2018

The Latino Father and the Role of Egalitarianism, Coping Skills, and Depressive Symptoms in the Post-Natal Period

Tania M. Paredes

THE LATINO FATHER AND THE ROLE OF EGALITARIANISM, COPING SKILLS, AND DEPRESSIVE SYMPTOMS IN THE POST-NATAL PERIOD

DISSERATATION
by
Tania M. Paredes
2018

Approved By:

_____

Mark Smith, Ph.D.
Chairperson, Dissertation Committee

_____

Eva Nowakowski-Sims, Ph.D.
Member, Dissertation Committee

_____

Manuel J. Tejeda, Ph.D.
Member, Dissertation Committee

_____

Phyllis F. Scott, Ph.D.
Dean, School of Social Work

ACKNOWLEDGEMENTS

This years long project was full of bumps along the way, but it was also full of support and love. It is with great humility that I was able to complete it with the help of my dissertation committee, Dr. Smith, Dr. Nowakowski-Sims, and Dr. Tejeda. These scholars took me on and did nothing but guide and mentor me. For this I am grateful for their example, guidance, and support. I am also grateful for their investment in my learning. The doctoral program professors who helped shape my thinking and my project were also a large part of my journey. My literature review wouldn't have been complete without the guidance of Dr. Ashley Austin. The support and guidance I received from my CSWE Minority Fellowship Program fellows was also a large part of shaping not only how I viewed research but also my role in it. I am in constant awe of them and the friendships I forged in my 3 years as a fellow are those that will last me a lifetime. Their research ignites my interest in all aspects of social justice. Susan Klumpner, I am forever in your debt for your help and support. Next, to my cohort, if there ever was a situation where strangers become family, is it this situation. These are my social work brothers and sisters, who will always know not only what it means but walked together with me the whole way through. Drs. Tammy Malloy, Revital Goodman, and Maria Teahan I love and admire you. To my Latino classmates, Claudia Vincencio, Fabio Naranjo, Dr. Maria Teahan, el honor ha sido mio caminar a sus lados. God has blessed me with the love and support of many and for that I am eternally grateful.

Lastly, as the daughter of immigrants to this country, I am grateful for the sacrifice my parents made so that I may even have had an opportunity to obtain higher education. A girl should only be so lucky to have been blessed with parents who have

always supported her but also a husband who is her biggest cheerleader. I am what I am in large part because of his vision of me. No one in my family has ever told me I can't do something. This has always been at the forefront of all that I do. And to my children, this is ultimately for them, so that they may know that life has no limits and they too can do anything.

Tania

Table of Contents

Abstract

Interest in all aspects of motherhood and related experiences have been the focus of research which have produced a voluminous, diverse, and rich body of work. However, fatherhood and its experience have not been given similar credence until recently. As gender roles shift in society, and the experiences associated with contemporary fatherhood become re-defined, research and inquiry about fatherhood emerges as a relevant topic. One facet of this emerging research focuses on men's experiences living with depressive symptoms following the birth of a child, or paternal postnatal depression, as it is known in the literature. Initially stemming from maternal health literature, paternal postnatal depression as a researchable topic has now developed its own body of scholarship (Buist, Morse, & Durkin, 2002; Letourneau, Duffet-Leger, Dennis, Stewart, & Tryphonopoulos, 2011). This dissertation surveys current knowledge about the phenomenon of depressive symptoms in postnatal fathers and its unique intersection with the Latino culture. Finally, using stress theory and masculine gender role stress theory, this dissertation explored the role of egalitarianism and the possible coping skills utilized by Latino fathers to deal with possible depressive symptoms in the postnatal Latino father.

A sample of 101 Latino men were surveyed and administered 3 measures (Edinburgh Postnatal Depression Scale, a coping scale developed by the researcher, and the Gender Role Attitudes Scale). The primary aim of this study was to examine the relationship between coping skills, egalitarianism, and depressive symptoms in post-natal Latino fathers. An additional aim was to examine the influence of coping skills and of egalitarianism on depressive symptoms among adult Latino fathers. Several important

findings were recognized in this research: 1) there is a negative correlation between egalitarianism and depressive symptoms; (2) there is a significant negative correlation between coping skills and depressive symptoms in postnatal Latino fathers; and finally (3) coping skills and egalitarianism are significantly related to depression scores, where coping skills contributes a greater percentage of the variance in depressive symptoms than egalitarianism among Latino fathers. Implications for social work assessment, practice, education, and future research is also discussed.

keywords: paternal postnatal depression, post-partum depression, fathers, latino, gender roles, masculine gender role stress, egalitarianism, family health,

Chapter I: Introduction

Background and Significance

While postpartum depression is increasingly recognized and addressed as a critical health concern among women, little attention has been paid to post-natal mental health issues experienced by fathers (Buist, Morse, & Durkin, 2002). Emerging research suggests that a number of fathers experience postnatal depression, and that it is a "clinically significant problem for families that is currently underscreened, underdiagnosed, and undertreated" (Musser, Ahmed, Foli, & Coddington, 2013, p.479). Because this is a understudied area, only preliminary incidence and prevalence data exist (Letourneau, Duffett-Leger, Dennis, Stewart, and Tryphonopoulos, 2011), and little is known about the factors that may either increase the likelihood of experiencing paternal postnatal symptoms or act as preventative factors. As these symptoms may have detrimental impact on the father and the family as a whole, this is an area that requires greater attention in the research. While the attention paid to postnatal depression symptoms in fathers, including its diagnosis, prevalence, and effect on men's health is growing, a clinical definition, diagnostic tool, research on minorities, and standardized guidelines are still lacking (Nazareth, 2011; Paulson & Bazemore, 2010). Paulson (2010) adds to this by stating that "close attention to representative samples sensitive to the considerable cultural variability in paternal involvement" should be looked at more closely (p. 52). Further, the research detailing the relationship between coping with the stressful situation of being a new father and the impact of gender role and egalitarianism on the cognitive appraisal of that stress is largely nonexistent. While a link between masculine gender role stress and poor health behaviors has been shown, research has

demonstrated negative outcomes to adherence of a strict male gender role, including restrictive emotionality (Jakupcak, Salters, Gratz, & Roemer, 2003).

This dissertation attempted to confirm the role of egalitarianism and coping skills on depressive symptoms in Latino postnatal fathers. To date there have been no studies discovered that explore this possible correlation, Studies of depression symptoms in postnatal fathers with minority populations are scant, yet other literature suggests that role conflict and gender role stress is a significant stressor for a new father that may impact mental health negatively and impair his engagement in the family as he adjusts to the needs of having a new infant in the home (Barclay, Donovan, & Genovese, 1996; Buist, Morse, & Durkin, 2002; Silverstein, Auerbach, & Levant, 2002).

Definition of Terms

Current literature does not articulate a specific definition of depression symptoms in postnatal fathers; however, several studies have used the maternal post-partum depression definition to build on for depression symptoms in postnatal fathers (Kim & Swain, 2007; Schumacher, Zubaran, & White, 2008; Melrose, 2010). The *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (American Psychiatric Association, 2013) defines maternal post-partum depression as a depressive disorder with peripartum onset, which is four weeks following delivery. The diagnostic criteria specifies that at least five of the following nine symptoms should be present within a two-week period: "feelings of sadness, emptiness, or hopelessness, nearly every day, for most of the day; loss of interest or pleasure in activities; weight loss or decreased appetite; changes in sleep patterns; feelings of restlessness; loss of energy; feelings of worthlessness or guilt; loss of concentration or increased indecisiveness; recurrent thoughts of death, with or

without plans of suicide" (American Psychiatric Association, 2013, p.186-187). While men are not diagnosed with a depressive episode with peripartum onset, these symptoms, as well as other similar behaviors, are likely to be present in depressed new fathers (Paulson & Bazemore, 2010; Kim & Swain, 2007) with the highest rate found at between 3 to 6 months post-partum (Goodman, 2003; Nazareth, 2011; Paulson & Bazemore, 2010).

Definitions of additional key terms relevant to this dissertation study are provided.

*Culture: "*the customary beliefs, social forms, and material traits of a racial, religious, or social group*"* (Merriam Webster, 2017).

Egalitarianism-the idea that all persons are equal in fundamental worth and social status and should be treated as equals (Merriam-Webster, 2017). For the purposes of this research study, egalitarianism is used to refer to the social construct that allows men and women to equally express certain behaviors based on gender equality.

Familismo- the importance and strong sense of identification with the immediate and extended family in the Latino culture (Davila, Reifsnider, Pecina, 2011).

Gender bias - "a systematic deviation from an expected value that is associated with the sex of the individual" (Hartung & Widiger, 1998, p. 261).

Gender roles – "behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females" (O'Neil, 1982, p. 10).

Gender role socialization-*"*a process by which children and adults acquire and internalize the values, attitudes, and behaviors associated with femininity, masculinity, or both" (O'Neil 1982, p. 10).

Restrictive emotionality- having difficulty and fears about expressing one's feelings (Wong, Pituch, Rochlen, 2006).

Postpartum/Postnatal-the period of time following the birth of a child (Merriam-Webster, 2017).

Sex Typing-the actual characteristics of a particular individual along sex role related dimensions (Pleck, 1981).

Statement of the Problem

The investigation attempted to discover the impact of egalitarianism and coping skills on depression symptoms in the postnatal period particularly as it manifests among fathers who identify as Latino. Few studies examine if the father experiences post-natal depressive symptoms. To date, there have been no studies that examine the possible relationship between Latino fathers, egalitarianism, and their coping skills. Studies of depression symptoms in postnatal fathers with minority populations are scant, yet some existing literature suggests that role conflict and rigid gender role adherence can negatively impact a new father's mental health (Barclay, Donovan, & Genovese, 1996; Buist, Morse, & Durkin, 2002). Current literature does show that adherence to egalitarianism and a flexible male gender role may act as an insulator against the inability to cope and express feelings of depression for men (Inglehart & Pippa, 2003; Saba, Kamal, Juzer, 2017).

