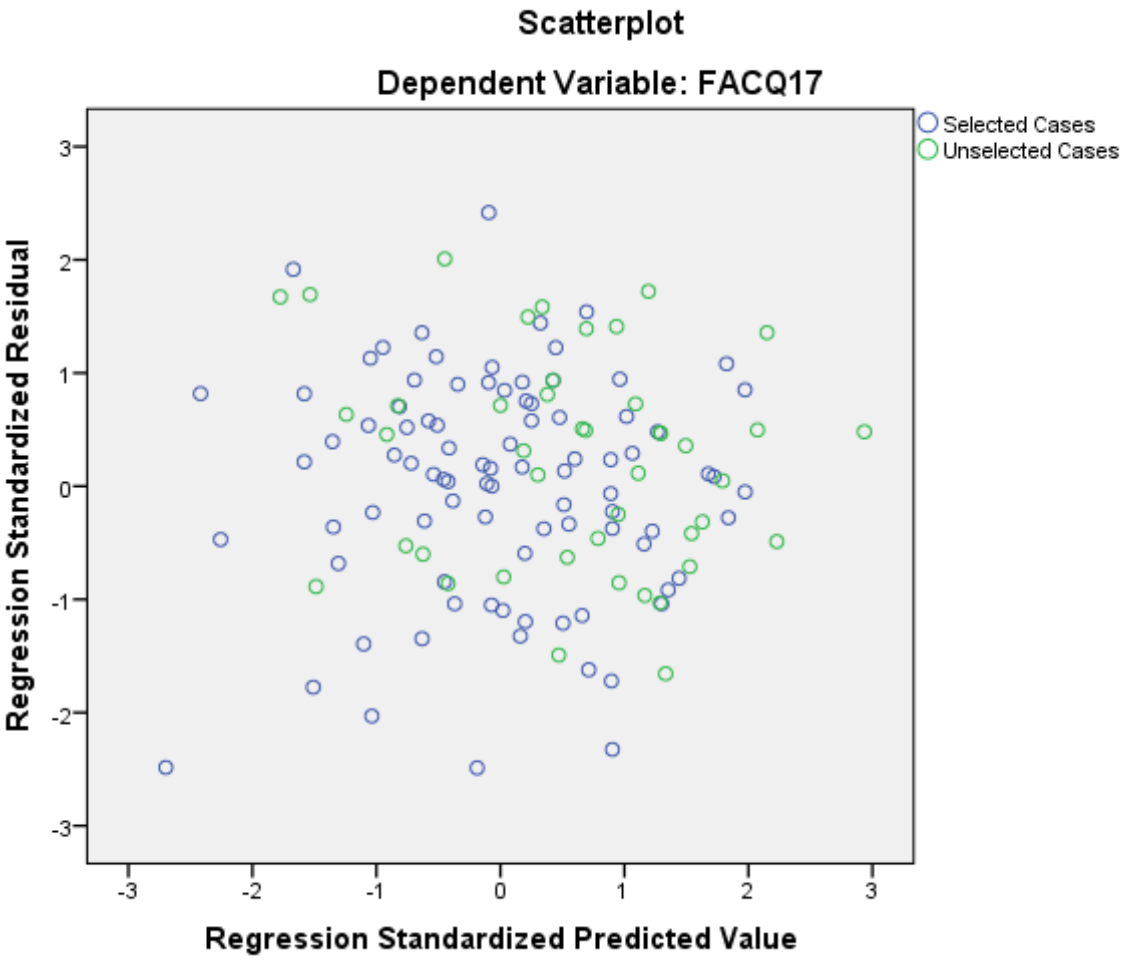

Figure J2: Plot of observed against predicted standardised residuals for Attachment (FACQ-17) scores for fathers in the Addiction group, predicted from the regression in Table 3:14 (Equation 3.1)

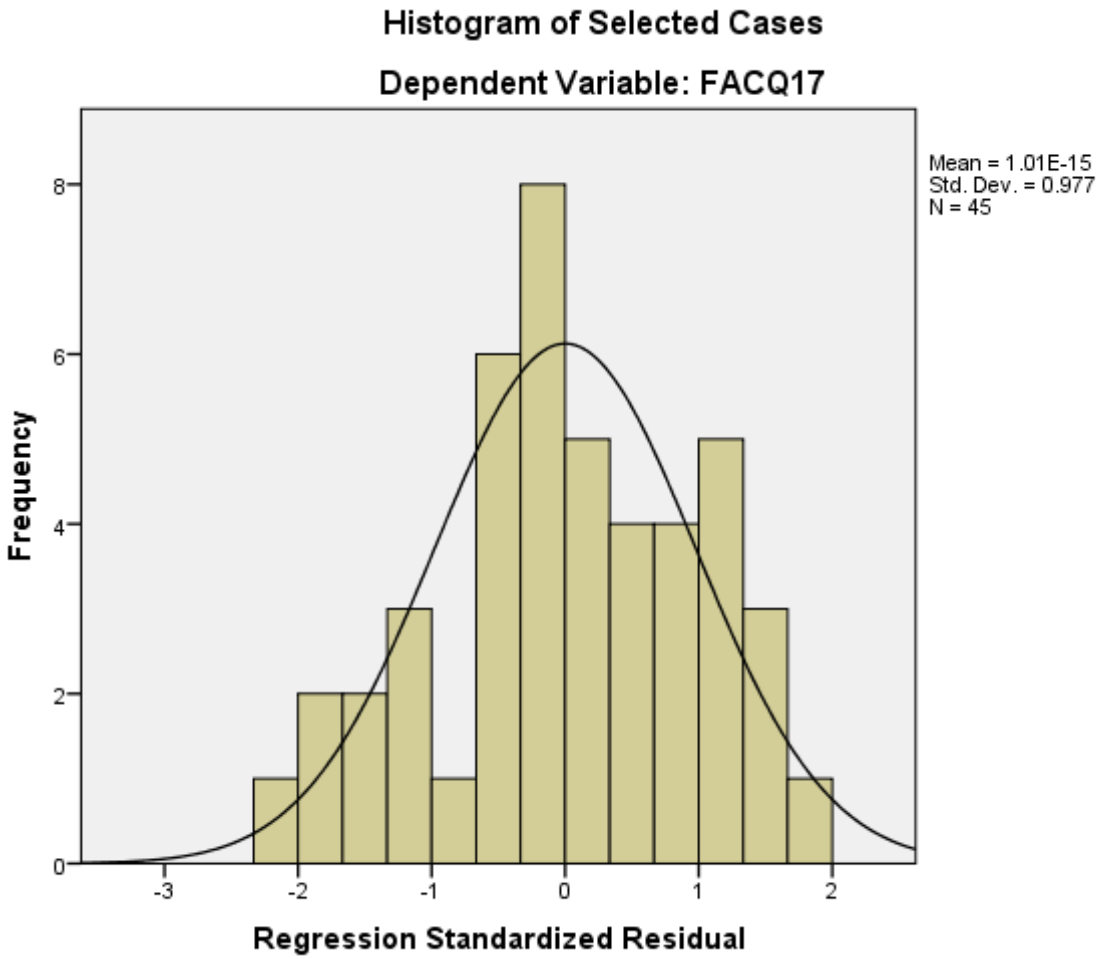

Figure J3: Standardised residuals for Attachment (FACQ-17) scores for fathers in the No Addiction group, predicted from the regression in Table 3:15 (Equation 3.2)

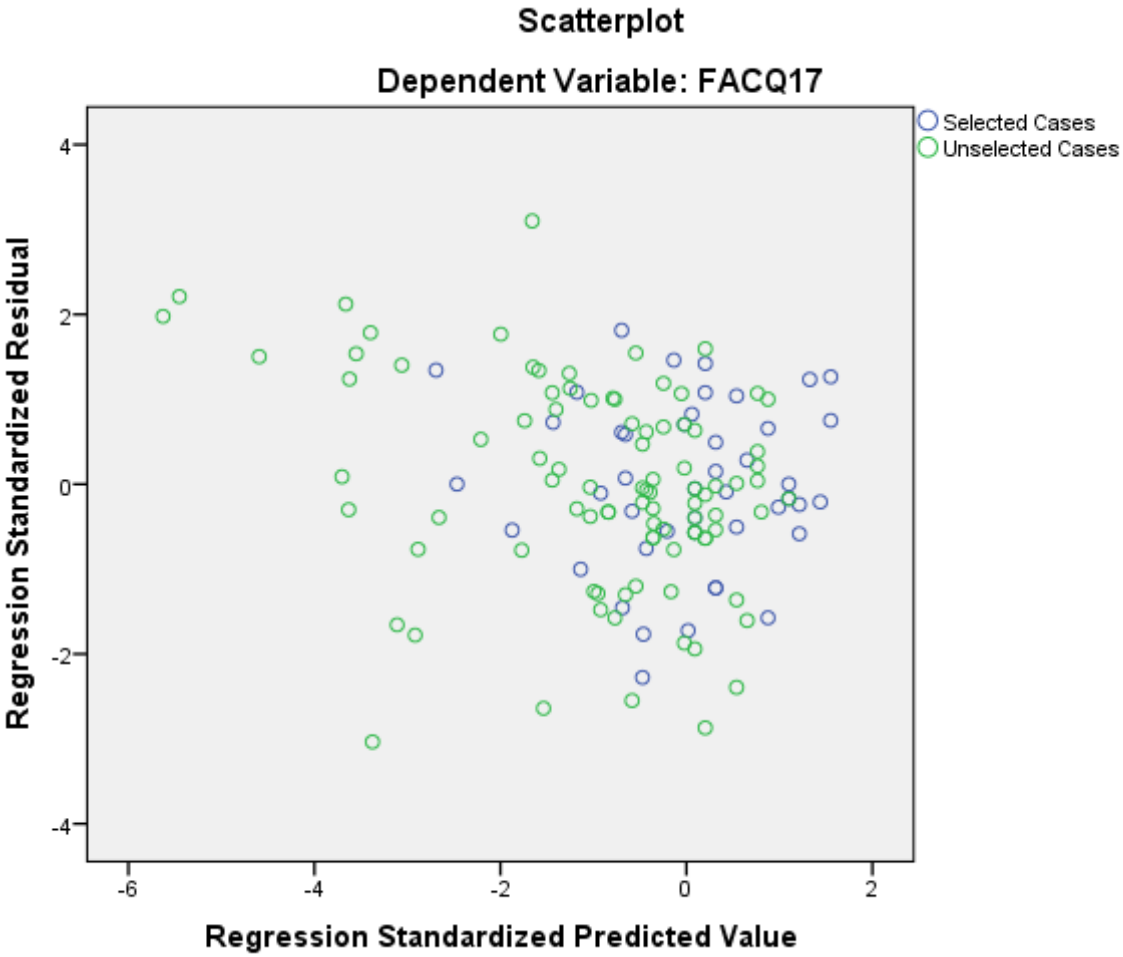

Figure J4: Plot of observed against predicted standardised residuals for Attachment (FACQ-17) scores for fathers in the No Addiction group, predicted from the regression in Table 3:15 (Equation 3.2)

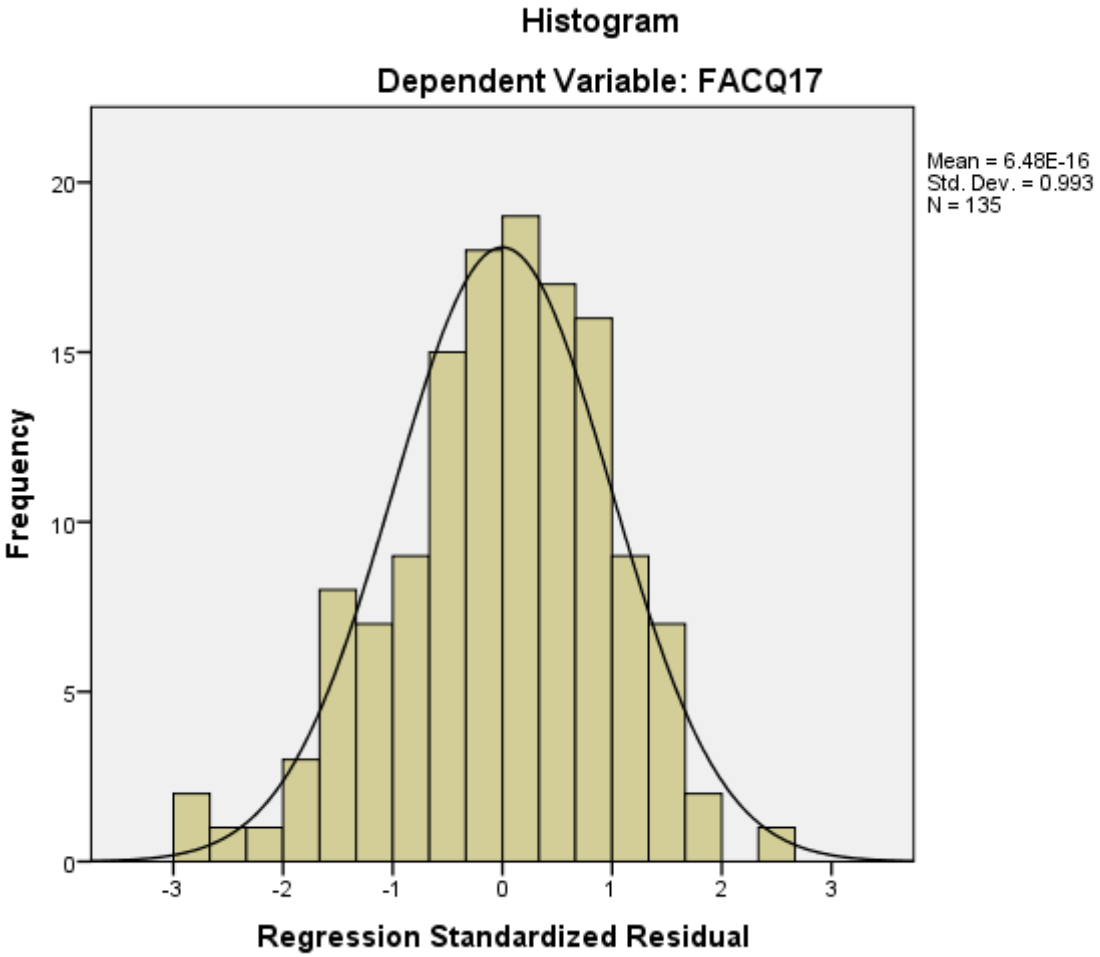

Figure J5: Standardised residuals for Attachment (FACQ-17) scores predicted from the regression in Table 3:16.