In relevance to social work practice, social workers need to be aware of all of the barriers that families are facing when providing appropriate services. This inquiry can help shape and define an important concept that Latino families may be struggling with. Paternal contributions are part of the family unit and the greater social ecology. It is imperative for the social work profession to promote optimal social functioning, and aid the entire ecology, in this case the family, in functioning optimally. With the increase of Latinos in the United States, the ever-changing face of the American workforce, and the restructuring of the American family, this is an important topic that has been under-researched by the social work profession.

Lastly, social workers are provided an advantage in informing policy, creating effective assessment tools, educating communities, families, and other social workers, while recognizing possible protective factors that will act as preventive measures. The research findings contribute to a notably understudied area of research and suggest further advanced inquiry that may benefit an often underserved population, the Latino man.

Background Literature

Much attention has been given to the problem of post-partum depression in new mothers. There has been ample scholarship on its history, prevalence, etiology, its impact on the mothering experience, as well as effectiveness of various treatment modalities (Beck, 1992, 1993, 2001; O'Hara & Swain, 1996; Berggren-Clive, 1998; Chung & Yue, 1999; Dankner, Goldberg, Fisch, & DCrum, 2000; Weismann & Jensen, 2002; Logsdon, Wisner, & Shanahan, 2007; Le, Perry, & Ortiz, 2010; Wisner, Sit, McShea, Rizzo, Zoretich, Hughes, Eng, Luther, Wisniewski, Constantino, Confer, Moses-Kolko, Famy,

& Hanusa, 2013). There has also been mounting evidence that supports the adverse effects of post-partum depression on the marital relationship and on child development (Stuart & O'Hara, 1995; Appleby, Warner, Whitton, & Faragher, 1997; Morgan, Matthey, Barnett, & Richardson, 1997). The dominant paradigm in the parenting mental health field has focused on mothers' experiences, health, and well-being.

Until recently, depression symptoms in postnatal fathers have only been explored and researched in relationship to maternal post-partum depression. The emotional life of fathers after the birth of a child has been largely overlooked, keeping the experience of paternal postnatal mental health a relatively unrecognized and obscured phenomenon. Recently, as a result of newly defined men's and women's gender roles, contemporary roles of parenting and rules for financial responsibility, as well as the increasing involvement of fathers in the lives of their children, researchers have begun to pay greater attention to father's experiences (Armenia & Gerstel, 2006; Coltrane, 2000; Fitzgerald & Bocknek, 2013; Garfield, Clark-Kauffman, & Davis, 2006; Geva, 2011). Initially this researcher's inquiry focused on how maternal post-partum depression is distressing and socially debilitating not only to the mother and infant, but also can have an adverse effect on the marital dyad and a detrimental impact on the father's own mental health (Ballard, Davis, Cullen, Mohan, & Dean, 1994; Boath, Pryce, & Cox, 1998; Cummings, Neff & Husaini, 2003; Dermott, 2006; Goodman, 2003; Jacob & Johnson, 2001). However, through researching this literature emerging scholarship suggests fathers also can and do experience symptoms similar to that of maternal post-partum depression symptoms independent of the mother's post-partum mental health (Musser et. al., 2013). It is through this inquiry that the focus changed to that of the father's experience.

When both parents experience depressive symptoms during the post-partum period, the interaction between mothers' and fathers' depressions may increase the risk to their child's development (Carro, Grant, Gotlib, & Compas, 1993; Anderson 1996a, 1996b, Zelkowitz & Milet 1997; Deater-Deckard, Pickering, Dunn, & Golding, 1998). Additionally, if the father is experiencing postnatal depression, he is rendered less capable to function as either a father, supportive care-giver for the infant or mother, or a wage-earner, the roles men have historically played in families (Schumacher, Zubaran, & White, 2008).

Scope and Prevalence

A number of recent studies have recognized the prevalence of depression in the post-natal period among new fathers. Paulson (2010) found that the incidence of depression among fathers has been estimated to range between 1.2% and 25.5%. This writer found most of the literature reports a 10% prevalence of paternal postnatal depression (Goodman, 2003; Ramchandani, Stein, Evans, O'Conner, & ALSPAC study team, 2005). This is a rate significantly higher than the 12-month prevalence of 5% for major depression in general populations of men (Kessler, Berglund, & Demler, 2003). Of note is the fact that the majority of the studies found and used in this literature review were conducted with Caucasian males. No available data on this topic was found that separates fathers by race, ethnicity, or marital status. There is some data from other countries, such as Canada, Australia, and European countries; however, their populations are generally considered more homogeneous than that of the United States which boasts vast diversity including38.9 million identifying as African-American, 14.7 million people Asian, 2.9 million American Indian, and 50.5 million Latino (US Census, 2010).

Moreover, Latinos are expected to form the largest minority group in the US by the year 2050 (Rastogi, Massey-Hastings, & Wielding, 2012). Yet research on Latino fathers has not kept pace with their growth as a minority group (Campos, 2008). In contrast, according to Statistics Canada (2011) the largest minority group in Canada were South Asians, Chinese, and Blacks (61.3% all combined). This emerging field of research is still in its infancy, and the wide range of incidence estimates and the lack of research on minority Latino populations are clear indications of this. Moreover, Fisher, Kopelman, and O'Hara (2012) postulate that any efforts to detect paternal depression are further limited because many fathers have minimal contact with the parent-child health care system which is acknowledged as being biased toward the maternal experience and not the father's. As such, it is likely that the prevalence of data underrepresents the problem of postnatal depression symptoms in fathers (Fisher, Kopelman, & O'Hara, 2012; Musser et. al. 2013).

It is well established that men display depressive symptoms much differently than women (Cochran & Rabinowitz, 2003; Kockler & Heun, 2002). Genuchi and Mitsunaga (2015) state that gender role socialization significantly affects how men and women think, feel, and behave, which subsequently affects their depressive symptom presentation (p. 243). Therefore, it is expected that medical professionals focused on women and their health concerns and oftentimes and pay less attention to men and their experience during the postpartum period. With the emergence of newer research, this has begun to change as evidenced by the increase in literature, particularly on etiology, environmental, and risk factors that impact fathers during the postnatal period.

Disparities within Minorities

Despite the limited research in this area, evidence of health and mental health disparities in Latino fathers is noted (Dunkel-Schetter, Schafer, Lanzi, Clark-Kauffman, Raju, Hillemeier, 2013). Although there is evidence that mental health care disparities have been reduced for some ethnic groups, there is still a gap of 40% of minorities that access health care as compared to their Caucasian counterparts (U.S. Department of Health and Human Services, 2013). Health care disparities between the general Caucasian population and Latinos seem to be widening, with lower mental health treatment rates continuing to be documented among Latinos (Alegría, Canino, Ríos, Vera, Calderón, Rusch, & Ortega, 2002; Blanco, Patel, Liu, Jiang, Lewis-Fernández, Schmidt, Olfson, 2007; Dennis & Chung-Lee, 2006).

Researchers have generally found that Latinos as a group are less likely to seek formal treatment for emotional distress. According to McGuire, Alegría, Cook, Wells, and Zaslavsky (2006), there are likely many systemic factors that contribute to these disparities. These include lack of access to predominantly Spanish speaking treatment providers and groups, and culturally induced role restriction patterns that handicap minority men from seeking help, such as reliance on the family system and alternative healing practices (Chiang, Hunter, & Yeah, 2004), stigma towards those with mental health issues as well as shame surrounding having mental illness (Brennan, Vega, Garcia, Abad, & Frieman, 2005). An additional factor influencing the acceptance of social support is the gendered nature of that support. Most pre- and postnatal support is delivered by women for women (Fletcher & St. George, 2011). As a result, all-male or male prevalent intervention formats are favored, as a female gendered service delivery

may prevent men from seeking help, particularly minority men (Friedewald, Fletcher, & Fairbairn, 2005).

Evident in the prevailing research on help-seeking behaviors and barriers to seeking help among Latino cultures, is the role of the man and father in a Latino family who is traditionally seen as being the emotional rock and the financial head of household. Further, the traditional Latino male's lack of adherence to an egalitarian sex role in his family also contributes to the lack of help seeking due to issues of stoicism and shame (Ishikawa, Cardemil, & Falmagne, 2010). This becomes a significant barrier and cultural prohibition for accessing help (Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Añez, Paris, Bedregalm, Davidson, & Grilo, 2005). Additionally, the fear of judgment and criticism (Rastogi, Massey-Hastings, & Wielding, 2012) is evident in the rationales provided for why Latino clients are reluctant to access mental health services. In Latinos, this lack of help seeking behaviors for possible depressive symptoms by fathers is further compounded by cultural norms of men's dominance and being emotionally stoic. In Latino culture, high adherence to the norm of *familismo*, or strong commitment toward family (Ishikawa, et al., 2010), means that the father will likely not seek help for paternal postnatal depression as this is seen in the culture as an individual issue and not a family issue.

This is further compounded by machismo, or hypermasculinity, which is the concept associated with the valuation of characteristics associated with masculine traits of dominance, power, and a man's obligation to provide for and protect his family (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008; Falicov, 2010). While there is not a consensus definition of the term, concepts of machismo emphasize negative traits such as

toughness, hypermasculinity, chauvinism, aggressiveness, virility, and emotional unavailability (Arciniega, et al, 2008; Mosher, 1991; Saez, Casado, & Wade, 2009). In addition, the lack of adherence to an egalitarian sex role, one in which both genders are equal and can serve equal functions as parents, as well as experience equal emotions about that experience, serves to hinder the Latino father from identifying, coping with, or seeking help for depressive symptoms in the post-natal period.

It is also been noted in the literature that machismo can be viewed as having positive attributes. Estrada and Arciniega (2015) states that machismo also encompasses *caballerismo* which suggests a prosocial view of machismo including "family centeredness, social responsibility, and emotional connectedness" (p.192). Noguera, Hurtado, and Fergus (2012) furthers that this type of machismo, *caballerismo*, can serve as an organizing principle that elevates pride, ethics, and honor. In contrast, adhering to a rigid gender role can serve to restrict men from adopting an egalitarian view in order to be able to identify possible symptoms of depression. In the Latino community mental illness is not discussed openly, which serves to limit information and knowledge about mental illness and reduce stigma (Ward & Besson, 2013). This, coupled with traditional characteristics of masculine ideology, particularly the kind that subscribes to a rigid male gender role, may be deleterious to the healthy psychological functioning of men.

Societal Norms and Men's Role

The role of fatherhood for a man may further involve a conflict between wants and needs. This conflict is reflected in the difficulties fathers often encounter in reconciling the desire to be actively participating fathers with the need to feel they are adequately providing for their families (Coltrane, 2000; Davey, Dziurawiec & O'Brien-

Malone, 2006; Prohaska & Zipp, 2011). Specifically, in Latinos, researchers have found that logistical barriers, such as multiple jobs and long work hours may also form conflicts for fathers and impact their ability to be active parents (Campos, 2008). In recognition of the importance of fathers' involvement in children's care, paternity leave has been offered in most Western countries in order to increase fathers' ability to take a major role in children's early development and strengthen parental bonding (Nomaguchi, Brown, Leyman, 2017), and there has been a proliferation of psychoeducational programs to support men in their transition to active parenting and fatherhood (United States Department of Health & Human Services, 2008). However, the historical norm that fathers are primarily wage-earners suggests that men should exhibit an even stronger commitment to work when they become father which is in direct conflict with feelings of obligation and responsibility towards bonding with the child (Chesely, 2011; Connell, 2005). It also goes in direct conflict with messages Latino fathers receive within their own family.

According to McGill (2014), society has created a social definition of masculinity in which men are not allowed to become caring fathers who are nurturing and supportive; if they are, they are seen as weak. Coupled with machismo in the Latino culture, this may impact father's acknowledgment of depressive symptoms. McGill (2014) further noted that certain societies do not accept a person as a man unless he fulfils certain expectations of that society, referred to as male gender and sexual roles. These roles can predispose a man's possible tendencies toward aggressiveness and emotional absence. It is this very mechanism that encourages fathers to spend less time at home, rather than more, since the provider and good worker roles are what are more revered in dominant

society (Townsend, 2002). Moreover, Good and Wood (1995) and Davis and Liang (2015) found a high correlation of depression in men were reported for reasons of conflict between work and family, as well as an inability to express difficult emotion. It is these societal oppressions that further compound paternal postnatal depression by encouraging emotional absence and distance in fathers from the experience of infant/child caregiving.

There has been a major shift in traditional gender roles and attitudes toward the acceptable roles of men and women in the workplace and the family (Levant, Majors, & Kelley, 1998; Gaunt, 2005). Over the last few decades, an increasing proportion of women have entered the labor force, limiting their availability to act as primary caregivers, and a larger number of men are now acting as the primary caregivers (Budig & England, 2001; Chesley, 2011; Geva, 2011). In order for paternal postnatal depression to be given the level of inquiry necessary in order to view it as a significant societal problem that impacts family systems, greater social change would have to occur in the form of reconstructing the fatherhood paradigm as well as the parent paradigm to include contemporary fathers. This updated version of fathering would allow an emotionally intimate relationship to exist between fathers and their children, elevating the father-child dyad to the same importance as the mother-child dyad in the emotional development of children as well as the emotional development of men (Buist, et. al., 2002; Meighan, David, Thomas, & Droppleman, 1999). Further, it would elevate paternal postnatal depression to a familial and social problem.

Risk Factors

Zartloudi (2011) states that mental health is gendered. Consistent with this perspective is the fact that women have significantly higher rates of depression and other

psychological diagnoses than men; 74% for women and 65 % for men (Kessler, et. al., 2003). The association between gender and mental health has become a prominent topic in the social sciences (Addis & Mahalik, 2003; Addis & Mahalik, 2003, Barn, 2008; Heppner, 1995). Consequently, the focus is typically on maternal post-partum depression, as mental health professionals do not typically look for this phenomenon as occurring in men (Boath, et. al., 1998; Cochran, & Rabinowitz, 2003; Draper, 2002). Further, a father's manifestation of this type of depression is very different from how it appears with women, and the associated risk and protective factors also deserve separate, yet equal, attention.

Risk factors in men can be related to the cultural construction of women as having greater biological vulnerability to psychological disorders; therefore, men's symptoms are often dismissed as being aggressive or other typically male behaviors (Genesoni & Talladini, 2009, McGill, 2014). Möller-Leimkühler (2002) found that although minor emotional symptoms increase the probability of consulting a general practitioner, physical symptoms were the determining factor for help seeking by men. Berger, Levant, McMillan, Kelleher, and Sellers (2005) found that stronger adherence to masculine ideologies is predictive of poorer attitudes towards psychological help seeking. In addition, according to Tokar, Fisher, Schaub, and Moradi (2000), women are more likely to be diagnosed with depression than men because it may be easier to diagnose due to the fear of the stigma and shame surrounding depression for men in general. It is this narrow construction of depression in men that limits the help seeking behaviors or education about mental health care of men (Paulson, 2010). Men may also view mental health practitioners and social workers in a negative light which can further increase their risk.

Additionally, men have historically had poorer social support networks and a higher incidence of externalizing disorders (Dudley, Roy, Kelk, & Bernard, 2010; Strauss & Goldberg, 1999).

Fathers can also exhibit other biological risk factors, such as having a past history of depression or other mental health issues that put them at higher risk for paternal postnatal depression (Paulson, 2010). This can handicap a father during the postnatal period, when stress, pressure, and demands on his time increase. Unlike mothers, for whom the onset for post-partum depression is usually in the immediate postpartum period, evidence exists that suggests that the onset for paternal postnatal depression is up to one year after the birth of a child or even later, with the highest risk being between 3-6 months (Fisher, Kopelman, & O'Hara, 2012; Goodman, 2003). Therefore, fathers tend to dismiss their symptoms as being unrelated to the birth of a child since it is past the typical window of post-partum depression (Marsiglio, Amato, Day & Lamb, 2000).

Much of the literature cites a possible link between the mother exhibiting post-partum depression and the father later exhibiting paternal postnatal depression (Anderson, 1996b; Bronte-Tinkew, Moore, Matthews, & Carrano, 2007; Paulson, 2010). Some studies show that up to 50% of men whose partner develops post-partum depression will also develop paternal postnatal depression (Madsen, 2009; Ramchandani et al., 2005). This finding supports the importance of the mother's mental health post-partum and the role this may play in paternal postnatal depression for fathers. However, and most importantly, it should serve as an alarm to mental health professionals that if a mother is experiencing post-partum depression to also assess the father.

Relationship difficulties and the lack of communication between the parents are also risk factors for men (Condon, Boyce, & Corkindale, 2004). Not surprisingly, marital distress has been implicated in both the etiology and the maintenance of depression (Ash & Byers, 1996; Fincham, Beach, Harold, & Osborne, 1997; Whisman, 2001). Conversely, research also has indicated that depression may perpetuate poor interpersonal relations, causing additional stress for an individual, which in turn increases the level of depression (Coyne & Benazon, 2000; Joiner, Steer, Abramson, Alloy, Metalsky, & Schmidt, 2000). Further, men's assessment of fatherhood as either beneficial or a burden has been linked to their perceptions of stressors and support (Garfield, et. al., 2006). During the postnatal period, this element can be magnified and may increase already poor communication skills between couples leading to further emotional isolation of fathers.

Lastly, for fathers, societal expectations and growing responsibilities during the postnatal period and increased emphasis on the man's role as financial provider may create psychological distress contributing to the development of depression (Kim & Swain, 2007). The decision of which parent, mother or father, takes unpaid parental leave, oftentimes is determined by gender, with women often making less income than men, therefore acquiring the burden of childcare (Rose & Hartmann, 2004). There are many factors that figure into who takes leave after a child is born. Many times the decision is made based on who produces less income and can afford to stay home to care for the child (Marks, 1997). This may increase the degree of emotional distance from spouse and child imposed upon fathers which may impact them negatively.

Protective Factors

Although men have a myriad of risk factors, there are also a number of protective factors that can insulate fathers from paternal postnatal depression (Walker, Fleschler, Heaman, 1998). Research that focuses specifically on paternal postnatal depression protective factors is limited; therefore, men's protective factors for any type of depression will be reviewed as likely protective factors for paternal postnatal depression. Studies show men benefit greatly if they have a close social network of other men with whom they are able to express themselves in a non-judgmental manner (Henwood & Procter, 2003). This may even apply to online formats which are able to guarantee greater anonymity. In a 2011 study, Fletcher and St. George (2011) examined messages in an asynchronous online chat room for new fathers to reveal how fathers requested, offered, and received social support. The asynchronous but informal and personal exchanges on the site allowed fathers to explain and shape particular meanings of fatherhood (Vayreda & Antaki, 2009). Further, they found the fathers were more focused on predicaments of involved fathering such as coping with their feelings of depression or work–life balance. Overall, they reported the chat rooms to be a key component of support. Considering that "men may hesitate to show their full range of emotions, especially with a male therapist for fear of being considered unmanly," offering an online version of support may be key in reaching this population (Berger et al., 2005, p. 193).

Changing gender roles and the acceptance of men's emotionality have allowed men to more openly express feelings of incompetence, inadequacy, and depression, so that they can feel a sense of identification with other men and process these feelings (Pollack, 1995). The coping capacity of men in relation to issues of emotional expression

has long been taken for granted, but a father's sense of competence and personal attachment security to their child may be more vulnerable and important to the mental health of fathers than has been imagined (Madsen & Juhl, 2007; Radojevic, 1994). An appropriate outlet for emotional expression, one that takes into consideration cultural factors, is a key factor to consider when thinking about protective factors for fathers.