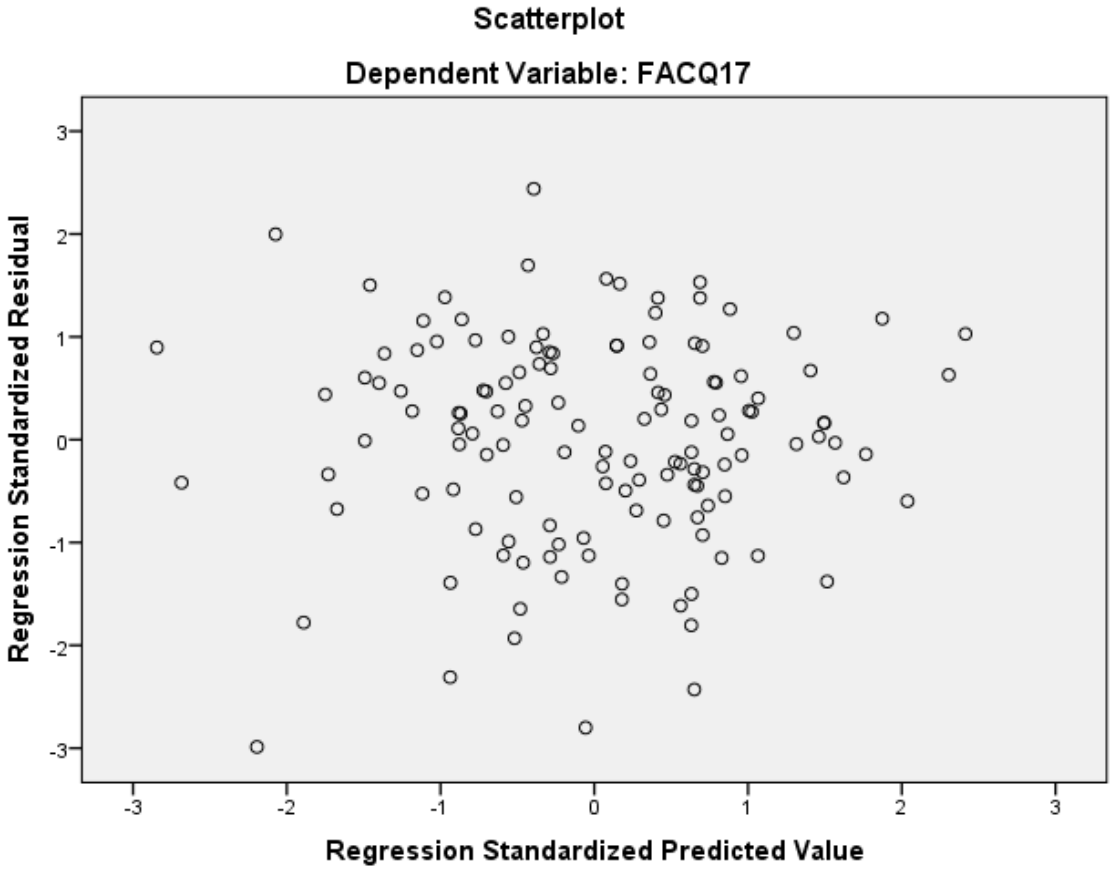

Figure J6: Plot of observed against predicted standardised residuals for Attachment (FACQ-17) scores from the regression in Table 3:16.

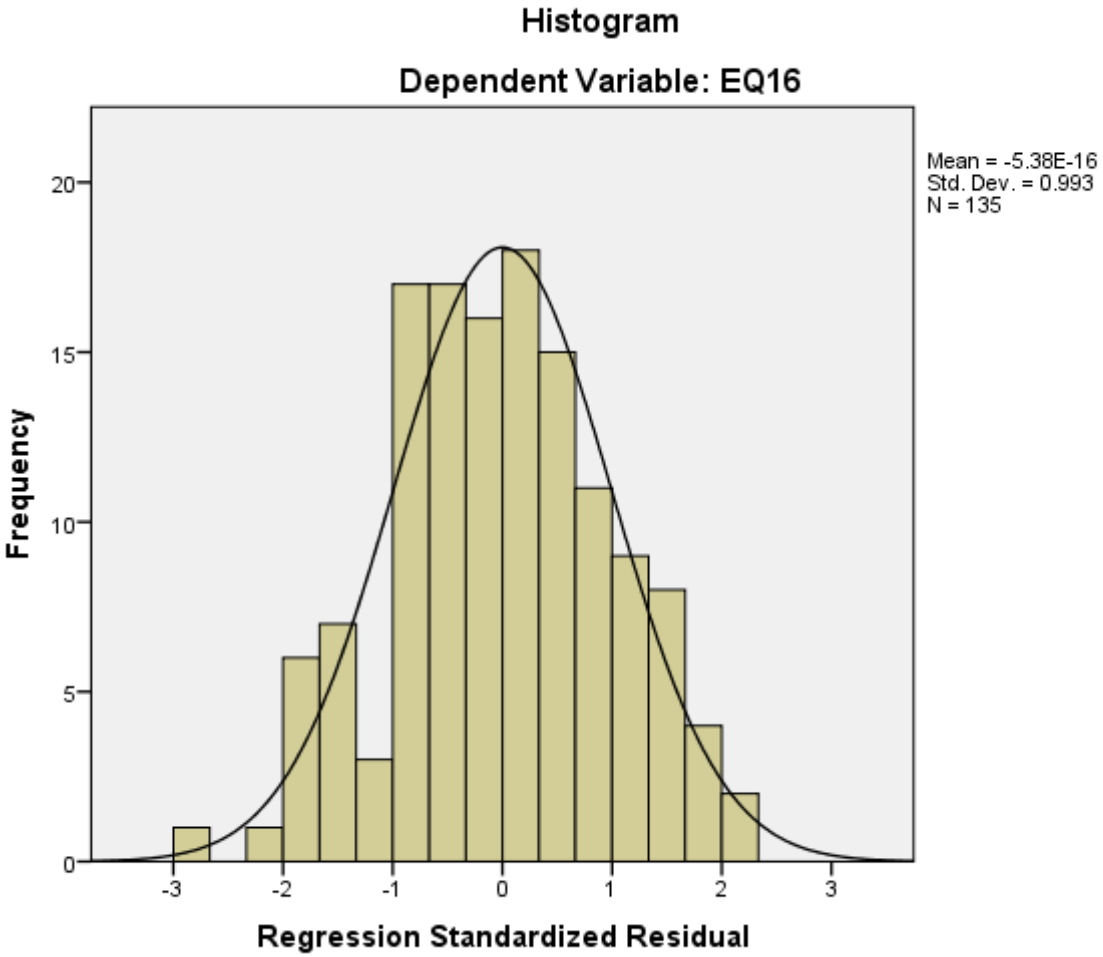

Figure J7: Standardised residuals for Empathy (EQ-16) scores predicted from the regression in Table 3:20.

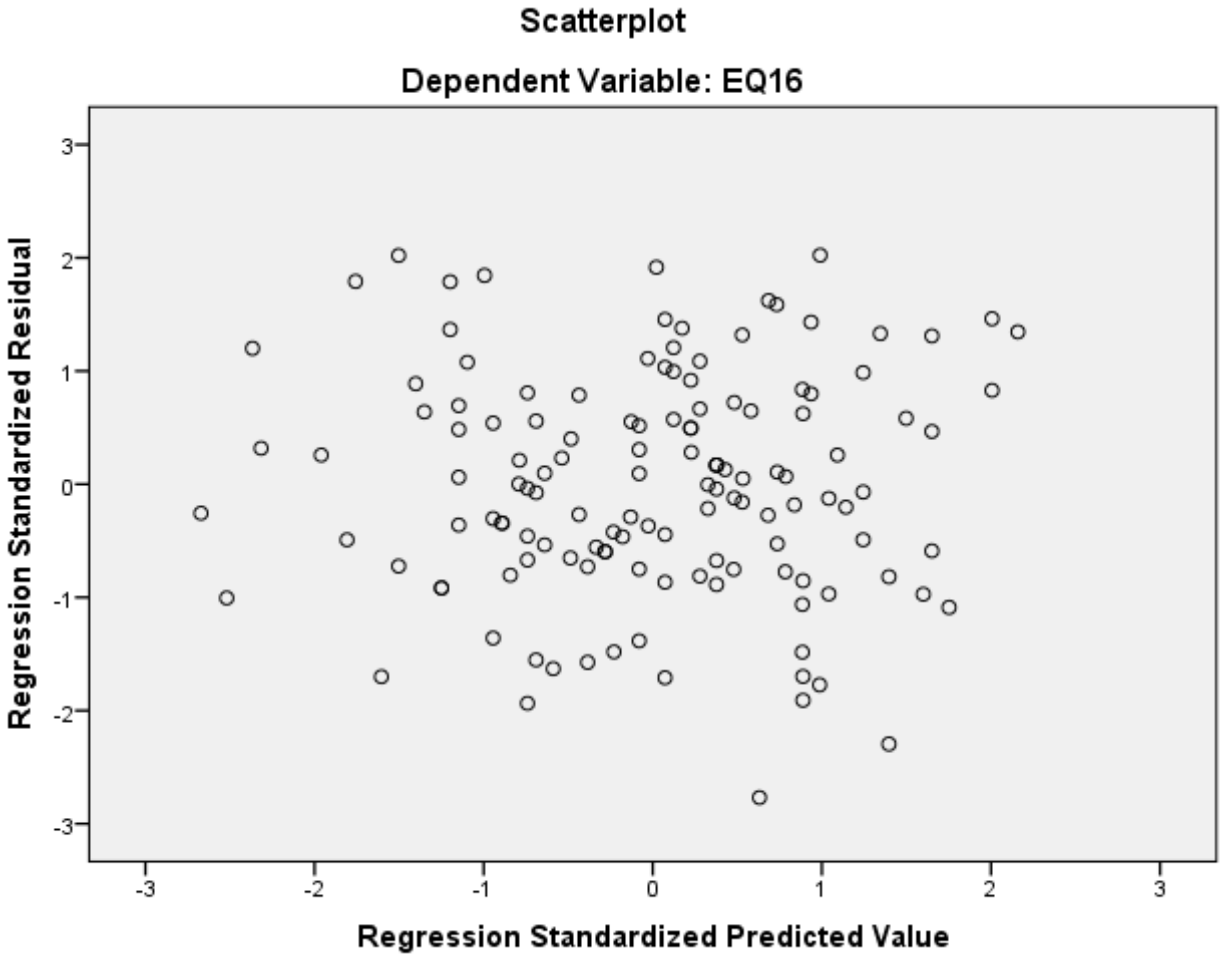

Figure J8: Plot of observed against predicted standardised residuals for Empathy (EQ-16) scores, predicted from the regression in Table 3:20.

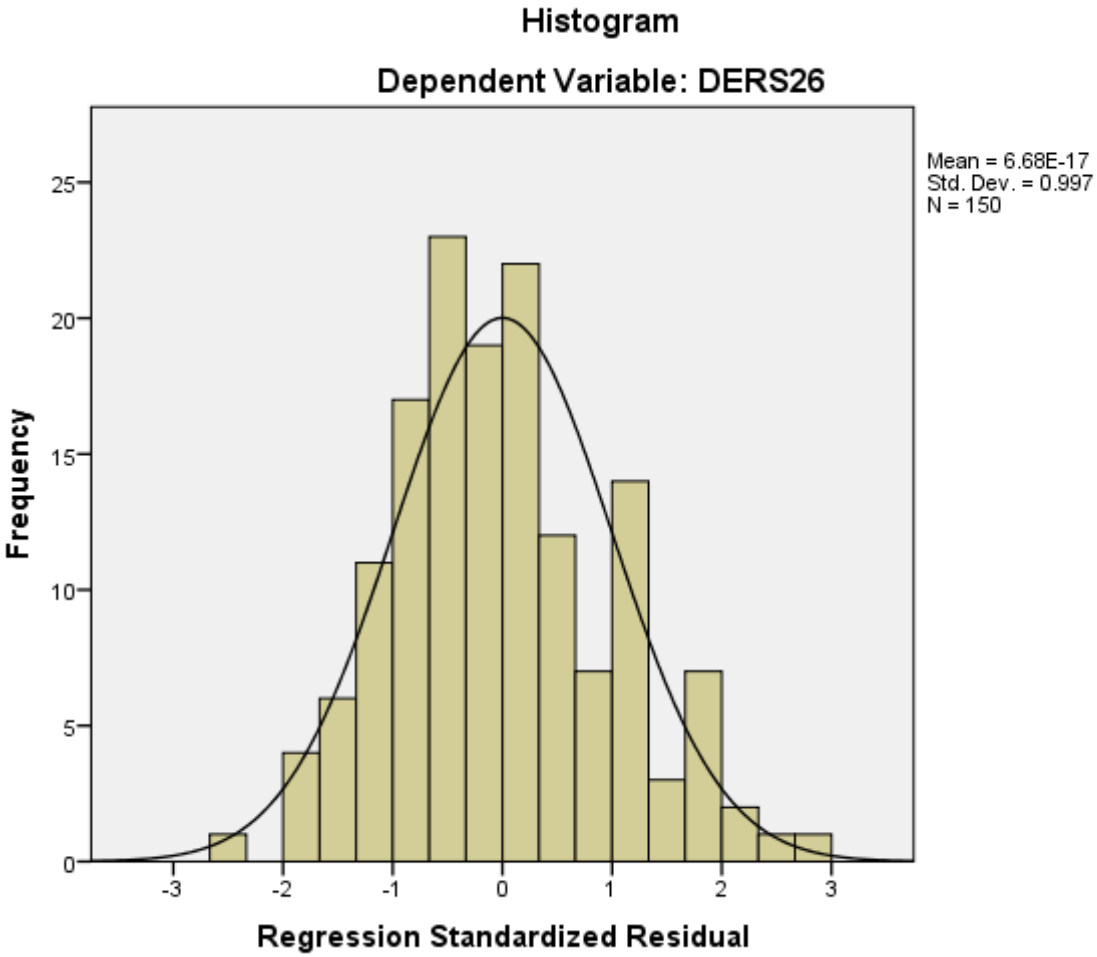

Figure J9: Standardised residuals for Emotion Regulation (DERS-26) scores predicted from the regression in Table 3:22.