The father's family can also serve as a protective factor. A family where gender roles are flexible, where both partners share an egalitarian view of themselves, and where child care is shared and encouraged by each other and external family, is of help (Wall & Arnold, 2007). Globally, access to preventive and educational mental health care is also important (World Health Organization, 2008). Additionally, a work environment in which fathers are allowed to remain with their newborns and physically bond both with mother and child can positively impact the father and attend to the issues of fathers feeling detached from the parenting experience (Armenia & Gerstel, 2006). Shapiro (1987) postulates there is little societal support for men who want to spend more time with their infants at home and little understanding from bosses or co-workers because of the dominant paradigm of mothers staying home with infants. Unfortunately, many fathers, particularly economically disadvantaged fathers, may not be able to afford to cut back work hours even if workplace circumstances allowed it. However, McGill (2014) states that men with this egalitarian attitude about fatherhood as well as access to workplace flexibility are more likely to successfully navigate the conflict of work and family time than do other men.

Lastly, while research has shown that men are reluctant to seek help, there are obvious links between seeking professional help and a reduction in depressive symptoms

(Patrick & Robertson, 2016). Further, in one study Cabassa (2007) found that Latino men trust their doctors and reported a preference of counseling. This qualitative study furthered that "79% reported they agreed or strongly agreed that counseling would help depressed individuals" (p. 502).

Gender Bias in the Diagnosis of Depression

Gender bias can influence whether depression in men is recognized, how supportive professionals are when it is recognized, and how depressed men are treated once they are properly diagnosed. Gender bias can be defined as "a systematic deviation from an expected value that is associated with the sex of the individual" (Hartung & Widiger, 1998, p. 261). Some have suggested that sanctions against deviations from expected gender norms reflect society's sexism (Kaplan, 1983). Although this kind of sexism may exist, Hartung and Widiger (1998) point out that sex bias can also result from "well-intentioned, conscientious efforts to provide accurate estimates of differential sex prevalence rates" (p. 261). Cultural prohibitions against displaying sadness, fear, and anxiety have frequently been described as reasons men may be less likely to show their distress in the social environment and more likely to communicate their depressive symptoms in a nonobvious or masked manner (Cochran & Rabinowitz, 2000). In essence, the muting of the behavioral expression of depression often makes it difficult for clinicians to identify clear and straightforward indications of male depression (Cochran & Rabinowitz, 2003; Shepard, 2002). In Latino men this can be magnified due to the adherence to rigid and traditional cultural norms and ethnic identity (Glass & Owen, 2010).

The diagnostic criteria for major depression found in the DSM-V (American Psychiatric Association, 2013) include symptoms that represent a feminine-gendered pattern of the disorder, such as "feelings of sadness, hopelessness; loss of interest in activities, and loss of concentration," to name a few (p. 184). A number of clinical researchers (Diamond, 2004; Lynch & Kilmartin, 1999; Real, 1997) suggest that women often 'act in' as a result of gender-role conditioning that emphasizes both the expression of 'feminine' feelings and focus on internal judgments of their own inadequacies. Men, on the other hand, are conditioned to 'act out', and thus, men's depression is more likely to be expressed through chronic anger, self-destructiveness, drug use, gambling, aggression, and workaholism (Rutz, 1999). This oftentimes leads to the underreporting and under diagnosing of men's depression. Underlying these behaviors are experiences of loss and persistent feelings of hopelessness, helplessness, and worthlessness, the hallmarks of female expression of depression (Kilmartin, 2005). Compounding this is the typical postnatal period where the focus is on the mother and child, and where fathers, oftentimes, do not receive mental health attention or consideration.

Ethnic Factors in Treatment

The delivery of specific assessment and treatment components for men who experience post-natal depression must take into account different experiences of depression and communication styles of men of different cultural backgrounds (Cochran & Rabinowitz, 2003) as well as their cultural beliefs about gender and gender roles. As such, cultural differences that can impact a response to treatment for paternal postnatal depression need to be considered. Latino fathers are specifically discussed in this

dissertation study as they will soon present the largest minority groups in the United States (U.S. Department of Health and Human Services, 2013).

Latinos

Cultural considerations need to be taken into account when working with Latino men. A small but growing number of studies (Cooper, Gonzales, Gallo, Rost, Meredith, Rubenstein, et al. 2003; Givens, Houston, Van Voorhees, Ford, & Cooper, 2007) examining Latino attitudes toward depression and other mental health treatments reveals that certain attitudes (e.g., being ashamed of discussing emotional problems with clinicians, not wanting to discuss emotional problems outside the family, believing that antidepressants are addictive, and endorsing self-reliant attitudes) may deter them from seeking mental health care. Moreover, help seeking and help receiving behaviors are interwoven through families and are culturally informed processes in the Latino culture as opposed to help seeking outside of the nuclear family (Ishikawa, et. al., 2010). This makes the adherence to coping skills dependent on those given by the family as opposed to evidence based coping skills. The intersection of relationships, context, culture, and mental health care options inform help-seeking and help-receiving processes in particularized ways in the Latino culture.

These particular characteristics of the Latino culture are highlighted in many studies. For example, Cabassa (2007) found that amongst his sample of Latino men (N=56) most agreed or strongly agreed that faith in God would heal depression (79%) and that asking God for forgiveness would help heal depression (68%). To address these negative attitudes towards mental health treatment and to improve treatment adherence among Latino patients, Lewis-Fernández, Das, Alfonso, Weissman, and Olfson (2005)

recommend that clinicians explore patients' explanatory models of their illness, assess the social and financial barriers to adherence, discuss and help mitigate patients' fears and concerns about treatment, and use therapeutic contracting to assess patients' understanding of their illness and treatment plan. This can also inform which modality to choose from in order to effectively treat Latino men experiencing paternal postnatal depression.

A common theme in many studies on the role of help seeking behaviors amongst Latinos is that of *familismo,* or the importance of family (Davila et al., 2011). These authors posited that high adherence to the norm of *familismo* meant that the individual would likely not seek help, whereas participants with lower adherence to *familismo* were more likely to seek help, regardless of their respective family's disapproval. According to Gil and Vasquez (1996) an individual's adherence to the norm of *familismo* influenced the decision to seek help outside of the family when that person's family dissuaded him or her from doing so. Further, the major theme of *familismo* and its patterns of family responsibility and familial support need to be taken into consideration at both the assessment and treatment level when working with Latino men.

Chapter II: Theoretical Perspectives

Stress theory

Stressors are demands made by the internal or external environment that upset emotional balance, thus affecting physical and psychological well-being and requiring action to restore balance (Lazarus & Cohen, 1977). Two concepts are central to any psychological stress theory: appraisal, such as an individuals' evaluation of the significance of what is happening for their well-being and individual's efforts to manage specific demands (Lazarus, 1993). Lazarus (1991) states that stress is regarded as a relational concept, and not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioral, or subjective reactions. Instead, stress is viewed as a relationship between individuals and their environment. "Psychological stress refers to a relationship with the environment that the person appraises as significant for his or her well-being and in which the demands exceed available coping resources" (Lazarus & Folkman, 1986, p. 63). This definition points to two processes as central mediators within the person–environment transaction: cognitive appraisal and coping. The concept of appraisal, introduced into emotion research by Arnold (1960) and expanded by Lazarus (1966), is a key factor for understanding stress-relevant transactions. This concept is based on the idea that emotional processes (including stress) are dependent on actual expectancies that persons manifest with regard to the significance and outcome of a specific encounter. Lazarus (1966) expands on this by adding that this concept is necessary to explain individual differences in quality, intensity, and duration of an elicited emotion in environments that are objectively equal for different individuals. It is generally assumed that the resulting emotional state is generated, maintained, and eventually altered by a specific pattern of appraisals. These appraisals, in turn, are

determined by a number of personal and situational factors. Of the most important personal factors are motivational dispositions, goals, values, and generalized expectancies. Relevant situational factors are predictability, controllability, and imminence of a potentially stressful event.

Parenting stress is a construct related to the parent role and influenced by expectations and perceptions of self and role (Epifanio, Genna, De Luca, Roccella, & La Grutta, 2015). It is the collection of bio-psycho-social factors (psychological and emotional tension, negative/maladaptive coping, adherence to rigid gender roles) which distorts the adaptive reaction and appraisal to stressors and predisposes the subject to high psychological and socio-relational vulnerability and response. Barclay, Donovan, and Genovese (1996) identified anxiety, ambivalence, and difficulties in fathers' adjustment to parenthood as well as confusion about their role in their partner's pregnancy and child rearing as one of the factors that contribute to paternal stress. In addition, Buist, Moorse, Durkin (2003) found that fathers who had a passive participation in their infant's life, especially in the first year of child rearing, contributed to feelings of being subordinate to their female counterparts and an increase in fear of emotions.

Mother's depressed mood and its stressful impact on the father.

The impact of stress during the post-natal period and the impact of mother's depression on the father has been examined. Goodman (2003) conducted a literature review of pertinent studies and found that between 1980-2002, the strongest predictor of paternal depression during the post-natal period was maternal depression. Further inquiry found that the rate of depression in fathers increased within the first year, following the onset of depression in mothers (Areias, et al., 1996a, 1996b; Matthey, et al., 2000). In

addition, the prevalence of postpartum depression in both parents was significant in various studies (Raskin, Richman, & Gaines, 1990; Harvey & McGrath, 1988; Thompson & Bolger, 1999; Zelkowitz & Milet, 2001). Previous research postulates that that the incidence of couple morbidity in the first year antenatally increases due to the added stress during this period. Lastly, previous research suggests that it is the appraisal of a father's stressful situation that may influence how he assesses his ability to deal with this new period. Thompson & Bolger (1999) posit that a defining feature of a close relationship is that one partner's psychological states and actions have the capacity to influence those of the other partner" (p.38). If a father typically turns to his partner for support during a stressful time, however that partner is depressed, his own psychological adjustment may be impaired.

Masculine Gender Role Stress Theory

The secondary theoretical framework utilized to guide this research was Masculine Gender Role Stress Theory (MGRS). This theory rests on the assumption that "rigid commitment to masculine schemata for the appraisal and coping with life's problems may produce stress and result in dysfunctional coping behaviors" (Eisler & Blalock, 1991, p.45). This theory is based on the assertion that gender plays an important role in how each sex responds to mental and physical problems; therefore, this theory and its tenets have implications for the understanding of psychosocial problems among men. Richard Eisler, a major contributor to MGRS, referred to the "cognitive appraisal of specific situations as stressful for men that include the individual's thoughts and behaviors, as well as environmental events" (Eisler & Skidmore, 1987, p. 125). James O'Neil, also a contributor of MGRS, asserts that this phenomena results from rigid

gender role socialization and is experienced in men's interpersonal, career, family, and health lives (O'Neil, 1981a). Simply put, men will experience stress when challenged with a situation that requires a traditionally feminine response that does not fit into traditional egalitarian male schema.

Gender refers to a social construction of what are considered acceptable behaviors considered to be masculine and/or feminine (Franklin, 1988). The cultural imposition of rigid masculine values and norms that may inhibit healthy expression of emotion during stressful times can lead to dysfunctional coping behaviors and mental health symptoms. For example, it is a cultural norm for many that masculine identified men should not openly display feelings of sadness, fear, or vulnerability (Connell, 2005). Latino men may show a disdain for emotional expressiveness, among other more typical feminine traits, and a penchant for aggression and assertion.

Heifner (1997) found, through interviews, that the male gender role identity affected the expectations that men had about depression. These men reported that they needed to be strong, successful, in control, capable of handling their own problems without help, and that they needed to conceal emotions. All of these were identified as traditional masculine traits. Similarly, Good & Mintz 's (1990) study with 401 males showed that men who identified more closely with the cultural expectations of the male role were more likely to have depression and were less inclined to seek counselling services. These findings suggest that such cultural or societal expectations of the male role could place men at an increased risk of depression during a stressful period such as the postnatal period, while more egalitarian attitudes may insulate men.

Adhering to such rigid masculine schemata, reinforced by the family system, peers, and the outside environment, eventually operate through a self-evaluation process to provide the basis for what men consider to be masculine. This adherence to rigid gender norms in turn can create unhealthy and dysfunctional behavior patterns and the lack of the ability to recognize and cope with depression symptoms. Masculinity is conceptualized to be an achieved status, or an identity, regulated by one's beliefs and societal/cultural expectations and enculturation.

Historical background of masculine gender role stress theory.

MGRS, most notably, has its roots in Sandra Lipsitz Bem's research. In Bem's Gender Schema Theory (1981) she posits that individuals become gendered in society and that one's gender serves as a "basic organizing principle" (Bem, 1981, p. 354). Bem continues to assert that this sex typing of genders frames perception and processing of environmental situations. Further, Bem discussed sex typing as being influenced by child rearing, media influences, as well as peer socializations and cultural transmission. Bem further suggests that the cognitive gender constraints males encounter can cause temperament and behavior to become dysfunctional due to the limited access to the full range of characteristics and coping schemas useful across genders. Bem's focus was on characteristics of masculinity that are socially desirable. Therefore, men were categorized as masculine if their self-perception included traditional male attributes.

Other researchers have subsequently supported Bem's belief of sex typing by expanding on the influence of social and culturally determined rules for expressive behavior in genders (Buck, Losow, Murphy, & Costanzo, 1992; Ekman, 1992; Ekman & Friesen, 1975; Ekman, Friesen, & Ellsworth, 1982). Simply put, according to Gross and

John (1997), women have more socially accepted norms for expressing negative emotions and stressful behavior so they are able to express their emotions more often and with greater ease than men when confronted with emotional or psychological distress. Within the Latino culture, sex typing can act as a barrier against expression of depressive symptoms due to its rigid adherence to male dominance and control.

Additionally, other researchers have discussed the social and emotional consequences faced by men according to gender role. In his seminal book *The Myth of Masculinity* (1981), Joseph Pleck discussed how men are societally condemned if they violate masculine gender role norms. The penalties for men violating masculine gender norms are far more severe than for women who violate feminine gender norms. The gender role strain paradigm (Pleck, 1981, 1995) hypothesized that masculine gender role discrepancy strain has a negative relationship with self-esteem. For example, violation of gender role norms leads to social condemnation and negative psychological consequences, such as negative self-judgments. Similarly, O'Neil (1982) enhanced this understanding of male dominance by hypothesizing that men's fears of appearing feminine or failing at exhibiting masculine power and control leads them to gender role conformity as well as dysfunctional responses to emotional and psychological stressors. Pleck's Gender Role Strain Model was pivotal in conceptualizing MGRS and the effects of rigid masculine gender norms on psychological stress.

MGRS and depression symptoms in postnatal fathers.

The impact of masculine gender role socialization and how men cope with stress, which puts a premium on stoicism and suppression of emotion, is one of several confounding cultural factors that obscure the expression of depressed mood in many men.

Culture-specific and ethnic-specific norms and practices further complicate the accurate identification, assessment, and treatment of depression in men. This is evident during the postnatal period, in which mother and child are usually of clinical concern. Since Latino fathers may process information under the masculine schemata, which is one of strength and power, the often stressful and unpredictable situation of the birth of a child doesn't allow them to exert this strength and power, therefore causing stress as it doesn't fit within their cognitive schema of dominance. Further, in Latinos, typical female expression of depression may be equated with emotional closeness, homosexuality, and might be seen as weak and devalue their masculinity (Berger, 2005; O'Neil, Helms, Gable, David, & Wrightsman, 1986).

In many racial, ethnic, and cultural groups, sensitivity to within group difference also plays an important role in gender-sensitive assessment of depression in men. For example, level of egalitarianism or gender role attitudes is a salient factor in determining the manner in which a Latino man might manifest depressive symptoms (e.g., Sue, 2001) and should be taken into account when assessing for possible depression in men.

Earlier research indicated that overall symptom profiles as well as the eventual course of a depressive episode were expected to be similar in both men and women (Coryell, Endicott, & Keller, 1992; Frank, Carpenter, & Kupfer, 1988; Simpson, Nee, & Endicott, 1997). However, other researchers have identified important masculine-specific modes of experiencing and expressing depression (Good & Wood, 1995). Men often show depression in an oblique or idiosyncratic manner. For example, for many men, due to masculine gender role socialization, might express anger as opposed to sadness, might withdraw from interpersonal support, or might use alcohol for self-

medication, all of which can obscure a depressive episode (Cochran & Rabinowitz, 2003).

As noted, cultural prohibitions placed on men against the experience of mood states directly related to depression (e.g., sadness) and the behavioral expression of these mood states (e.g., crying) make clear and simple descriptions of male depression difficult (Cochran & Rabinowitz, 2000). Coupled with the postnatal period, which is an adjustment for all members of the family, and the gender restrictive norms fathers' face, the picture of understanding father's possible depressive symptoms in the postnatal period through this lens becomes clearer.

Chapter III: Research Design and Methods

Research design

A cross-sectional survey design was used to examine the relationship between coping skills, egalitarianism, and depressive symptoms in postnatal Latino fathers. The purpose of selecting the specific design and methodology was to determine possible relationships between the independent variables (coping skills and egalitarianism) and the dependent variable (depression symptoms in postnatal fathers), and to answer the study's research questions. This present investigation is unique because it attempts to address the aforementioned gaps in identifying possible depressive symptoms of the Latino father as well as the role of egalitarianism and coping skills. The study will include an adequate sample size of diverse Latino fathers from various private practice mental health practitioners in Miami, Florida. All the fathers who participate in this study will have been born in multiple Latin American countries or be US born with at least one parent from a Latin American country. Since prior research on this topic is still in its infancy, it has not yielded enough data to conduct an appropriate power analysis. However, a sample size of 101 was used for this study.

Research Questions and Hypotheses

The current study explored the following research questions:

Research Question 1: Is there a relationship between egalitarianism (IV) and postnatal depressive (DV) symptomology in the sample of post-natal Latino fathers?

$H1_1$ There is a negative relationship between egalitarianism (IV) as measured by the Gender Role Attitudes Scale (GRAS) and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in the sample of Postnatal Latino fathers.

Research Question 2: Is there a relationship between coping skills (IV) and depression symptoms (DV) in the sample of post-natal Latino fathers?

$H2_1$ There is a significant negative relationship in coping skills (IV) as measured by the introduced father's coping skills scale and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in postnatal Latino fathers.

$H2_2$: There is a significant negative relationship in the coping behavior of seeking professional treatment (IV) as measured by a single item on the introduced coping skills measure and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in postnatal Latino fathers.

Research Question 3: Do coping skills and egalitarianism (IV) influence depressive symptoms (DV) among the sample of post-natal Latino fathers?

H3: Both coping skills and egalitarianism will have significance on the variance of depressive symptoms.

H4: Coping skills will contribute a greater percentage of the variance in depressive symptoms than egalitarianism.

Variables and measures are listed as follows in Table 1:

Table 1

Variables and measures

Variable	Measure	Levels of Measurement
Independent Variable (IV) Egalitarianism	Gender Role Attitudes Scale (GRAS) 20 questions	Interval

	Likert Scale	
Independent Variable (IV) Coping skills	Created measure Fathers Coping Scale 7 questions Likert Scale	Interval
Dependant Variable (DV) Paternal Postnatal Depression	Edinburgh Postnatal Depression Scale (EPDS) 10 Questions Likert Scale	Interval

Sample and Sampling Procedures

A convenience sampling strategy was used to access a larger sample among a difficult to reach population. The sample was collected from various mental health private practitioners in Miami, Fl. Inclusion criteria included: heterosexual Latino fathers who have at least one infant under the age of 1 year old (12 months) for whom they are financially responsible for, they have participated in the pre-natal maternal care, and have a relationship with the mother. They also will identify as Latino, having been born in Central or South America, Cuba, Puerto Rico, Dominican Republic, or US born with Latino heritage.

A simple non-random convenience sampling strategy was employed. The advantage of convenience sampling is that it will yield a sufficiently large pool of relatively diverse participants. Further, due to South Florida being home to diverse ethnic communities, various ethnicities were sampled.

Instruments

Three instruments were used for data collection purposes: The Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987), the Gender Role Attitudes Scale (GRAS) (Garcia-Cueto, Rodriguez-Diaz, Bringas-Molleda, Lopez-Cepero, Paino-Quesada, Rodriguez-Franco, 2015), and an author created scale on father's coping skills. The instruments were available to participants in English and Spanish.