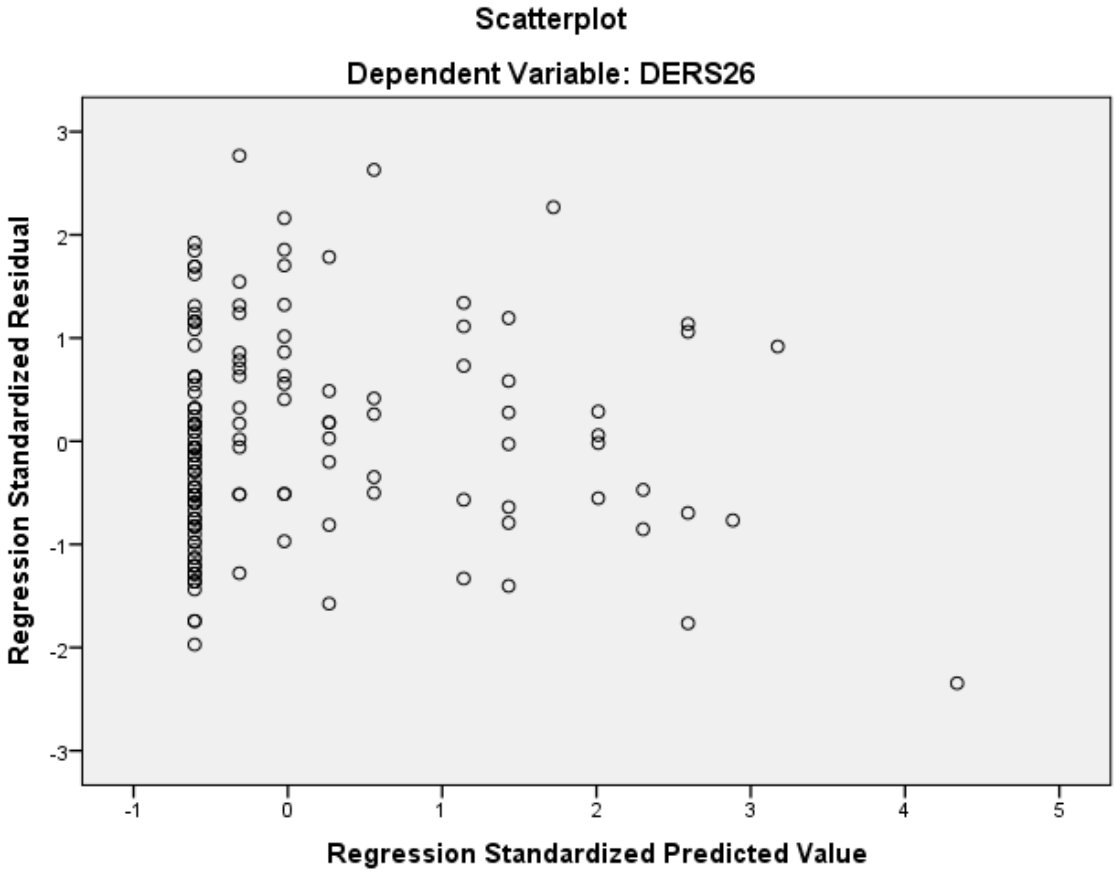

Figure J10: Plot of observed against predicted standardised residuals for Emotion Regulation (DERS-26) scores predicted from the regression in Table 3:22.

Appendix K: Questionnaire Item Distributions; Item intercorrelations; Tests for bivariate linearity and factorability

Table K1: Means, Standard Deviations, Skewness and Kurtosis for each item on Fathers' Attachment to Children Questionnaire (FACQ)

	N	Min.	Max.	Mean	Std. Dev.	Skewness		Kurtosis	
	Number	Score	Score	Statistic	Statistic	Statistic	Std. Error	Statistic	S.E.
A1	168	1	5	3.24	1.086	.068	.187	-1.333	.373
A2	168	2	5	4.29	.813	-1.247	.187	1.430	.373
A3	167	2	5	4.01	.764	-.583	.188	.275	.374
A4	167	1	5	4.01	.784	-.933	.188	1.471	.374
A5	167	1	5	3.77	.878	-.498	.188	.176	.374
A6	168	1	5	4.17	.922	-1.186	.187	.958	.373
A7	168	1	5	3.85	1.027	-.693	.187	-.472	.373
A8	167	1	5	3.63	.771	-.381	.188	.284	.374
A9	168	1	5	3.60	.877	-.457	.187	.248	.373
A10	165	1	5	4.63	.783	-2.643	.189	7.431	.376
A11	165	1	5	3.32	.949	-.540	.189	-.334	.376
A12	165	1	5	3.79	1.045	-.844	.189	.000	.376
A13	165	2	5	4.48	.590	-.817	.189	.683	.376
A14	164	2	5	4.15	.793	-.642	.190	-.111	.377
A15	165	1	5	4.04	.987	-1.229	.189	1.386	.376
A16	165	1	5	4.17	.928	-1.133	.189	.773	.376
A17	165	2	5	4.27	.758	-.999	.189	1.006	.376
A18	165	1	5	3.79	1.009	-.765	.189	-.041	.376
A19	165	1	5	4.46	.830	-2.269	.189	6.379	.376
A20	164	1	5	4.34	.868	-1.750	.190	3.593	.377
A21	163	1	5	4.28	.906	-1.447	.190	1.959	.378
A22	163	1	5	3.39	1.204	-.353	.190	-.988	.378
A23	164	2	5	4.60	.572	-1.314	.190	1.847	.377
A24	164	2	5	4.34	.785	-1.209	.190	1.287	.377
A25	163	2	5	4.23	.788	-1.040	.190	1.053	.378
A26	164	2	5	4.26	.790	-1.033	.190	.870	.377
A27	162	2	5	4.67	.590	-1.962	.191	4.475	.379
A28	164	2	5	3.87	.800	-.565	.190	.128	.377
A29	164	1	5	2.32	1.085	.610	.190	-.645	.377
A30	162	1	5	3.12	1.233	-.146	.191	-1.229	.379
A31	163	1	5	3.46	1.193	-.490	.190	-.836	.378
A32	163	1	5	4.30	.755	-1.260	.190	2.469	.378
A33	163	2	5	3.98	.757	-.918	.190	1.227	.378
A34	163	2	5	4.02	.741	-.490	.190	.156	.378

Table K2: Means, Standard Deviations, Skewness and Kurtosis for each item on Difficulties in Emotion Regulation Scales (DERS)

	N	Min.	Max.	Mean	Std. Dev.	Skewness		Kurtosis	
	Number	Score	Score	Statistic	Statistic	Statistic	S.E.	Statistic	Std. Error
ER1	161	1	5	2.34	.987	.784	.191	.080	.380
ER2	160	1	5	2.46	1.069	.552	.192	-.562	.381
ER3	160	1	5	1.86	.843	1.223	.192	2.045	.381
ER4	160	1	5	1.78	.916	1.444	.192	2.206	.381
ER5	158	1	5	1.89	1.026	1.294	.193	1.155	.384
ER6	161	1	5	2.85	1.195	-.042	.191	-1.329	.380
ER7	160	1	5	2.61	1.165	.364	.192	-1.054	.381
ER8	161	1	5	2.24	1.041	.642	.191	-.618	.380
ER9	161	1	5	1.84	.901	1.417	.191	2.299	.380
ER10	161	1	5	2.75	1.178	.193	.191	-1.134	.380
ER11	158	1	5	2.28	1.135	.744	.193	-.395	.384
ER12	158	1	5	2.15	1.089	1.070	.193	.482	.384
ER13	158	1	5	2.46	1.075	.770	.193	-.071	.384
ER14	158	1	5	1.58	.876	1.749	.193	2.991	.384
ER15	158	1	5	1.75	.942	1.347	.193	1.425	.384
ER16	158	1	5	1.92	1.120	1.142	.193	.380	.384
ER17	157	1	5	2.69	1.060	.214	.194	-1.126	.385
ER18	158	1	5	2.73	1.120	.321	.193	-.911	.384
ER19	158	1	5	1.81	1.048	1.398	.193	1.259	.384
ER20	158	1	5	2.65	1.046	.367	.193	-.813	.384
ER21	157	1	5	1.99	1.059	1.193	.194	.819	.385
ER22	157	1	5	2.28	1.085	.580	.194	-.730	.385
ER23	157	1	5	1.98	1.065	1.103	.194	.360	.385
ER24	157	1	5	2.25	1.115	.691	.194	-.617	.385
ER25	157	1	5	2.05	1.043	.997	.194	.255	.385
ER26	157	1	5	2.48	1.004	.967	.194	.287	.385
ER27	157	1	5	1.83	.926	1.368	.194	1.935	.385
ER28	156	1	5	1.79	1.016	1.520	.194	1.964	.386
ER29	157	1	5	2.08	1.031	1.075	.194	.710	.385
ER30	157	1	5	2.01	1.047	1.107	.194	.590	.385
ER31	156	1	5	1.78	.979	1.161	.194	.493	.386
ER32	156	1	5	1.61	.906	1.860	.194	3.534	.386
ER33	156	1	5	2.35	1.151	.730	.194	-.466	.386
ER34	156	1	5	3.08	1.156	-.126	.194	-1.143	.386
ER35	154	1	5	2.12	.992	.928	.195	.387	.389
ER36	154	1	5	2.22	1.133	.920	.195	-.028	.389

Table K3: Means, Standard Deviations, Skewness and Kurtosis for each item on Empathy Quotient (EQ)

	N	Min.	Max.	Mean	Std. Dev.	Skewness		Kurtosis	
	Number	Score	Score	Statistic	Statistic	Statistic	S.E.	Statistic	Std. Error
E1	153	0	2	1.39	.717	-.727	.196	-.737	.390
E4	154	0	2	.75	.786	.468	.195	-1.233	.389
E6	153	0	2	1.07	.775	-.114	.196	-1.322	.390
E8	154	0	2	.88	.840	.225	.195	-1.549	.389
E10	154	0	2	1.05	.765	-.088	.195	-1.279	.389
E11	153	0	2	.99	.807	.012	.196	-1.463	.390
E12	151	0	2	1.30	.807	-.595	.197	-1.210	.392
E14	152	0	2	1.33	.779	-.650	.197	-1.055	.391
E15	152	0	2	.82	.790	.328	.197	-1.324	.391
E18	151	0	2	1.34	.765	-.660	.197	-.993	.392
E19	152	0	2	1.07	.678	-.080	.197	-.800	.391
E21	149	0	2	.82	.754	.313	.199	-1.178	.395
E22	148	0	2	.95	.693	.063	.199	-.897	.396
E25	150	0	2	.86	.635	.123	.198	-.547	.394
E26	149	0	2	1.15	.672	-.182	.199	-.781	.395
E27	150	0	2	.95	.758	.089	.198	-1.245	.394
E28	149	0	2	.60	.676	.678	.199	-.630	.395
E29	149	0	1	.43	.497	.288	.199	-1.944	.395
E32	150	0	2	.99	.733	.021	.198	-1.122	.394
E34	150	0	2	.80	.803	.379	.198	-1.349	.394
E35	150	0	2	.92	.764	.137	.198	-1.269	.394
E36	149	0	2	1.05	.676	-.065	.199	-.785	.395
E37	150	0	2	.74	.660	.337	.198	-.746	.394
E38	148	0	2	1.48	.733	-1.033	.199	-.377	.396
E39	147	0	2	.34	.602	1.592	.200	1.435	.397
E41	145	0	2	1.13	.637	-.118	.201	-.555	.400
E42	145	0	2	.90	.690	.129	.201	-.882	.400
E43	144	0	2	1.03	.694	-.046	.202	-.898	.401
E44	145	0	2	1.02	.629	-.015	.201	-.429	.400
E46	144	0	2	1.03	.810	-.051	.202	-1.474	.401
E48	144	0	2	1.14	.781	-.249	.202	-1.317	.401
E49	145	0	2	.97	.697	.037	.201	-.916	.400
E50	145	0	2	.94	.724	.084	.201	-1.075	.400
E52	143	0	2	.99	.661	.015	.203	-.675	.403
E54	142	0	2	.79	.628	.192	.203	-.576	.404
E55	142	0	2	.99	.607	.006	.203	-.235	.404
E57	140	0	2	.68	.660	.458	.205	-.723	.407
E58	142	0	2	.83	.641	.166	.203	-.609	.404
E59	142	0	2	.66	.629	.406	.203	-.658	.404
E60	142	0	2	1.11	.695	-.155	.203	-.912	.404

Table K4: Means, Standard Deviations, Skewness and Kurtosis for each item on General Health Questionnaire (GHQ-28)

	N	Minimum	Maximum	Mean	Std. Dev.	Skewness		Kurtosis	
	Number	Score	Score	Statistic	Statistic	Statistic	S.E.	Statistic	S.E.
H1	154	1	4	1.84	.745	.561	.195	-.100	.389
H2	153	1	4	1.83	.793	.715	.196	.049	.390
H3	154	1	4	2.00	.856	.508	.195	-.421	.389
H4	154	1	4	1.60	.828	1.134	.195	.248	.389
H5	153	1	4	1.55	.760	1.242	.196	.814	.390
H6	154	1	4	1.49	.743	1.449	.195	1.427	.389
H7	154	1	4	1.28	.600	2.384	.195	5.868	.389
H8	154	1	4	1.86	.881	.748	.195	-.271	.389
H9	154	1	4	1.75	.860	.952	.195	.117	.389
H10	154	1	4	1.99	.863	.520	.195	-.457	.389
H11	154	1	4	1.79	.729	.651	.195	.169	.389
H12	154	1	4	1.47	.734	1.599	.195	2.219	.389
H13	154	1	4	1.81	.817	.811	.195	.121	.389
H14	153	1	4	1.68	.824	1.086	.196	.536	.390
H15	154	1	4	1.86	.616	.768	.195	2.462	.389
H16	154	1	4	2.11	.518	1.576	.195	4.968	.389
H17	154	1	4	1.86	.681	.942	.195	2.102	.389
H18	154	1	4	1.90	.664	.787	.195	1.780	.389
H19	153	1	4	1.90	.776	.771	.196	.581	.390
H20	151	1	4	1.87	.629	.433	.197	.846	.392
H21	153	1	4	1.94	.690	.563	.196	.735	.390
H22	154	1	4	1.51	.802	1.517	.195	1.476	.389
H23	154	1	4	1.32	.623	1.952	.195	3.187	.389
H24	154	1	4	1.19	.512	3.221	.195	12.105	.389
H25	154	1	4	1.30	.678	2.233	.195	4.025	.389
H26	152	1	3	1.25	.518	1.993	.197	3.163	.391
H27	154	1	4	1.22	.539	2.908	.195	9.624	.389
H28	154	1	4	1.32	.711	2.100	.195	3.184	.389

Table K5: Means, Standard Deviations, Skewness and Kurtosis for full-scale FACQ, DERS, GHQ, EQ

Descriptive Statistics

	N	Min.	Max.	Mean	Std. Dev.	Skewness		Kurtosis	
	Number	Score	Score	Statistic	Statistic	Statistic	S.E.	Statistic	S.E.
Attachment Scale (FACQ)	156	82.00	166.00	134.8141	15.29107	-.544	.194	.367	.386
Emotion Regulation Scale (DERS)	153	37.00	148.00	79.4837	23.59279	.612	.196	.032	.390
General Health Questionnaire (GHQ)	149	29.00	93.00	46.2819	12.26569	1.592	.199	3.205	.395
Empathy Quotient (EQ)	134	8.00	70.00	38.4627	11.95522	.133	.209	.196	.416
Valid N (listwise)	126								

Table K6: Means, Standard Deviations, Skewness and Kurtosis for revised scales: FACQ-17, DERS-26, DEP, EQ-16

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Number	Score	Score	Statistic	Statistic	Statistic	S.E.	Statistic	S.E.
FACQ17	163	40.00	83.00	67.1963	7.64398	-.534	.190	.446	.378
DERS26	152	27.00	106.00	58.9737	16.44173	.529	.197	-.087	.391
Depression scale on GHQ	153	7.00	24.00	9.0458	3.41502	1.930	.196	3.260	.390
EQ16	138	3.00	31.00	16.8913	5.92863	.095	.206	-.215	.410
Valid N (listwise)	135								

Tables K7: Selected Intercorrelations from FACQ

Table K7(a): Items 1-14

Item	A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11	A12	A13
A2	.36**												
A3	.22**	.43**											
A4	.23**	.31**	.44**										
A5	.12	.31**	.51**	.53**									
A6	.51**	.55**	.25**	.25**	.21**								
A7	.25**	.56**	.35**	.24**	.26**	.33**							
A8	.21**	.23**	.41**	.37**	.6-**	.27**	.26**						
A9	.12	.27**	.40**	.44**	.70**	.16*	.37**	.47**					
A10	.13	.35**	.30**	.19*	.23**	.34**	.39**	.27**	.34**				
A11	-.09	.16*	.18*	.03	.22**	.03	.15	.12	.19*	.11			
A12	.20**	.28**	.27**	.15	.30**	.12	.31**	.35**	.33**	.40**	.11		
A13	.08	.31**	.33**	.35**	.36**	.26**	.22**	.33**	.32**	.41**	.11	.34**	
A14	.09	.34**	.51**	.40**	.48**	.20**	.33**	.36**	.47**	.36**	.19*	.36**	.57**

*p<.05; **p<.01

Table K7(b): Items 15-22

Item	A15	A16	A17	A18	A18	A20	A21
A16	.51**						
A17	.34**	.44**					
A18	.45**	.59**	.47**				
A19	.35**	.25**	.29**	.41**			
A20	.49**	.42**	.41**	.54**	.51**		
A21	.09	.12	.09	.28**	.48**	.25**	
A22	.19*	.28**	.27**	.48**	.28**	.38**	.19*

*p<.05; **p<.01

Table K7(c): Items 23-28

Item	A23	A24	A25	A26	A27
A24	.44**				
A25	.48**	.51**			
A26	.35**	.16*	.31**		
A27	.55**	.49**	.40**	.33**	
A28	.35**	.54**	.44**	.13	.34**

*p<.05; **p<.01

Table K7(d): Items 29-34

Item	A29	A30	A31	A32	A33
A30	.53				
A31	.41	.59**			
A32	.10	.31**	.27**		
A33	.14	.16*	.10	.23**	
A34	.10	.30**	.32**	.41**	.44**

*p<.05; **p<.01

Table K8: Test of Bivariate Linearity – Items A1 & A6

			Sum of Squares	df	Mean Square	F	Sig.
A6 * A1	Between Groups	(Combined)	37.940	4	9.485	14.858	.000
		Linearity	37.477	1	37.477	58.707	.000
		Deviation from Linearity	.463	3	.154	.242	.867
	Within Groups		104.054	163	.638		
	Total		141.994	167			

Table K9: Test of Bivariate Linearity – Items A2 & A3

			Sum of Squares	df	Mean Square	F	Sig.
A3 * A2	Between Groups	(Combined)	19.068	3	6.356	13.295	.000
		Linearity	18.141	1	18.141	37.946	.000
		Deviation from Linearity	.927	2	.463	.969	.382
	Within Groups		77.926	163	.478		
	Total		96.994	166			

Table K10: Test of Bivariate Linearity – Items A4 & A5

			Sum of Squares	df	Mean Square	F	Sig.
A5 * A4	Between Groups	(Combined)	37.322	4	9.331	16.868	.000
		Linearity	35.883	1	35.883	64.868	.000
		Deviation from Linearity	1.440	3	.480	.867	.459
	Within Groups		89.612	162	.553		
	Total		126.934	166			

Table K11: Test of Bivariate Linearity – Items A7 & A10

			Sum of Squares	df	Mean Square	F	Sig.
A10 * A7	Between Groups	(Combined)	18.292	4	4.573	8.906	.000
		Linearity	14.909	1	14.909	29.036	.000
		Deviation from Linearity	3.383	3	1.128	2.196	.091
	Within Groups		82.156	160	.513		
	Total		100.448	164			

Table K12: Test of Bivariate Linearity – Items A8 & A9

			Sum of Squares	df	Mean Square	F	Sig.
A9 * A8	Between Groups	(Combined)	30.944	4	7.736	12.929	.000
		Linearity	28.238	1	28.238	47.193	.000
		Deviation from Linearity	2.707	3	.902	1.508	.214
	Within Groups		97.532	163	.598		
	Total		128.476	167			

Table K13: Test of Bivariate Linearity – Items A15 & A16

			Sum of Squares	df	Mean Square	F	Sig.
A16 * A15	Between Groups	(Combined)	38.882	4	9.721	15.193	.000
		Linearity	36.132	1	36.132	56.475	.000
		Deviation from Linearity	2.750	3	.917	1.433	.235
	Within Groups		102.366	160	.640		
	Total		141.248	164			

Table K14: Test of Bivariate Linearity – Items A17 & A18

			Sum of Squares	df	Mean Square	F	Sig.
A18 * A17	Between Groups	(Combined)	40.976	3	13.659	17.450	.000
		Linearity	37.011	1	37.011	47.285	.000
		Deviation from Linearity	3.966	2	1.983	2.533	.083
	Within Groups		126.018	161	.783		
	Total		166.994	164			

Table K15: Test of Bivariate Linearity – Items A19 & A20

			Sum of Squares	df	Mean Square	F	Sig.
A20 * A19	Between Groups	(Combined)	34.452	4	8.613	15.487	.000
		Linearity	31.972	1	31.972	57.490	.000
		Deviation from Linearity	2.480	3	.827	1.486	.220
	Within Groups		88.426	159	.556		
	Total		122.878	163			

Table K16: Test of Bivariate Linearity – Items A23 & A24

			Sum of Squares	df	Mean Square	F	Sig.
A24 * A23	Between Groups	(Combined)	19.707	3	6.569	13.000	.000
		Linearity	18.993	1	18.993	37.588	.000
		Deviation from Linearity	.714	2	.357	.706	.495
	Within Groups		80.848	160	.505		
	Total		100.555	163			

Table K17: Test of Bivariate Linearity – Items A25 & A28

			Sum of Squares	df	Mean Square	F	Sig.
A28 * A25	Between Groups	(Combined)	25.957	3	8.652	17.562	.000
		Linearity	19.921	1	19.921	40.433	.000
		Deviation from Linearity	6.036	2	3.018	6.126	.003
	Within Groups		78.337	159	.493		
	Total		104.294	162			

Table K18: Test of Bivariate Linearity – Items A26 & A27

			Sum of Squares	df	Mean Square	F	Sig.
A27 * A26	Between Groups	(Combined)	6.492	3	2.164	6.583	.000
		Linearity	6.391	1	6.391	19.442	.000
		Deviation from Linearity	.101	2	.051	.154	.857
	Within Groups		52.268	159	.329		
	Total		58.761	162			

Table K19: Test of Bivariate Linearity – Items A29 & A30

			Sum of Squares	df	Mean Square	F	Sig.
A30 * A29	Between Groups	(Combined)	77.507	4	19.377	18.416	.000
		Linearity	68.758	1	68.758	65.350	.000
		Deviation from Linearity	8.749	3	2.916	2.772	.043
	Within Groups		167.292	159	1.052		
	Total		244.799	163			

Table K20: Test of Bivariate Linearity – Items A31 & A34

			Sum of Squares	df	Mean Square	F	Sig.
A34 * A31	Between Groups	(Combined)	12.699	4	3.175	6.532	.000
		Linearity	9.206	1	9.206	18.942	.000
		Deviation from Linearity	3.493	3	1.164	2.396	.070
	Within Groups		77.276	159	.486		
	Total		89.976	163			

Tables K21: Selected Intercorrelations from EQ

Table K21(a): Items 1, 25, 26, 36, 41, 44, 52, 54, 55, 58

Item	E1	E25	E26	E36	E41	E44	E52	E54	E55
E25	.23**								
E26	.40**	.51**							
E36	.31**	.48**	.48**						
E41	.42**	.30**	.53**	.43**					
E44	.41**	.38**	.49**	.51**	.58**				
E52	.42**	.34**	.49**	.49**	.34**	.44**			
E54	.22**	.44**	.42**	.42**	.27**	.33**	.49**		
E55	.27**	.34**	.49**	.45**	.43**	.47**	.48**	.46**	
E58	.16	.32**	.36**	.49**	.25**	.39**	.44**	.44**	.45**

*p<.05; **p<.01

Table K21(b): Items 4, 8, 12, 14, 35, 57

Item	E4	E8	E12	E14	E35
E8	.00				
E12	.16	.39**			
E14	.11	.20*	.30**		
E35	.14	41**	.23**	.26**	
E57	.09	.09	.06	.07	.10

*p<.05; **p<.01

Table K21(c): Items 21, 22, 27, 29, 32, 42, 43, 48, 50, 59

Item	E21	E22	E27	E29	E32	E42	E43	E48	E50
E22	.37**								
E27	.21*	.14							
E29	-.06	-.06	-.06						
E32	.12	.16	.29**	.10					
E42	.07	.37**	.09	-.14	.30**				
E43	.25**	.43**	.19*	-.06	.37**	.41**			
E48	.35**	,24**	.29**	-.05	.19*	.21*	.31**		
E50	.15	.09	.31**	.04	.26**	.13	.05	.13	
E59	.07	.01	-.02	.10	.12	.14	.15	-.02	-.09

*p<.05; **p<.01

Table K22: Test of Bivariate Linearity – Items E1 & E41

			Sum of Squares	df	Mean Square	F	Sig.
E41 * E1	Between Groups	(Combined)	11.038	2	5.519	16.509	.000
		Linearity	10.407	1	10.407	31.131	.000
		Deviation from Linearity	.631	1	.631	1.887	.172
	Within Groups		47.472	142	.334		
	Total		58.510	144			

Table K23: Test of Bivariate Linearity – Items E25 & E26

			Sum of Squares	df	Mean Square	F	Sig.
E26 * E25	Between Groups	(Combined)	17.718	2	8.859	26.377	.000
		Linearity	17.213	1	17.213	51.252	.000
		Deviation from Linearity	.505	1	.505	1.503	.222
	Within Groups		49.034	146	.336		
	Total		66.752	148			

Table K24: Test of Bivariate Linearity – Items E36 & E44

			Sum of Squares	df	Mean Square	F	Sig.
E44 * E36	Between Groups	(Combined)	14.762	2	7.381	25.255	.000
		Linearity	14.348	1	14.348	49.093	.000
		Deviation from Linearity	.414	1	.414	1.417	.236
	Within Groups		41.210	141	.292		
	Total		55.972	143			

Table K25: Test of Bivariate Linearity – Items E52 & E55

			Sum of Squares	df	Mean Square	F	Sig.
E55 * E52	Between Groups	(Combined)	13.013	2	6.507	23.215	.000
		Linearity	11.940	1	11.940	42.600	.000
		Deviation from Linearity	1.074	1	1.074	3.830	.052
	Within Groups		38.959	139	.280		
	Total		51.972	141			

Table K26: Test of Bivariate Linearity – Items E54 & E58

			Sum of Squares	df	Mean Square	F	Sig.
E54 * E58	Between Groups	(Combined)	10.752	2	5.376	16.639	.000
		Linearity	10.726	1	10.726	33.197	.000
		Deviation from Linearity	.026	1	.026	.082	.775
	Within Groups		44.910	139	.323		
	Total		55.662	141			

Table K27: Test of Bivariate Linearity – Items E4 & E8

			Sum of Squares	df	Mean Square	F	Sig.
E8 * E4	Between Groups	(Combined)	5.912	2	2.956	4.377	.014
		Linearity	5.865	1	5.865	8.684	.004
		Deviation from Linearity	.047	1	.047	.069	.793
	Within Groups		101.984	151	.675		
	Total		107.896	153			

Table K28: Test of Bivariate Linearity – Items E12 & E14

			Sum of Squares	df	Mean Square	F	Sig.
E14 * E12	Between Groups	(Combined)	8.704	2	4.352	7.818	.001
		Linearity	8.263	1	8.263	14.843	.000
		Deviation from Linearity	.441	1	.441	.792	.375
	Within Groups		82.395	148	.557		
	Total		91.099	150			

Table K29: Test of Bivariate Linearity – Items E35 & E57

			Sum of Squares	df	Mean Square	F	Sig.
E57 * E35	Between Groups	(Combined)	1.548	2	.774	1.798	.170
		Linearity	.598	1	.598	1.390	.241
		Deviation from Linearity	.950	1	.950	2.206	.140
	Within Groups		58.988	137	.431		
	Total		60.536	139			

Table K30: Test of Bivariate Linearity – Items E21 & E22

			Sum of Squares	df	Mean Square	F	Sig.
E22 * E21	Between Groups	(Combined)	15.422	2	7.711	20.377	.000
		Linearity	9.815	1	9.815	25.937	.000
		Deviation from Linearity	5.607	1	5.607	14.818	.000
	Within Groups		55.249	146	.378		
	Total		70.671	148			

Table K31: Test of Bivariate Linearity – Items E27 & E50

			Sum of Squares	df	Mean Square	F	Sig.
E27 * E50	Between Groups	(Combined)	8.065	2	4.032	7.770	.001
		Linearity	8.054	1	8.054	15.521	.000
		Deviation from Linearity	.010	1	.010	.020	.888
	Within Groups		73.687	142	.519		
	Total		81.752	144			

Table K32: Test of Bivariate Linearity – Items E42 & E43

			Sum of Squares	df	Mean Square	F	Sig.
E43 * E42	Between Groups	(Combined)	12.008	2	6.004	14.899	.000
		Linearity	11.822	1	11.822	29.337	.000
		Deviation from Linearity	.185	1	.185	.460	.499
	Within Groups		56.819	141	.403		
	Total		68.826	143			

Table K33: Test of Bivariate Linearity – Items E48 & E59

			Sum of Squares	df	Mean Square	F	Sig.
E59 * E48	Between Groups	(Combined)	.190	2	.095	.238	.788
		Linearity	.012	1	.012	.029	.865
		Deviation from Linearity	.179	1	.179	.447	.505
	Within Groups		55.143	138	.400		
	Total		55.333	140			

Table K34: Selected Intercorrelations from DERS

Table K34(a): Items 1, 4, 5, 7, 9

Item	ER1	ER4	ER5	ER7
ER4	.30**			
ER5	.34**	.68**		
ER7	.48**	.53**	.55**	
ER9	.31**	.58**	.62**	.42**

*p<.05; **p<.01

Table K34(b): Items 2, 6, 8, 10, 17, 34

Item	ER2	ER6	ER8	ER10	ER17
ER6	.53**				
ER8	.59**	.63**			
ER10	.53**	.58**	.54**		
ER17	.32**	.44**	.39**	.37**	
ER34	.38**	.44**	.39**	.45**	.22**