Demographic Questionnaire

All participants completed a demographics questionnaire. The demographics questionnaire asked age of father, if they are a father (parent) of a child less than one year of age (12 months), what is the birth order of the child, how many children they have, what is the gender of the most recent child born, what country are they born in and what country their parents were born in, if the participant was not US born, how many years they had been living in the US, the highest education level they attained, if their wife/partner is/had been in treatment for post-partum depression, to what degree did they identify with the Latino culture, highest education level completed, and income. The demographics questionnaire was available in English and Spanish.

The Edinburgh Postnatal Depression Scale

Although originally developed to screen for depression in mothers, the EPDS is also used to assess fathers who may suffer from postpartum depression. The EPDS has been found to be a valid and reliable measure of paternal depression (Matthey et al. 2001). The EPDS is a 10-item self-rating Likert-type interval scale. It was created to screen a large population for postnatal depression. The scale was originally created for

mothers. The questionnaire is scored on a 4-point scale (0 to 3), with a minimum score of 0 and a maximum of 30 (Cox, Holden & Sagovsky, 1987). Sample items include: I have blamed myself unnecessarily when things went wrong, I have felt sad or miserable, and I have been so unhappy I have difficulty sleeping.

The reliability and validity of the EPDS was tested by using Cronbach's alpha coefficient (0.8) and Guttman split-half coefficient (0.8). The EPDS can be scored quickly and is a widely used assessment tool for mothers and fathers in the post-natal period, as it has a high level of reliability (75%) (Adouard, Glangeaud-Freudenthal & Golse, 2005; Ramchandani et al., 2005). Scores of 10 or more indicate a possible diagnosis of major depressive disorder along with a high specificity (95.7%) and sensitivity (81.1%) (Cox.et al., 1981). The cut-off points for the EPDS that have been widely acceptable necessary for a referral to aid in determining depression in parents is 10 (less severe depression and 12/13 (more severe depression) (Psychogiou, 2010; Paulson, & Bazemore, 2010). However, there have been variations in the sensitivity of the instrument to detect depression due to methodology used, cut-off points, and diagnosing criteria (Deater-Deckard et al., 1998; Edmondson, Psychogiou, Vlachos, Netsi, Ramchandani, 2010; Matthey, Barnett, Kavanagh, & Howie, 2001).

Gender Role Attitudes Scale

The Gender Role Attitudes Scale is a 5 point Likert type scale consisting of 20 items. Responses range from totally agree, 1, to totally disagree, 5. Garcia-Cueto, Rodriguez-Diaz, Bringas-Molleda, Lopez-Cepero, Paino-Quesada, Rodriguez-Franco (2015) sought to "provide an improved scale for the assessment of gender role attitudes, based on the theoretical perspective of gender equality" (p. 61). Using a sample of 2,136

young Spanish people, the scale was created by identifying 20 out of 50 items which reflect attitudes that identify the gender role to be played in society and family. Sample items include: People should be treated equally, regardless of their sex; I think it is worse to see a man cry than a woman; a father's main responsibility is to help his children financially; and mothers should make most of the decisions on how to bring up their children. This measure is highly reliable, with an alpha coefficient of .99.

Coping Scale

The coping scale was developed by the researcher specifically for this study to ascertain how Latino fathers attempt to cope with their post-natal status. The scale includes 7 items: (1) I have used substances like alcohol or drugs, (2) I have avoided my wife, (3) I have avoided my child, (4)I have spent more time at work, (5) I have done nothing and ignored it, (6) I have turned to faith, and (7) I spoke to a mental health professional. Psychometric assessment of this measure will be conducted and its refinement will be undertaken prior to its use in analyses. A higher score indicates the father participates in more coping techniques.

Data Collection Procedures

The researcher obtained permission from Barry University's Institutional Review Board (IRB) to conduct the proposed study. After obtaining IRB permission, and over the course of 7 months, the researcher recruited participants for the current study from local mental health practitioners in private practices in Miami, FL. Flyers were given to local colleagues explaining the study with the researcher's contact information listed. The flyer had the title of the research study, the purpose of the study, and the office number to contact to make an appointment with the researcher. The flyer also contained the

researcher's contact information should they have any questions and the number and contact information of the dissertation committee chair as well as the IRB point of contact, Barbara Cook.

When a participant expressed interest in the study, the researcher contacted them by phone and scheduled a meeting within two weeks of the initial phone call in Miami, at the participant's convenience. First, inclusion criteria was reviewed with each participant. Then, all participants were given an opportunity to read the cover letter and consent form and asked if they have any questions before being asked to sign the consent forms. Once consents were signed participants received the questionnaires. The fathers were be given the full battery that took no more than 20 minutes to complete. The total interview took around 40 minutes. Participants were assured their information would be kept confidential. The participants filled out the short measures in one meeting with the researcher nearby. Participants were told that they are free to leave the study at any time for any reason, and that they may feel free to not answer any question they feel uneasy about. They were provided with the contact information of the chair of the dissertation and point of contact person of the IRB in the event they have additional questions or concerns about their participation. Lastly, there is always the risk of asking the participants about a difficult period in their life and their feelings as it relates to the birth of their child. This potentially can upset participants and trigger negative reactions. A list of hotline numbers, 99support sites, and mental health sources were given to each participant if further services are needed in Miami.

The researcher made every effort to protect the participant's identity and any data acquired. Each participant completed the paper-pencil assessment survey within

approximately 20 minutes in a one-time sitting. Measures were given to the participant in English or Spanish, depending on the participant's preferred language. The researcher remained in close proximity in order to be available upon request if any questions or concerns arise. As per Barry University's IRB standards (2000) data will be kept in a locked file in the researcher's office and the participants' signed consent form will be kept separate from the data. Each assessment battery will be marked with an identification number. The data is confidential. This researcher has obtained NIH training and received certification. Non identifying data will be kept for at least 7 years, then indefinitely. Additionally, participants were given a copy of their signed consent with the researcher's name and contact information.

Ethical Considerations

The researcher administered the assessment survey and placed the data in a locked, secure cabinet. The researcher did not have any personal or professional relationship with the participant. The researcher reiterated the participant's right to withdraw from the study at any time without consequence. Grinnell and Unrau (2011) support that survey research posits fewer ethical dilemmas than that of experimental or field research design; however, confidentiality is of the utmost importance when conducting survey research. The participants were given a number to ensure that no names are printed on the survey. The surveys were entered into SPSS upon collection on a computer that is password protected and then be stored in a locked office inside a locked cabinet. Survey research methodology is well established and is largely supported in both its scientific reliability and practical efficacy (Meenaghan, Kilty, Long, & McNutt, 2013).

Additional ethical considerations encompass the sensitive nature of the study. Examining a participant's coping skills and depression symptoms could prove traumatic for some individuals participating in the study. Participants will be able to reach out to their mental health therapist, if they have one, or outside resources provided should they feel emotionally strained. In addition, the consent and description of this exploratory study lists the risks and benefits of one's participation and stresses that it is a voluntary process with the right to withdraw at any time.

Statistical Analysis

Descriptive Statistics

At the initial stage, data was screened for missing values and outliers. Demographic information was gathered to facilitate descriptive statistics regarding the composition of the sample. Demographic categories that will be reported for purposes of this study will be: age of father; marital status; number of children; age of oldest child; age of youngest child; gender of youngest child; education level; and country of birth. Age will be measured on a ratio scale and mean and standard deviation will be reported. Ethnicity will be measured on a nominal scale including the categories of Cuban, Central American, Dominican, Mexican, Puerto Rican, South American, and Other, and will be reported as percentages. Income will be measured on an interval scale.

Internal consistency approximations, Cronbach alphas, were calculated for all instrument scales utilized in the research study and are reported together with the results. Bivariate Analysis were conducted to explore the correlations between each IV (egalitarianism and coping skills) and the DV (depression symptoms) in order to examine

the strength and direction between each IV and the DV and to exclude variables of non-significance.

Research Question 1: Is there a relationship between egalitarianism (IV) and postnatal depressive (DV) symptomology in the sample of post-natal Latino fathers?

$H1_1$ There is a significant negative relationship between egalitarianism (IV) as measured by the Gender Role Attitudes Scale (GRAS) and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in the sample of Postnatal Latino fathers. This hypothesis was measured using Pearson product-moment correlation. This statistical analysis is used when the researcher is seeking to identify how strongly and in what direction a continuous IV and a continuous DV are related (Pallant, 2013).

Research Question 2: Is there a relationship between coping skills (IV) and depression symptoms (DV) in the sample of post-natal Latino fathers.

$H2_1$ There is a significant negative relationship between coping skills (IV) as measured by the introduced father's coping measure and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in Postnatal Latino fathers. This hypothesis was measured using Pearson product-moment correlation.

$H2_2$: There is a significant negative relationship in the coping behavior of seeking professional treatment (IV) as measured by a single item on the introduced father's coping skills measure and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in postnatal Latino fathers. This hypothesis was measured using Pearson product-moment correlation.

Research Question 3: Do coping skills and egalitarianism (IV) influence depressive symptoms (DV) among the sample of post-natal Latino fathers?

H3: Both coping skills and egalitarianism will have significance on the variance of depressive symptoms. A multiple linear regression was used to measure how much unique variance in the dependent variable each of the independent variables can explain (Pallant, 2013).

H4: Coping skills will contribute a greater percentage of the variance in depressive symptoms than egalitarianism. A simple multivariate linear regression with stepwise entry was used to measure how much unique variance in the dependent variable each of the independent variables can explain (Pallant, 2013).

Chapter IV: Results

Data Cleaning

Data was thoroughly screened for missing values and errors. Missing values and data were at-random, there was no pattern of missing data to confound estimates.

Descriptive Analysis

Frequency distributions and descriptive statistics (mean) were produced for: demographic variables (participant age, partner age, marital status, years total in a relationship, number of children, age of child one in months, age of child two in months, birth order of youngest child, highest grade completed, household income, country of birth, and how does the participant identify).