*p<.05; **p<.01

Table K34(c): Items 3, 14, 19, 24, 27, 32

Item	ER3	ER14	ER19	ER24	ER27
ER14	.54**				
ER19	.61**	.69**			
ER24	.41**	.42**	.51**		
ER27	.58**	.69**	.70**	.45**	
ER32	.56**	.66**	.63**	.32**	.73**

*p<.05; **p<.01

Table K34(d): Items 11, 12, 21, 23, 25, 29

Item	ER11	ER12	ER21	ER23	ER25
ER12	.73**				
ER21	.64**	.62**			
ER23	.50**	.50**	.62**		
ER25	.60**	.56**	.65**	.58**	
ER29	.59**	.57**	.76**	.58**	.65**

*p<.05; **p<.01

Table K34(e): Items 13, 18, 20, 26, 33

Item	ER13	ER18	ER20	ER26
ER18	.62**			
ER20	.45**	.51**		
ER26	.61**	.72**	.52**	
ER33	.53**	.68**	.41**	.67**

*p<.05; **p<.01

Table K34(f): Items 15, 16, 22, 28, 30, 31, 35, 36

Item	ER15	ER16	ER22	ER28	ER30	ER31	ER35
ER16	.63**						
ER22	.48**	.42**					
ER28	.58**	.70**	.57**				
ER30	.40**	.59**	.30**	.58**			
ER31	.48**	.63**	.44**	.68**	.62**		
ER35	.54**	.61**	.45**	.63**	.54**	.63**	
ER36	.47**	.62**	.35**	.59**	.63**	.63**	.62**

*p<.05; **p<.01

Table K35: Test of Bivariate Linearity – Items ER1 & ER7

			Sum of Squares	df	Mean Square	F	Sig.
ER7 * ER1	Between Groups	(Combined)	57.044	4	14.261	13.985	.000
		Linearity	49.445	1	49.445	48.488	.000
		Deviation from Linearity	7.599	3	2.533	2.484	.063
	Within Groups		159.080	156	1.020		
	Total		216.124	160			

Table K36: Test of Bivariate Linearity – Items ER4 & ER5

			Sum of Squares	df	Mean Square	F	Sig.
ER5 * ER4	Between Groups	(Combined)	77.928	4	19.482	34.008	.000
		Linearity	75.701	1	75.701	132.145	.000
		Deviation from Linearity	2.226	3	.742	1.295	.278
	Within Groups		87.648	153	.573		
	Total		165.576	157			

Table K37: Test of Bivariate Linearity – Items ER2 & ER10

			Sum of Squares	df	Mean Square	F	Sig.
ER2 * ER10	Between Groups	(Combined)	54.305	4	13.576	16.508	.000
		Linearity	50.922	1	50.922	61.920	.000
		Deviation from Linearity	3.382	3	1.127	1.371	.254
	Within Groups		127.470	155	.822		
	Total		181.775	159			

Table K38: Test of Bivariate Linearity – Items ER6 & ER17

			Sum of Squares	df	Mean Square	F	Sig.
ER6 * ER17	Between Groups	(Combined)	43.768	4	10.942	9.457	.000
		Linearity	42.316	1	42.316	36.571	.000
		Deviation from Linearity	1.452	3	.484	.418	.740
	Within Groups		175.875	152	1.157		
	Total		219.643	156			

Table K39: Test of Bivariate Linearity – Items ER8 & ER34

			Sum of Squares	df	Mean Square	F	Sig.
ER8 * ER34	Between Groups	(Combined)	25.084	4	6.271	6.661	.000
		Linearity	25.034	1	25.034	26.590	.000
		Deviation from Linearity	.050	3	.017	.018	.997
	Within Groups		142.166	151	.941		
	Total		167.250	155			

Table K40: Test of Bivariate Linearity – Items ER3 & ER19

			Sum of Squares	df	Mean Square	F	Sig.
ER3 * ER19	Between Groups	(Combined)	39.799	4	9.950	24.459	.000
		Linearity	37.560	1	37.560	92.332	.000
		Deviation from Linearity	2.239	3	.746	1.835	.143
	Within Groups		61.832	152	.407		
	Total		101.631	156			

Table K41: Test of Bivariate Linearity – Items ER14 & ER27

			Sum of Squares	df	Mean Square	F	Sig.
ER27 * ER14	Between Groups	(Combined)	65.308	4	16.327	36.290	.000
		Linearity	63.043	1	63.043	140.124	.000
		Deviation from Linearity	2.266	3	.755	1.678	.174
	Within Groups		68.386	152	.450		
	Total		133.694	156			

Table K42: Test of Bivariate Linearity – Items ER24 & ER32

			Sum of Squares	df	Mean Square	F	Sig.
ER24 * ER32	Between Groups	(Combined)	31.244	4	7.811	7.327	.000
		Linearity	19.687	1	19.687	18.467	.000
		Deviation from Linearity	11.557	3	3.852	3.613	.015
	Within Groups		160.980	151	1.066		
	Total		192.224	155			

Table K43: Test of Bivariate Linearity – Items ER11 & ER12

			Sum of Squares	df	Mean Square	F	Sig.
ER11 * ER12	Between Groups	(Combined)	109.060	4	27.265	44.796	.000
		Linearity	106.933	1	106.933	175.688	.000
		Deviation from Linearity	2.127	3	.709	1.165	.325
	Within Groups		93.124	153	.609		
	Total		202.184	157			

Table K44: Test of Bivariate Linearity – Items ER21 & ER29

			Sum of Squares	df	Mean Square	F	Sig.
ER21 * ER29	Between Groups	(Combined)	107.155	4	26.789	60.023	.000
		Linearity	101.984	1	101.984	228.506	.000
		Deviation from Linearity	5.171	3	1.724	3.862	.011
	Within Groups		67.839	152	.446		
	Total		174.994	156			

Table K45: Test of Bivariate Linearity – Items ER23 & ER25

			Sum of Squares	df	Mean Square	F	Sig.
ER23 * ER25	Between Groups	(Combined)	63.412	4	15.853	21.224	.000
		Linearity	59.145	1	59.145	79.186	.000
		Deviation from Linearity	4.266	3	1.422	1.904	.131
	Within Groups		113.531	152	.747		
	Total		176.943	156			

Table K46: Test of Bivariate Linearity – Items ER13 & ER18

			Sum of Squares	df	Mean Square	F	Sig.
ER13 * ER18	Between Groups	(Combined)	76.695	4	19.174	28.052	.000
		Linearity	70.028	1	70.028	102.454	.000
		Deviation from Linearity	6.668	3	2.223	3.252	.023
	Within Groups		104.577	153	.684		
	Total		181.272	157			

Table K47: Test of Bivariate Linearity – Items ER26 & ER20

			Sum of Squares	df	Mean Square	F	Sig.
ER26 * ER20	Groups	(Combined)	44.662	4	11.166	15.085	.000
		Linearity	42.246	1	42.246	57.074	.000
		Deviation from Linearity	2.417	3	.806	1.088	.356
	Within Groups		112.510	152	.740		
	Total		157.172	156			

Table K48: Test of Bivariate Linearity – Items ER15 & ER16

			Sum of Squares	df	Mean Square	F	Sig.
ER16 * ER15	Between Groups	(Combined)	80.506	4	20.127	26.414	.000
		Linearity	79.161	1	79.161	103.889	.000
		Deviation from Linearity	1.345	3	.448	.588	.624
	Within Groups		116.583	153	.762		
	Total		197.089	157			

Table K49: Test of Bivariate Linearity – Items ER30 & ER31

			Sum of Squares	df	Mean Square	F	Sig.
ER30 * ER31	Between Groups	(Combined)	68.009	4	17.002	24.930	.000
		Linearity	66.251	1	66.251	97.140	.000
		Deviation from Linearity	1.759	3	.586	.859	.464
	Within Groups		102.984	151	.682		
	Total		170.994	155			

Table K50: Test of Bivariate Linearity – Items ER28 & ER36

			Sum of Squares	df	Mean Square	F	Sig.
ER28 * ER36	Between Groups	(Combined)	57.630	4	14.407	21.220	.000
		Linearity	55.214	1	55.214	81.321	.000
		Deviation from Linearity	2.416	3	.805	1.186	.317
	Within Groups		100.488	148	.679		
	Total		158.118	152			

Table K51: Tests for Factorability of the FACQ

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.864
Bartlett's Test of Sphericity	Approx. Chi-Square	2634.905
	df	561
	Sig.	.000

Table K52: Tests for Factorability of the EQ

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.792
Bartlett's Test of Sphericity	Approx. Chi-Square	2038.035
	df	780
	Sig.	.000

Table K53: Tests for Factorability of the DERS

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.919
Bartlett's Test of Sphericity	Approx. Chi-Square	3897.804
	df	630
	Sig.	.000

Appendix L: Tables showing results of Invariance tests

Table L1: Tests for configural invariance for FACQ-17 across face-to-face and online groups

Model Fit

Number of distinct sample moments	340
Number of distinct parameters estimated	114
Degrees of freedom (340 - 114)	226
Chi-square	347.5
Chi-square divided by degrees of freedom	1.54
RMSEA default model	.057
RMSEA independence model	.142
CFI default model	.882
CFI independence model	.000

Table L2: Tests for metric invariance for FACQ-17 across face-to-face and online groups

Model Fit

Number of distinct sample moments	340
Number of distinct parameters estimated	97
Degrees of freedom (340 - 97)	243
Chi-square	369.9
Chi-square divided by degrees of freedom	1.52
RMSEA default model	.056
RMSEA independence model	.142
CFI default model	.877
CFI independence model	.000

Table L3: Tests for configural invariance for EQ-16 across face-to-face and online groups

Model Fit

Number of distinct sample moments	304
Number of distinct parameters estimated	108
Degrees of freedom (304 - 108)	196
Chi-square	249.1
Chi-square divided by degrees of freedom	1.27
RMSEA default model	.040
RMSEA independence model	.111
CFI default model	.905
CFI independence model	.000

Table L4: Tests for metric invariance for EQ-16 across face-to-face and online groups

Model Fit

Number of distinct sample moments	304
Number of distinct parameters estimated	92
Degrees of freedom (304 - 92)	212
Chi-square	288.9
Chi-square divided by degrees of freedom	1.36
RMSEA default model	.047
RMSEA independence model	.111
CFI default model	.862
CFI independence model	.000

Table L5: Tests for configural invariance for DERS-26 across face-to-face and online groups

Model Fit

Number of distinct sample moments	754
Number of distinct parameters estimated	176
Degrees of freedom (754 - 176)	578
Chi-square	996.0
Chi-square divided by degrees of freedom	1.72
RMSEA default model	.066
RMSEA independence model	.147
CFI default model	.836
CFI independence model	.000

Table L6: Tests for metric invariance for DERS-26 across face-to-face and online groups

Model Fit

Number of distinct sample moments	754
Number of distinct parameters estimated	150
Degrees of freedom (754 - 150)	604
Chi-square	1040.8
Chi-square divided by degrees of freedom	1.72
RMSEA default model	.066
RMSEA independence model	.147
CFI default model	.828
CFI independence model	.000

Appendix M: Exploratory Factor Analysis (EFA) tables

Table M1: Communalities for original FACQ items using Principal Axis Factoring (PAF)

Communalities

	Initial	Extraction
A1	.535	.461
A2	.627	.556
A3	.609	.510
A4	.540	.510
A5	.716	.852
A6	.615	.626
A7	.545	.452
A8	.501	.502
A9	.616	.548
A10	.514	.456
A11	.169	.113
A12	.470	.360
A13	.581	.528
A14	.593	.603
A15	.551	.493
A16	.661	.645
A17	.490	.383
A18	.694	.707
A19	.639	.583
A20	.620	.561
A21	.628	.669
A22	.442	.437
A23	.588	.563
A24	.595	.576
A25	.551	.500
A26	.593	.505
A27	.620	.635
A28	.544	.546
A29	.575	.582
A30	.643	.701
A31	.534	.481
A32	.525	.437
A33	.390	.320
A34	.649	.674

Extraction Method: Principal Axis Factoring

Table M2: Eigenvalues and percentage of variance explained by initial factors of FACQ

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings		
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	10.296	30.282	30.282	9.847	28.963	28.963
2	3.265	9.603	39.884	2.845	8.368	37.331
3	2.138	6.288	46.173	1.696	4.989	42.320
4	1.779	5.232	51.405	1.388	4.082	46.402
5	1.410	4.148	55.553	.978	2.877	49.279
6	1.212	3.566	59.119	.701	2.063	51.343
7	1.138	3.347	62.466	.618	1.819	53.161
8	.970	2.853	65.319			
9	.940	2.765	68.084			
10	.873	2.568	70.652			
11	.817	2.403	73.055			
12	.771	2.268	75.323			
13	.732	2.152	77.475			
14	.642	1.888	79.364			
15	.591	1.738	81.102			
16	.560	1.647	82.749			
17	.542	1.594	84.343			
18	.527	1.549	85.892			
19	.475	1.398	87.290			
20	.459	1.350	88.641			
21	.424	1.247	89.888			
22	.394	1.158	91.046			
23	.381	1.121	92.167			
24	.342	1.005	93.172			
25	.321	.945	94.117			
26	.293	.862	94.980			
27	.289	.849	95.829			
28	.255	.750	96.579			
29	.252	.740	97.319			
30	.245	.720	98.039			
31	.199	.586	98.626			
32	.186	.547	99.172			
33	.146	.429	99.601			
34	.136	.399	100.000			

Extraction Method: Principal Axis Factoring.

Table M3: Table showing unrotated factor loadings for all FACQ items

Factor Matrix[a]

	Factor						
	1	2	3	4	5	6	7
A18	.707						
A34	.700						
A14	.678						
A3	.636						
A20	.635						
A24	.632						
A16	.626		.442				
A15	.619						
A23	.615	-.331					
A10	.615						
A19	.614				.328		
A2	.596		.356				
A13	.596						
A32	.594						
A25	.588						
A9	.576			-.454			
A28	.571						
A27	.569	-.364					
A7	.566						
A17	.564						
A8	.548						
A4	.541						
A12	.516						
A22	.440				.327		
A33	.398						-.336
A29		.742					
A30		.679					
A26		-.675					
A21	.321	-.655			.355		
A31		.545					
A6	.464		.578				
A1			.526				
A5	.610			-.662			
A11							

Extraction Method: Principal Axis Factoring.

a. 7 factors extracted. 10 iterations required.

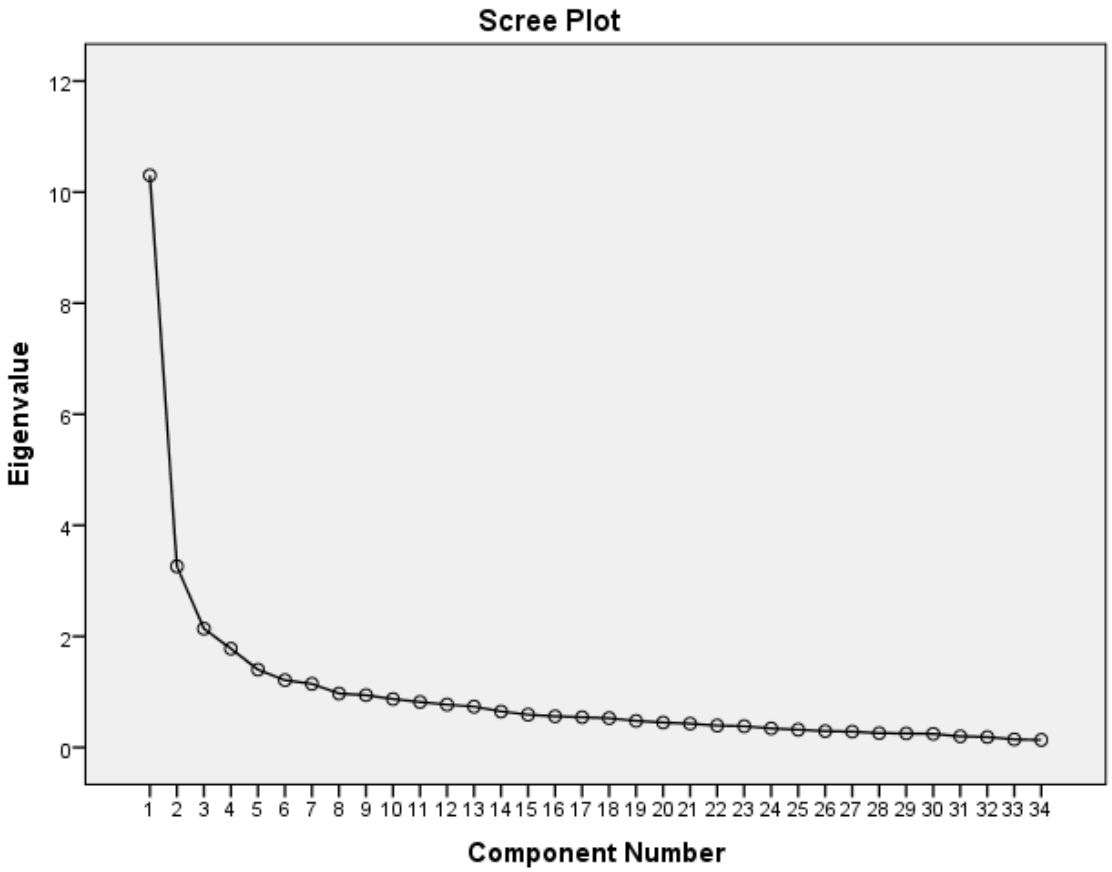

Figure M1: Plot of Eigenvalues for FACQ factor scores

Table M4: Communalities for FACQ (21-item model)

Communalities

	Initial	Extraction
A1	.402	.405
A2	.514	.525
A3	.507	.463
A4	.498	.393
A5	.684	.948
A6	.528	.672
A8	.453	.390
A9	.554	.512
A10	.445	.394
A13	.477	.441
A16	.497	.543
A17	.383	.358
A19	.506	.428
A23	.512	.505
A24	.531	.532
A25	.482	.463
A27	.579	.620
A29	.411	.463
A30	.577	.739
A31	.449	.475
A34	.562	.526

Extraction Method: Principal Axis Factoring.

Table M5: Eigenvalues and percentage of variance explained by factors of FACQ (21-item model)

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	6.876	32.745	32.745	6.390	30.428	30.428	5.270
2	2.225	10.597	43.341	1.793	8.539	38.966	2.286
3	1.847	8.797	52.139	1.382	6.582	45.548	3.472
4	1.586	7.550	59.689	1.232	5.865	51.413	4.398
5	.909	4.330	64.019				
6	.886	4.220	68.239				
7	.745	3.546	71.785				
8	.670	3.190	74.975				
9	.631	3.005	77.979				
10	.574	2.734	80.713				
11	.528	2.513	83.227				
12	.501	2.384	85.611				
13	.467	2.223	87.834				
14	.440	2.095	89.929				
15	.414	1.971	91.900				
16	.385	1.832	93.732				
17	.320	1.525	95.256				
18	.301	1.433	96.689				
19	.254	1.209	97.898				
20	.251	1.194	99.092				
21	.191	.908	100.000				

Extraction Method: Principal Axis Factoring.

Table M6: Pattern matrix for 21-item FACQ

Pattern Matrix

	Factor			
	1	2	3	4
A27	.878			
A24	.700			
A25	.662			
A23	.628			
A19	.615			
A13	.581			
A10	.540			
A34	.512			
A30		.858		
A29		.685		
A31		.662		
A6			.830	
A1			.676	
A16			.618	
A2			.561	
A17			.358	
A5				-1.078
A9				-.695
A8				-.544
A4				-.491
A3				-.371

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

Table M7: Communalities for FACQ (final 17-item model)

Communalities

	Initial	Extraction
A1	.379	.413
A2	.474	.503
A5	.611	.913
A6	.503	.675
A8	.425	.386
A9	.548	.542
A13	.453	.436
A16	.485	.556
A19	.496	.458
A23	.485	.503
A24	.482	.501
A25	.429	.448
A27	.580	.662
A29	.405	.470
A30	.545	.753
A31	.436	.484
A10	.432	.403

Extraction Method: Principal Axis Factoring.

Table M8: Eigenvalues and percentage of variance explained by factors of FACQ (final 17-item model)

Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings[a]
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	5.421	31.886	31.886	4.952	29.130	29.130	4.244
2	2.146	12.621	44.506	1.726	10.154	39.284	1.934
3	1.748	10.282	54.788	1.304	7.672	46.956	2.778
4	1.463	8.606	63.394	1.123	6.606	53.562	3.114
5	.831	4.888	68.282				
6	.724	4.259	72.541				
7	.642	3.777	76.318				
8	.583	3.432	79.750				
9	.535	3.148	82.897				
10	.500	2.944	85.841				
11	.454	2.670	88.511				
12	.428	2.520	91.031				
13	.380	2.234	93.265				
14	.361	2.124	95.389				
15	.297	1.748	97.136				
16	.263	1.549	98.685				
17	.224	1.315	100.000				

Extraction Method: Principal Axis Factoring.

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

Table M9: Pattern matrix for final 17-item FACQ

Pattern Matrix

	Factor			
	1	2	3	4
A27	.895			
A24	.668			
A25	.651			
A23	.641			
A19	.631			
A13	.573			
A10	.524			
A30		.861		
A29		.684		
A31		.668		
A6			.819	
A1			.672	
A16			.608	
A2			.544	
A5				1.017
A9				.702
A8				.536

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

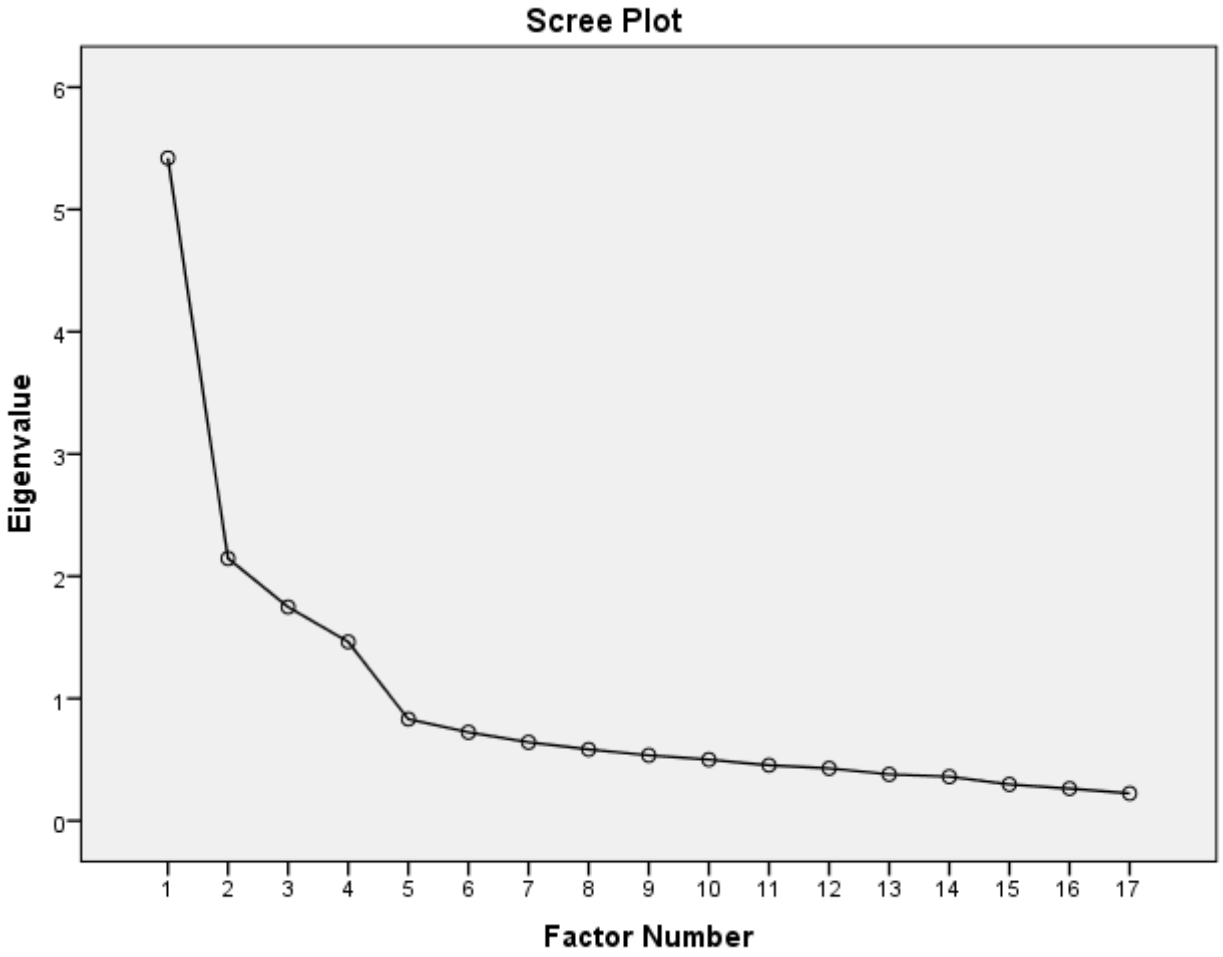

Figure M2: Plot of Eigenvalues for FACQ-17 factor scores

Table M10: Communalities for EQ (40-item model)

Item	Initial	Extraction	Item	Initial	Extraction
E1	.585	.618	E35	.445	.334
E4	.437	.351	E36	.628	.579
E6	.481	.456	E37	.424	.425
E8	.562	.779	E38	.467	.510
E10	.582	.678	E39	.363	.451
E11	.410	.626	E41	.650	.591
E12	.533	.514	E42	.520	.519
E14	.419	.320	E43	.669	.598
E15	.528	.495	E44	.689	.641
E18	.436	.304	E46	.549	.401
E19	.535	.516	E48	.599	.621
E21	.423	.467	E49	.279	.181
E22	.575	.522	E50	.453	.464
E25	.494	.454	E52	.649	.614
E26	.624	.569	E54	.641	.627
E27	.474	.445	E55	.555	.511
E28	.371	.441	E57	.316	.360
E29	.299	.210	E58	.587	.610
E32	.443	.609	E59	.340	.384
E34	.489	.574	E60	.556	.664

Extraction Method: Principal Axis Factoring.

Table M11: Eigenvalues and percentage of variance explained by factors of EQ (original 40-item model)

Table M11	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.728	21.821	21.821	8.279	20.697	20.697
2	3.367	8.418	30.239	2.901	7.252	27.949
3	1.974	4.935	35.174	1.497	3.743	31.692
4	1.935	4.837	40.010	1.435	3.588	35.280
5	1.641	4.101	44.112	1.119	2.798	38.079
6	1.541	3.852	47.964	.999	2.497	40.576
7	1.455	3.638	51.603	.958	2.394	42.971
8	1.313	3.281	54.884	.844	2.109	45.080
9	1.214	3.036	57.920	.713	1.783	46.862
10	1.173	2.933	60.853	.659	1.648	48.511
11	1.117	2.792	63.645	.631	1.576	50.087
12	.978	2.444	66.089			
13	.965	2.413	68.502			
14	.922	2.304	70.807			
15	.905	2.261	73.068			
16	.805	2.012	75.080			
17	.782	1.956	77.036			
18	.705	1.763	78.800			
19	.680	1.700	80.499			
20	.650	1.624	82.123			
21	.598	1.495	83.619			
22	.576	1.440	85.059			
23	.565	1.413	86.473			
24	.511	1.277	87.750			
25	.462	1.155	88.905			
26	.434	1.086	89.991			
27	.411	1.029	91.020			
28	.397	.993	92.013			
29	.386	.966	92.979			
30	.362	.906	93.885			
31	.345	.864	94.748			
32	.327	.817	95.566			
33	.296	.741	96.306			
34	.283	.707	97.013			
35	.261	.653	97.666			
36	.234	.585	98.251			
37	.199	.498	98.750			
38	.188	.471	99.220			
39	.173	.432	99.653			
40	.139	.347	100.000			