Demographics

101 participants agreed to participate in this study by contacting the research via a flyer that was given to colleagues of this researcher in Miami, Florida to place in their waiting/lobby areas. Participants contacted the researcher and completed the survey in a one-time sitting.

In this sample, 100% of the participants were male; therefore, female and transgender are not represented. The mean age of this sample was 31 years old (SD= 4.65). The mean partner age was 29 (SD=4.102). Out of the sample of 101 participants, 44 were not married and 57 were married; the mean for total years in a relationship was 4.1 years (SD=2.17). Finally, frequency analysis reveals that 57.4% had one child, and 42.6% had two children; 23% had at one older child that was 24 months and 9% had one child that was 10 months old; 66.3% reported their youngest child was a male and 33.7% reported their youngest child was a female. This is shown as follows in Table 2:

Table 2

Demographics of Sample

Demographic	N	Percent
Gender: Male	101	100%
Age (In ranges)	20 – 30	63%
	31 – 40	34%
	41 – 50	3%
Relationship Status:		
Married	57	44%
Un-Married	44	56%
Number of Children:		
1	58	57%
2	43	43%
Age of Oldest Child (in Months)	5 – 12	57%
	22 – 36	26%
	42 – 60	14%
	72 - 120	3%
Gender of Youngest Child (in Months)		
Male	67	66%
Female	34	34%

(N=101)

Additional information on the sample includes educational level, with 31.7 % having some college. With regards to income level 40.6 % reported an income in the range of $30,000-$51,000. This is shown as follows below in Table 3:

Table 3

Education and Income Level of Sample

Demographic	N	Percent
Highest grade completed		
Some high school	11	10.9%
High school graduate or equivalent	27	26.7%
Some college	32	31.7%
Completed undergraduate	25	24.8%
Some graduate school	1	1%
Completed Graduate school	5	5%

Income Level	
31,000-50,000	40.6
51,000-80,000	20.8
81,000-100,000	3
101,000 +	3
Prefer not to answer	32.7

(N=101)

All the participants were asked about their country of birth, with USA being reported the most with 44% and Honduras and Mexico (9.9% both) being next most frequently (M=15.42, SD=7.31) . This is shown as follows below in Table 4:

Table 4

Country of Birth of Sample

Demographic	N	Percent
Country of Birth		
El Salvador	1	1
Guatemala	4	4
Honduras	10	9.9
Nicaragua	8	7.9
Mexico	10	9.9
Colombia	9	8.9
Venezuela	7	6.9
Cuba	3	3
Dominican Republic	3	3
Puerto Rico	2	2
USA	44	43.6

(N=101)

Edinburgh Postnatal Depression Scale (EPDS)

The EPDS has a Cronbach's alpha of .724 (M=13.68, SD=5.08). Answers on this scale ranged from "Yes all the time" to "no not at all". Items 3, 5 and 10 are reverse scored and a total sum is given when all answers are added. The range of scores in this sample was from 1-27. In this sample, 81% of participants scored over 10, which is the clinical cutoff for a referral to a mental health provider for further evaluation.

Coping Scale

The 7 item coping sale developed by the researcher yielded a Cronbach's alpha of .63 (M=11.01, SD=3.54). While this is not optimal, if item #1 (I have used substances like drugs or alcohol) and/or item #6 (I have turned to faith) were removed, a higher Cronbach's alpha will be achieved (.66). A higher score indicates the father participates in more coping techniques. Scores associated with participants' responses ranged from 'Everytime' to 'Never. Items 6 and 7 are reverse scored. A total sum is given when all answers are added. The range of scores in this sample was from 4-28.

Gender Role Attitudes Scale (GRAS)

The Gender Role Attitudes Scale has a Cronbach's alpha of .845 (M=58.28, SD=11.25). Participants' responses ranged from "Totally agree" to "Totally disagree". Items 8-20 are reverse scored. A total sum is given when all answers are added. The range of scores in this sample was from 38-98.

Correlations of measures are shown below in Table 5:

Table 5

Correlations of Measures

	M(SD)	EPDS	Egalitarianism	Coping
EPDS Total Score	13.38 (5.08)	-	-	-
Egalitarianism	58.25 (11.25)	-.226*	-	-
Coping Skills	11.01 (3.54)	-.276**	.136	-

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

Inferential Statistics

Hypothesis 1 stated that there is a negative relationship between egalitarianism (IV) as measured by the Gender Role Attitudes Scale (GRAS) and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in the sample of Postnatal Latino fathers. A Pearson Product Moment Correlation was calculated. Based on the results of the study there is a negative weak correlation between egalitarianism (IV) as measured by the Gender Role Attitudes Scale (GRAS) and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS), $r = -.23$, $p < .05$. This indicates that the higher the father's egalitarianism the lower his depressive symptoms.

Hypothesis 2_1 stated that there is a significant negative relationship in coping skills (IV) as measured by the introduced father's coping skills scale and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in postnatal Latino fathers. A Pearson Product Moment Correlation was calculated. Based on the results of the study there is a significant negative relationship between coping skills (IV) as measured by the introduced father's coping skills scale and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression, Scale (EPDS), $r = -.28$, $p < .01$. This indicates that the higher the father's coping skills the lower his depressive symptoms.

Hypothesis 2_2 stated that there is a significant negative relationship in the coping behavior of seeking professional treatment (IV) as measured by a single item on the introduced father's coping skills measure and depressive symptoms (DV) as measured by the Edinburgh Postnatal Depression Scale (EPDS) in postnatal Latino fathers. A Pearson

product-moment correlation was calculated. Based on the results of the study there is a significant negative relationship in seeking professional treatment and depressive symptoms, $r = -.20$, $p < .05$. This indicates that the greater the likelihood that a father seeks professional treatment the less depressive symptoms will be reported.

Hypothesis 3 stated that both coping skills and egalitarianism will have significance on the variance of depressive symptoms. A simple multivariate linear regression was calculated. Based on the results of the study the model was found to be significant, $f = 6.2$, $p < .05$, with an R^2 of .11. This states that 11.2% of the variance in the depression scores can be accounted for by egalitarianism and coping skills. The results can be interpreted to mean that coping skills and egalitarianism are significantly related to depression scores. Results are in Table 6:

Table 6

Unstandardized Coefficients

Model		**B**	**Std. Error**	**t**	**Sig.**
1	(Constant)	24.826	3.240	7.663	.000
	Coping Skills	-.358	.138	-2.598	.011
	Egalitarianism	-.087*	.043	-2.001	.048

* p<.05

Hypothesis 4 stated that coping skills will have higher predictive power compared with egalitarianism on the variance of depressive symptoms. A simple multivariate linear regression with stepwise entry was calculated. Model 1 with coping skills was significant by itself ($f = 8.15$, $p < .01$). Model 2 was also significant when egalitarianism was added with coping skills ($f = 6.20$, $p < .01$). The results indicate that while both egalitarianism and coping skills predict decreased symptoms, coping skills ($B = -.36$, $p < .01$) contributes

a greater percentage of the variance than egalitarianism (B= -.09, p <.05). Results are in Table 7:

Table 7

Unstandardized Coefficients

Model		B	Std. Error	t	Sig.
1	(Constant)	20.402	2.404	8.485	.000
	Coping Skills	-.395	.139	-2.854	.005
2	(Constant)	24.826	3.240	7.663	.000
	Coping Skills	-.358	.138	-2.598	.011
	Egalitarianism	-.087	.043	-2.001	.048

Chapter V: Discussion

Summary of Results

The primary aim of this study was to examine the relationship between coping skills, egalitarianism, and depressive symptoms in post-natal Latino fathers. An additional aim was to examine the influence of coping skills (IV) and of egalitarianism (IV) on depressive symptoms (DV) among adult Latino fathers. Several important findings were recognized in this research: 1) there is a negative correlation between egalitarianism and depressive symptoms. This indicates that the higher the father's egalitarianism the lower his depressive symptoms; (2) there is a significant negative correlation between coping skills and depressive symptoms in postnatal Latino fathers. This indicates that the higher the father's coping skills the lower his depressive symptoms; and finally (4) coping skills and egalitarianism are significantly related to depression scores, where coping skills contributes a greater percentage of the variance in depressive symptoms than egalitarianism among Latino fathers.

Discussion of Major Findings

Research question 1.

The findings indicate that there is a relationship between egalitarianism and postnatal depressive symptomology in Latino men in the postnatal period. The higher father's egalitarianism score, the lower his depressive symptoms. This finding is consistent with the literature. Buist, Morse, & Durkin (2002) found that role conflict and rigid gender role adherence can negatively impact a new father's mental health. Current literature does show that adherence to egalitarianism and a flexible male gender role may act as an insulator against the inability to cope and express feelings of depression for

men. Inglehart & Pippa (2003) and Saba, Kamal, Juzer (2017) found that adherence to egalitarianism and a flexible male gender role may act as an insulator against feelings of depression for men. This suggests that the level of egalitarianism or gender role attitudes is possibly a salient factor in determining the manner in which a Latino man might manifest depressive symptoms (e.g., Sue, 2001) and should be taken into account when assessing for possible post-natal depression in men. Further, these results signal to how important dominant scripts around masculinity can have systematic effects on Latino men.

Research question 2.

The current study found a significant negative correlation between coping skills and depressive symptoms in Latino fathers in the post-natal period. This indicates that the lower the father's coping skills, the higher his depressive symptoms. While research agrees that coping skills alleviate stress and promote positive psychological outcomes (Smith, Saklofske, Keefer, & Tremblay, 2016), the specific coping skills needed for fathers in the post-natal period have not been researched thoroughly in relation to mother's coping skills in the post-natal period (Epifano, Genna, DeLuca, Roccella, La Grutta, 2015). This finding is significant because it indicates that fathers would benefit from assistance in developing positive coping skills that they can utilize in the post-natal period to offset depressive symptoms. Further it informs social workers of the importance to help fathers identify coping skills in order to identify potential characteristics of depression in the post-natal period.