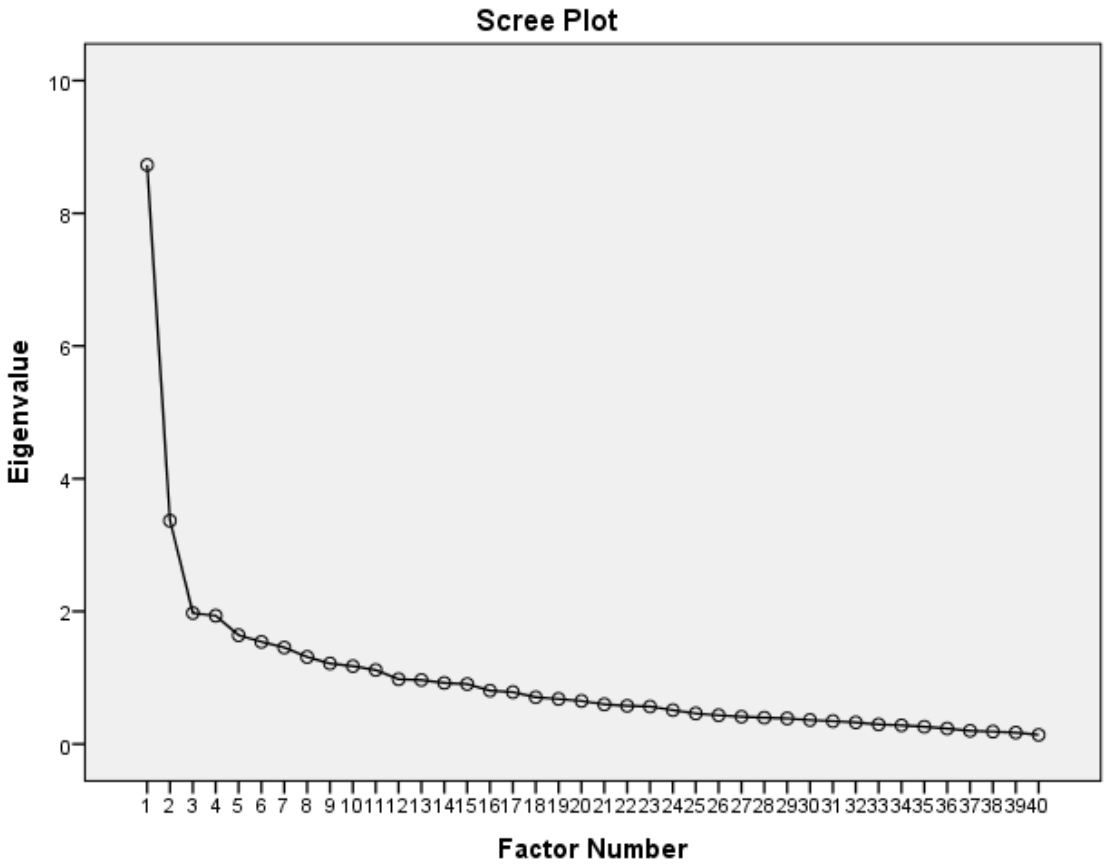

Figure M3: Plot of Eigenvalues for EQ factor scores

Table M12: Communalities for EQ (28-item model)

Communalities

	Initial	Extraction
E1	.510	.467
E8	.517	.489
E10	.509	.534
E11	.328	.106
E12	.441	.374
E22	.485	.429
E25	.455	.375
E26	.579	.513
E27	.398	.314
E32	.339	.187
E34	.428	.400
E35	.391	.226
E36	.576	.516
E37	.363	.118
E38	.433	.396
E39	.314	.164
E41	.576	.554
E42	.426	.344
E43	.650	.545
E44	.646	.576
E46	.497	.415
E48	.553	.514
E50	.343	.142
E52	.590	.527
E54	.559	.603
E55	.509	.472
E58	.555	.563
E60	.466	.300

Extraction Method: Principal Axis Factoring.

Table M13: Eigenvalues and percentage of variance explained by factors of EQ (28-item model)

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	7.384	26.372	26.372	6.854	24.479	24.479	6.484
2	2.649	9.462	35.834	2.091	7.468	31.947	2.739
3	1.818	6.493	42.327	1.172	4.187	36.134	1.595
4	1.628	5.815	48.142	1.046	3.735	39.869	1.918
5	1.341	4.788	52.930				
6	1.212	4.328	57.258				
7	1.115	3.983	61.241				
8	1.088	3.885	65.126				
9	.978	3.494	68.620				
10	.845	3.016	71.637				
11	.819	2.927	74.563				
12	.692	2.472	77.035				
13	.643	2.297	79.332				
14	.605	2.161	81.494				
15	.588	2.100	83.594				
16	.517	1.847	85.441				
17	.496	1.771	87.212				
18	.466	1.664	88.876				
19	.437	1.561	90.437				
20	.406	1.449	91.886				
21	.373	1.331	93.218				
22	.357	1.273	94.491				
23	.329	1.176	95.667				
24	.309	1.104	96.771				
25	.266	.951	97.722				
26	.244	.871	98.593				
27	.226	.806	99.399				
28	.168	.601	100.000				

Extraction Method: Principal Axis Factoring.

Table M14: Pattern matrix for 28-item EQ

Pattern Matrix

	Factor			
	1	2	3	4
E58	.763			
E54	.712			-.405
E36	.706			
E52	.700			
E43	.693			
E55	.693			
E26	.653			
E44	.646			
E22	.628			
E41	.550			.403
E25	.545			
E42	.518			
E60	.433			
E1	.422			.387
E37	.331			
E10		.682		
E34		.649		
E46		.638		
E48		.621		
E50				
E8			-.638	
E12			-.546	
E39			.401	
E35			-.393	
E38				.481
E27				
E11				
E32				

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

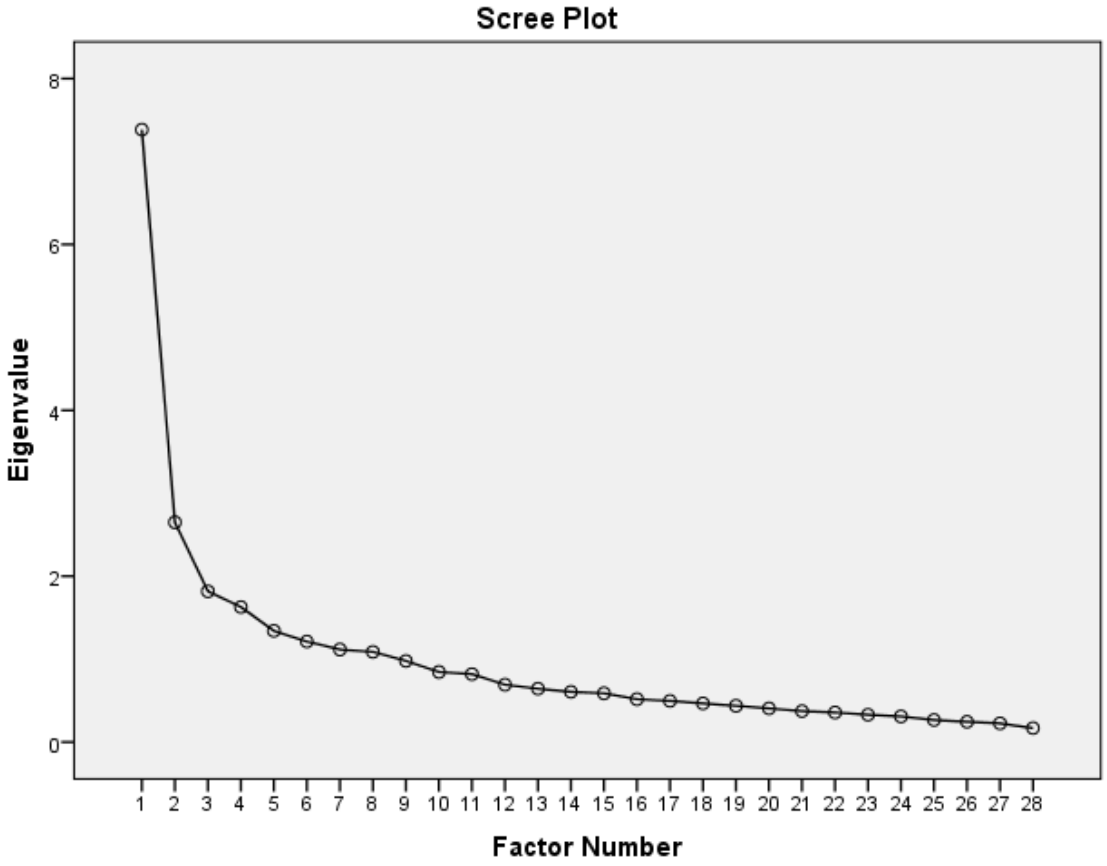

Figure M4: Plot of Eigenvalues for EQ-28 factor scores

Table M15: Communalities for EQ (final 16-item model)

Communalities

	Initial	Extraction
E1	.444	.464
E8	.388	.247
E10	.413	.495
E12	.204	.141
E22	.411	.447
E25	.371	.394
E35	.315	.114
E38	.299	.340
E41	.506	.574
E44	.522	.546
E46	.375	.346
E48	.455	.462
E54	.459	.595
E55	.439	.473
E58	.410	.503
E60	.389	.368

Extraction Method: Principal Axis Factoring.

Table M16: Eigenvalues and percentage of variance explained by factors of EQ (16-item model)

Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	4.695	29.342	29.342	4.155	25.969	25.969	3.023
2	2.089	13.058	42.401	1.494	9.338	35.307	2.271
3	1.428	8.927	51.327	.859	5.370	40.677	3.254
4	1.387	8.670	59.997				
5	.815	5.093	65.090				
6	.776	4.847	69.937				
7	.664	4.148	74.085				
8	.642	4.015	78.100				
9	.622	3.888	81.988				
10	.545	3.404	85.392				
11	.502	3.139	88.531				
12	.429	2.681	91.212				
13	.402	2.513	93.725				
14	.390	2.438	96.164				
15	.333	2.083	98.247				
16	.281	1.753	100.000				

Extraction Method: Principal Axis Factoring.

Table M17: Pattern matrix for final 16-item EQ

Pattern Matrix

	Factor		
	1	2	3
E54	.777		
E58	.677		
E25	.541		
E55	.541		
E22	.512		
E10		.704	
E48		.609	
E46		.590	
E8		.485	
E12		.365	
E35			
E41			-.711
E1			-.660
E38			-.632
E44			-.594
E60			-.535

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

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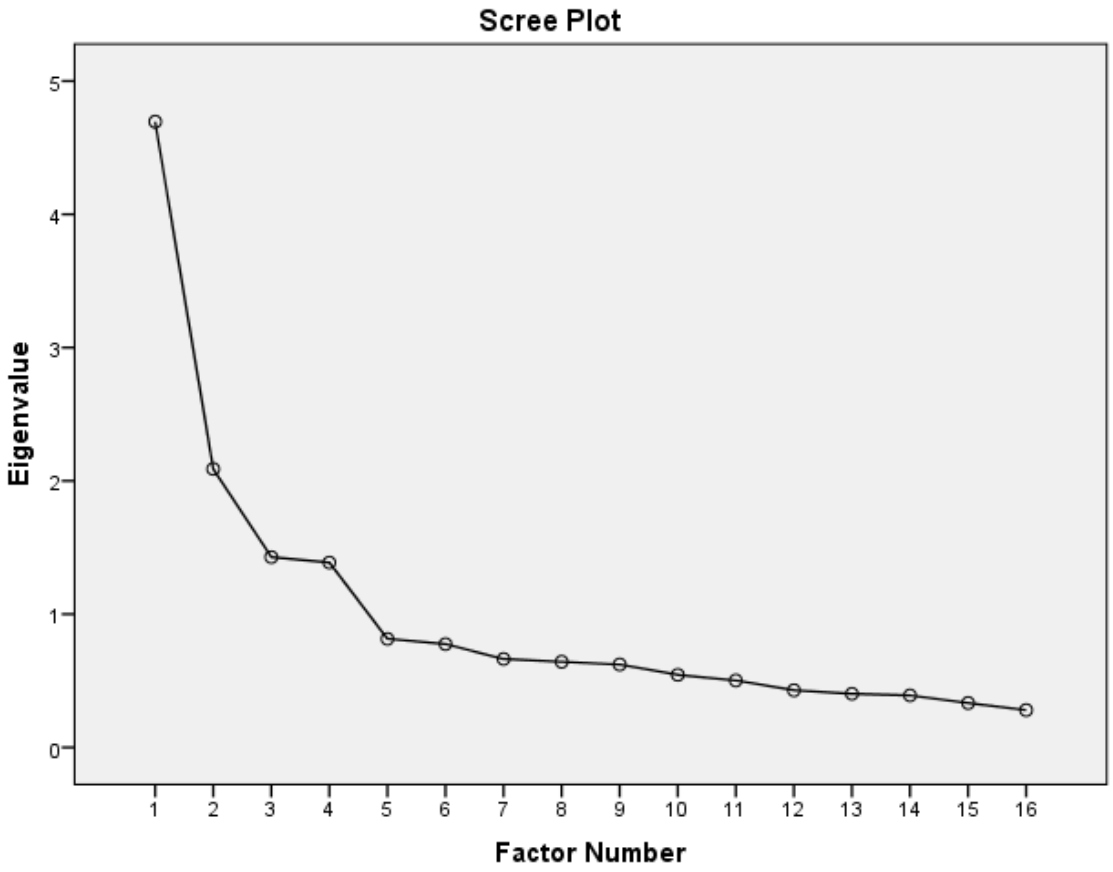

Figure M5: Plot of Eigenvalues for EQ-16 factor scores

Table M18: Communalities for DERS (original 36-item model)

Communalities

	Initial	Extraction
ER1	.542	.429
ER2	.618	.524
ER3	.676	.570
ER4	.715	.571
ER5	.697	.633
ER6	.680	.640
ER7	.710	.663
ER8	.642	.624
ER9	.674	.657
ER10	.601	.559
ER11	.731	.747
ER12	.681	.665
ER13	.615	.619
ER14	.732	.684
ER15	.722	.597
ER16	.704	.622
ER17	.527	.314
ER18	.723	.730
ER19	.687	.707
ER20	.497	.439
ER30	.742	.687
ER31	.734	.666
ER32	.745	.714
ER33	.785	.743
ER34	.393	.280
ER35	.704	.604
ER36	.734	.657
ER21	.748	.731
ER22	.677	.539
ER23	.700	.592
ER24	.591	.440
ER25	.705	.680
ER26	.727	.724
ER27	.789	.731
ER28	.817	.754
ER29	.766	.717

Extraction Method: Principal Axis Factoring

Table M19: Eigenvalues and percent of variance explained by factors of DERS (36 items)

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Loadings
Factor	Total	% Variance	Cum %	Total	% Variance	Cum %	Total
1	14.832	41.200	41.200	14.483	40.231	40.231	6.624
2	3.445	9.569	50.769	3.005	8.347	48.578	6.839
3	2.244	6.234	57.003	1.891	5.252	53.830	7.213
4	1.539	4.276	61.279	1.208	3.356	57.186	9.079
5	1.235	3.431	64.710	.865	2.402	59.589	5.031
6	1.181	3.281	67.992	.803	2.230	61.819	8.776
7	.995	2.763	70.755				
8	.932	2.588	73.343				
9	.825	2.291	75.634				
10	.748	2.077	77.712				
11	.669	1.857	79.569				
12	.631	1.754	81.322				
13	.558	1.549	82.871				
14	.501	1.392	84.263				
15	.482	1.338	85.602				
16	.435	1.207	86.809				
17	.420	1.167	87.976				
18	.399	1.108	89.084				
19	.358	.994	90.078				
20	.349	.970	91.048				
21	.319	.885	91.934				
22	.309	.858	92.791				
23	.298	.829	93.620				
24	.278	.772	94.392				
25	.244	.677	95.069				
26	.230	.639	95.709				
27	.227	.630	96.339				
28	.188	.523	96.862				
29	.184	.511	97.373				
30	.172	.478	97.851				
31	.157	.435	98.286				
32	.145	.403	98.689				
33	.136	.378	99.067				
34	.130	.361	99.428				
35	.109	.302	99.730				
36	.097	.270	100.000				

Table M20: Pattern matrix for original 36-item DERS

	Factor					
	1	2	3	4	5	6
ER28	.560					
ER31	.519					
ER35	.512					
ER23	.414		.377			
ER30	.391		.326			
ER16	.354					
ER8		.807				
ER10		.741				
ER6		.733				
ER2		.659				
ER7		.627				
ER17		.575				
ER1		.523				
ER34		.509				
ER22		.453				
ER11			.865			
ER12			.809			
ER21			.646			
ER25			.631			
ER29			.496			
ER14				.763		
ER19				.759		
ER27				.706		
ER32				.669		
ER24				.547		
ER3				.529		
ER15				.478	-.376	
ER36	.337			.351		
ER9					-.599	
ER5					-.509	
ER4					-.454	
ER13						.796
ER26						.776
ER18						.771
ER20						.547
ER33	.358					.503

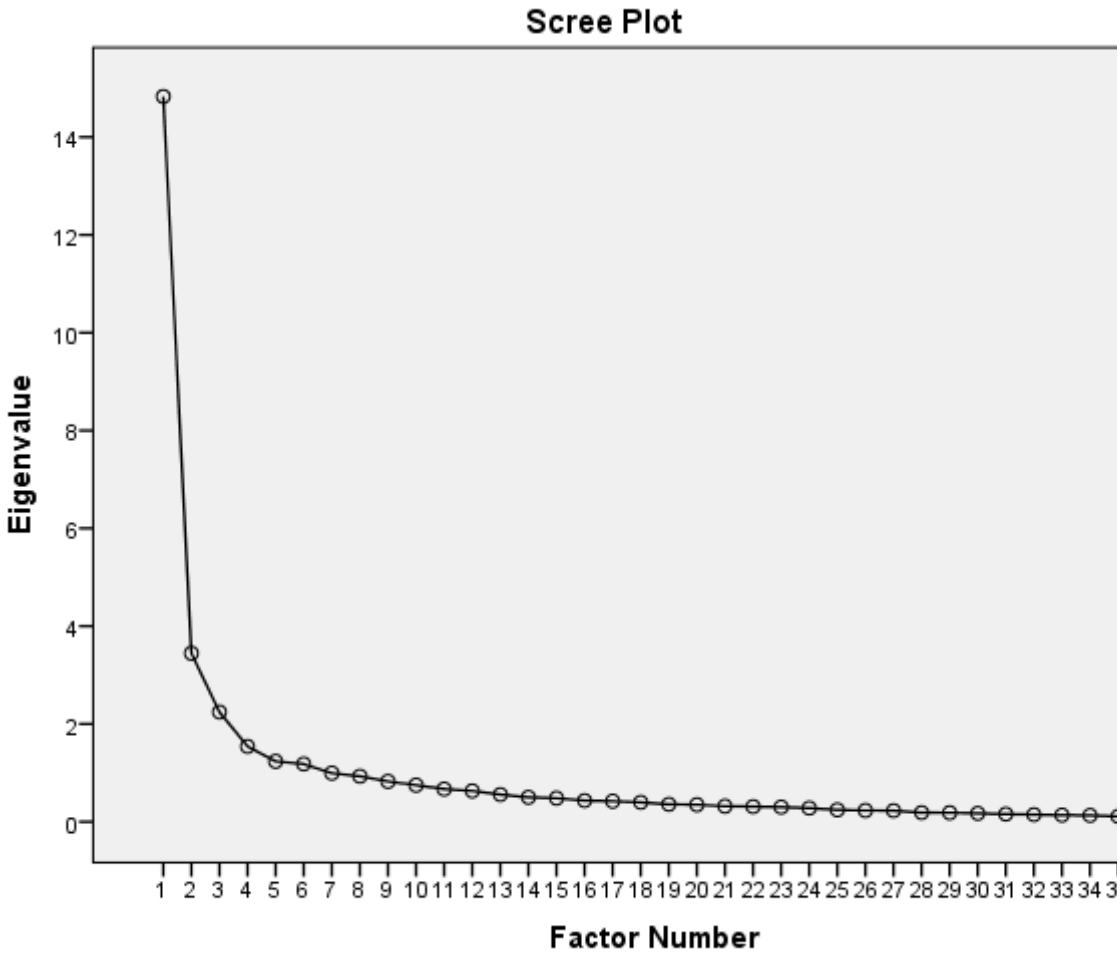

Figure M6: Plot of Eigenvalues for DERS-36 factor scores

Table M21: Communalities for DERS (final 26-item model)

Communalities

	Initial	Extraction
ER1	.470	.411
ER2	.598	.554
ER4	.660	.654
ER5	.684	.746
ER6	.632	.637
ER7	.683	.662
ER8	.625	.606
ER9	.616	.648
ER10	.549	.570
ER11	.673	.642
ER12	.634	.605
ER13	.556	.518
ER14	.673	.686
ER17	.378	.304
ER18	.694	.764
ER19	.656	.689
ER20	.442	.398
ER21	.711	.744
ER24	.439	.363
ER25	.626	.653
ER26	.685	.737
ER27	.726	.748
ER29	.739	.712
ER32	.703	.701
ER33	.646	.629
ER34	.327	.280

Extraction Method: Principal Axis Factoring.

Table M22: Eigenvalues and percentage of variance explained by factors of DERS (26-item model)

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Loadings
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	9.899	38.074	38.074	9.545	36.713	36.713	5.995
2	3.198	12.301	50.376	2.760	10.614	47.328	5.230
3	1.921	7.390	57.765	1.543	5.933	53.261	5.282
4	1.393	5.358	63.123	1.062	4.086	57.347	5.799
5	1.111	4.273	67.396	.750	2.885	60.232	5.350
6	.909	3.495	70.891				
7	.842	3.240	74.131				
8	.752	2.894	77.025				
9	.595	2.287	79.312				
10	.585	2.251	81.563				
11	.477	1.836	83.399				
12	.472	1.815	85.213				
13	.438	1.684	86.897				
14	.420	1.616	88.513				
15	.382	1.469	89.982				
16	.328	1.263	91.245				
17	.327	1.259	92.504				
18	.288	1.108	93.612				
19	.263	1.011	94.623				
20	.252	.967	95.590				
21	.245	.942	96.532				
22	.212	.814	97.346				
23	.204	.784	98.129				
24	.180	.691	98.820				
25	.160	.614	99.435				
26	.147	.565	100.000				

Extraction Method: Principal Axis Factoring.

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Table M23: Pattern matrix for final 26-item DERS

Pattern Matrix

	Factor				
	1	2	3	4	5
ER18	.826				
ER26	.774				
ER13	.701				
ER33	.539				
ER20	.512				
ER8		.792			
ER10		.763			
ER2		.689			
ER6		.684			
ER7		.620			
ER1		.560			
ER17		.538			
ER34		.520			
ER21			.769		
ER11			.764		
ER12			.725		
ER25			.707		
ER29			.639		
ER14				-.748	
ER27				-.734	
ER19				-.713	
ER32				-.659	
ER24				-.465	
ER5					-.751
ER9					-.700
ER4					-.676

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

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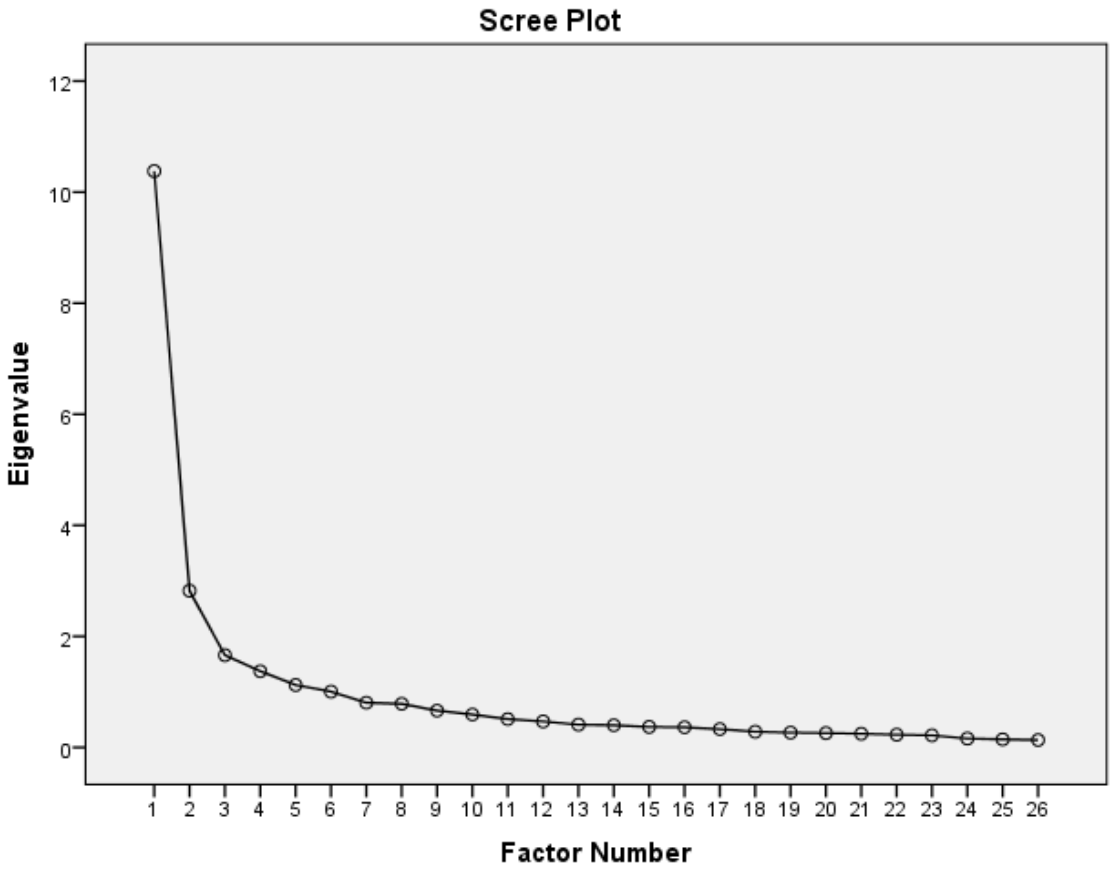

Figure M7: Plot of Eigenvalues for DERS-26 factor scores

Table M24: Factor Correlation Matrix for original FACQ

Factor Correlation Matrix

Factor	1	2	3	4	5	6	7
1	1.000	-.036	.300	-.352	.166	-.158	-.354
2	-.036	1.000	.132	-.114	.034	-.208	-.251
3	.300	.132	1.000	-.360	.204	-.101	-.362
4	-.352	-.114	-.360	1.000	-.177	.289	.321
5	.166	.034	.204	-.177	1.000	-.116	-.110
6	-.158	-.208	-.101	.289	-.116	1.000	.191
7	-.354	-.251	-.362	.321	-.110	.191	1.000

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

Table M25: Factor Correlation Matrix for original EQ

Factor Correlation Matrix

Factor	1	2	3	4	5	6	7	8	9	10	11
1	1.000	.078	.371	.132	.170	.098	.185	-.003	.026	.261	-.163
2	.078	1.000	.092	.071	.249	-.002	.141	-.079	.201	.260	-.087
3	.371	.092	1.000	.132	.155	.036	.262	-.107	-.045	.211	-.103
4	.132	.071	.132	1.000	-.068	.016	.030	-.049	.079	.007	-.069
5	.170	.249	.155	-.068	1.000	.006	.203	-.026	.192	.249	-.187
6	.098	-.002	.036	.016	.006	1.000	-.010	-.052	.040	-.044	-.038
7	.185	.141	.262	.030	.203	-.010	1.000	-.095	-.014	.222	-.008
8	-.003	-.079	-.107	-.049	-.026	-.052	-.095	1.000	-.087	.004	-.029
9	.026	.201	-.045	.079	.192	.040	-.014	-.087	1.000	.071	-.073
10	.261	.260	.211	.007	.249	-.044	.222	.004	.071	1.000	-.115
11	-.163	-.087	-.103	-.069	-.187	-.038	-.008	-.029	-.073	-.115	1.000

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

Table M26: Factor Correlation Matrix for original DERS

Factor Correlation Matrix

Factor	1	2	3	4	5	6
1	1.000	.179	.396	.328	-.176	.407
2	.179	1.000	.257	.326	-.375	.240
3	.396	.257	1.000	.334	-.187	.370
4	.328	.326	.334	1.000	-.322	.540
5	-.176	-.375	-.187	-.322	1.000	-.342
6	.407	.240	.370	.540	-.342	1.000

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

Appendix N: Missing data

Data collection and coding was transferred from the hard copies and online software to SPSS data analysis software. Missing data were excluded from the analysis except for the following cases:

- For the FACQ: respondents 16; 71; 82; 110; and 169 (items 30; 27; 8 & 14; 5; and 30-34 respectively), whereupon a value of 3 (Not sure) was inserted;
- For the DERS: respondents 116; 121; 138; and 153 (items 7; 5; 36; and 30 respectively), whereupon a value of 3 ('About half the time') was inserted;
- For the GHQ: respondent 158 (item 26), whereupon a 1 ('Not at all') was inserted, based on the average score on other items on the same subscale;
- For the EQ: respondent 99 (item 22), whereupon a 1 ('Slightly agree') was inserted, based on the average score on other items on the same subscale.

Appendix O: Internal Consistency of Subscales

Scale	Items	Cronbach's alpha (α)
Fathers' Attachment to Children Questionnaire (FACQ)	34 items (full scale – n = 156*)	.91
Trust-Avoidance	1-14	.84
Burden-Patience	15-22	.81
Pleasure-Detachment	23-28	.78
Anxiety-Competence	29-34	.72
Difficulties in Emotion Regulation Scale (DERS)	36 items (full scale – n = 153)	.95
Lack of emotional clarity	1, 4, 5, 7, 9	.82
Lack of emotional awareness	2, 6, 8, 10, 17, 34	.83
Impulse control difficulties	3, 14, 19, 24, 27, 32	.83
Emotional non-acceptance	11, 12, 21, 23, 25, 29	.89
Difficulties engaging in goal-directed behaviour	13, 18, 20, 26, 33	.87
Limited access to emotion regulation strategies perceived as effective	15, 16, 22, 28, 30, 31, 35, 36	.89
General Health Questionnaire (GHQ)	28 items (full scale – n = 149)	.94
Somatisation	1-7	.81
Anxiety/Insomnia	8-14	.90
Social Dysfunction	15-21	.85
Severe Depression	22-28	.90
Empathy Quotient (EQ)	40 items (full scale – n = 134)	.88
Cognitive Empathy	1, 19, 25, 26, 36, 41, 44, 52, 54, 55, 58	.89
Social Skills	4, 8, 12, 14, 35, 57	.59
Emotional Reactivity	6, 21, 22, 27, 29, 32, 42, 43, 48, 50, 59	.68

*Values of n show numbers of completed questionnaires for each of the four full-scale instruments.