The next finding indicates that that there is a significant negative relationship in the coping behavior of seeking professional treatment and depressive symptoms in

postnatal Latino fathers. This indicates that the greater the likelihood that a father seeks professional treatment the less depressive symptoms will be reported. Recognizing and including the father as part of the post-natal care system is an important task for social workers and other allied professionals. Even more important is helping fathers identify possible depressive symptoms in the post-natal period. Specifically for Latinos, the traditional male's lack of adherence to an egalitarian sex role in his family also contributes to the lack of help seeking due to issues of stoicism and shame (Ishikawa, Cardemil, & Falmagne, 2010). This becomes a significant barrier and cultural prohibition for accessing help (Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Añez, Paris, Bedregalm, Davidson, & Grilo, 2005). In Latinos, this lack of help seeking behaviors for possible depressive symptoms by fathers is further compounded by cultural norms of men's dominance and being emotionally stoic. While the reasons for men, specifically Latino men, not to seek help are numerous, research agrees that seeking professional help can alleviate depression in men (Addis & Mahalik, 2003). Creating opportunities for a father to be able to seek professional treatment is key in reducing the impact of depression on the father in the post-natal period.

Research question 3.

The current study's findings indicate that coping skills and egalitarianism significantly influence depression scores. Further, the results indicate that while both egalitarianism and coping skills predict depressive symptoms, coping skills contributed a greater percentage of the variance in explaining depressive symptoms in Latino fathers in the post-natal period. Although not specific to postnatal Latino fathers, research has documented the importance of coping skills and their ability to offset depression in the

post-natal period (Hung, 2005; Nayak & Shetty, 2015).

With egalitarianism and coping skills significantly predicting depressive symptoms, Latinos might benefit from learning coping skills to combat possible depression. Additionally, there is the possibility that traditional and cultural male responses to depression may inhibit a father's ability to identify these feelings. Indirect evidence has shown a strong effect exerted by social and cultural factors to the onset of depression in men (Jenkins, 1985). And while these very factors may serve as an insulator they can also serve to inhibit Latino men from identifying and seeking help for depression. Next steps for clinicians and specific circumstances for the treatment and prevention of depression in Latino men is written about in the section on implication for social work practice.

Study Limitations

While this current research represents an important step toward expanding understanding of the relationship between coping skills, egalitarianism, and depressive symptoms in postnatal Latino fathers, certain limitations were present that could have affected the validity of the study. Participants volunteered after seeing a flyer posted in a therapy office, and were more likely to participate in this study if they were either in treatment themselves or accompanying a family members or friend to their therapy appointment. This clinical sample could have been more prone to symptoms of depression making the sample less generalizable to the population. Further, sampling from private therapy offices may limit the population to only those persons who can attend to those centers or seek treatment. It may represent a particular socio-economical class only. Next, participants were given an option to meet with the researcher at the

location of their choice, their home or office, a public location or the researcher's office, therefore a participant's response may have differed based on location that was chosen and the level of comfort of the participant in that location. Participants were asked to think about their symptoms since their last child was born, this introduces issues such as poor recall or perhaps a lack of willingness to report having these feelings/thoughts. Literature suggests that relying on self-report and symptom recall leads to underreporting conditions with male participants (Frank et. al, 1988). Men appear to be less willing to admit to the presence of symptoms that threaten their self-image of manhood, both during and after, their depressive episode (Addis & Mahalik, 2003). Finally, a non-random (non-probability) exploratory, cross-sectional survey design has lower external validity and limited ability to generalize to the larger study population because no randomization or control has occurred (Kerlinger & Lee, 2000).

Additionally, the researcher sampled fathers with a small infant who may be exhibiting depression, therefore some fathers may not want to participate or disclose due to stigmatizing gender norms discussed earlier. Also, the fathers who choose to respond to the researcher's inquiry may represent specific qualities or traits and not necessarily be representative of fathers of the greater population. For example, they may be fathers who are more involved in their infant's care than others.

Possible threats to construct validity were also present. The participants could have been in therapy for separate issues at the time of this study. This could have had an impact on how they answered the survey. In addition, marital status, length of time the fathers have been married, employment status, temperament of the infant, and previous issues of depression, may each be a factor in the development of paternal post-natal

depression. Alternate explanations for what might bring about a change in the dependent variable are unlimited. Also, this study only involved one contact which was not designed to measure change (Kumar, 2014). Further, this sample was taken in the highly Latinized major metropolitan city of Miami, Florida. This study should be replicated in areas of the United States in which there is greater distance between the dominant culture and Latino culture. Repeating this study with fathers in different income brackets is also recommended as it may yield other results. Even though this current research experienced some limitations, this study notably adds to the literature and addresses the dearth of knowledge regarding the paternal post-natal period.

Study Strengths

Research exploring possible paternal depression in the postnatal period is scant and has led to a possible belief that depressed mood in the postnatal period is a phenomenon that is only associated with being female. This current research is both timely and necessary to gain insight and knowledge into how egalitarianism and coping skills affect depression in fathers in the postnatal period. Moreover, studying the Latino father leads to advances in an area that is otherwise limited. This researcher had feasible access to this population in a large Metropolitan city where many different types of ethnicities live together. To date studies of the many diversities of Latinos in the area of post-natal depression are not plentiful. In addition, studies of depression symptoms in postnatal fathers with minority populations are scant so this inquiry adds to the knowledge base. Literature suggests that role conflict and gender role stress is a significant stressor for a new father that may impact mental health negatively and impair his engagement in the family as he adjusts to the needs of having a new infant in the

home (Barclay, Donovan, & Genovese, 1996; Buist, Morse, & Durkin, 2002; Silverstein, Auerbach, & Levant, 2002). This study adds also to the knowledge base on egalitarianism in the Latino father.

Implications for Social Work Practice

Prevention and screening.

Traditionally, care for postpartum depression has been directed towards mothers only (Dennis & Chung Lee, 2006). Only in the past decade, has increased attention been paid in the literature regarding paternal experience, thus increasing the body of knowledge that describes the characteristics of paternal depression, risk factors, and effect of the father's mental health.

This current study showed that paternal depression is a clinically significant problem for fathers that is also underdiagnosed and undertreated. It is only in the past 10 years that the current literature on depression in early fatherhood has been advanced. Further, it has not found a clear center. This may be because many studies that address paternal depression tend to be incidental to larger studies on mothers. More work is needed that specifically focuses on prevention of paternal depression, with close attention to representative samples sensitive to the considerable cultural variability in paternal involvement prenatally and postnatally. With this increased interest in father's postnatal experience, implications from this study presents a unique opportunity to develop prevention tools and literature that can be presented to fathers in the pre-natal period in order to address possible symptoms in the post-natal period.

According to Edoka, Petrou, and Ramchandani (2011) paternal depression is proving to be a public health concern because it is associated with increased community

care costs such as primary care, psychologist contacts, mental health groups, and outpatient hospital services or utilization. Anticipatory guidance may be one of the most important aspects of care for social workers and medical professionals to incorporate in their practice when they are working with expectant and new parents. The focus of the pre-natal world in the past has been on mothers; however, fathers have pre and post-natal needs as well. Goals of parent education and prevention include increasing awareness and decreasing the potential stigma associated with paternal depression in the post-natal period. This is increasingly important when dealing with men of color (ie, Latino and African American). Prenatal and obstetric examinations, expectant parent visits, the birth hospital stay, and newborn and infant well-child checkups all provide ideal opportunities for a social worker to educate both parents about depression in the post-natal period. Providing anticipatory guidance such as signs, symptoms, and risk factors gives social workers a unique opportunity to help fathers recognize their new feelings after the birth of their baby and know if and when to seek help. Verbal education and discussion, brochures, handouts, posters in examination rooms, and including paternal depression in hospital discharge instructions are potential avenues for providing education, screening, and prevention. And while to date no diagnostic tool has been developed to exclusively screen for paternal depression, screening and prevention programs can encompass the fathers' experience in the education of being a parent to a newborn. The inclusion of the identified characteristics of paternal depression should be an integral part of any prevention and screening program with new parents (Musser, Ahmed, Foli, & Coddington, 2013). Further, this inquiry encourages social workers to possibly identify in a couple their roles with respect to parenting and help them have a more egalitarian

view in an effort to help them reduce the possibility of depression symptoms. And lastly, this knowledge will allow social workers and other helping professionals to productively highlight the seriousness of depression conditions in men in the post-natal period.

Assessment specific to the Latino father.

Gender specific assessment for Latino fathers with possible depression in the post-natal phase is crucial to their overall treatment planning and continuing care. Social workers need to have an attuned understanding that Latino fathers may present depression very differently than their Caucasian counterparts. Other than this study, current literature does show that adherence to egalitarianism and a flexible male gender role may act as an insulator against the inability to cope and express feelings of depression for men. (Inglehart & Pippa, 2003; Saba, Kamal, Juzer, 2017). Social workers should also be aware that traditionally Latino men may not seek treatment for their depression. McGill (2014) postulates that society has created a social definition of masculinity in which men are not allowed to become caring fathers who are nurturing and supportive; if they are, they are seen as weak. Coupled with machismo in the Latino culture this may impact father's acknowledgment of depressive symptoms. McGill (2014) further noted that society does not accept a person as a man unless he fulfils certain expectations of society, referred to as male gender and sexual roles. These roles speak to a man's possible tendency toward aggressiveness and emotional absence. This may be more so in the Latino culture. Additionally, men have historically had poorer social support networks and a higher incidence of externalizing disorders (Dudley, Roy, Kelk, & Bernard, 2010; Strauss, & Goldberg, 1999). These are all factors to be taken

into consideration when conducting an assessment on a Latino father for depression in the post-natal period.

Implications for Social Work Education

Social work education follows Educational Policy and Accreditation Standards (EPAS) and ascribes to nine competencies to provide a system that demands a level of performance, integrity, and quality that entitles them to the confidence of the educational community and the public served (CSWE, 2015). Of particular interest is competency four, which states social workers must engage in practice informed research and research informed practice, and demands that social workers continue to add to the current knowledge base. A social worker must understand all environmental and cultural factors that may be influencing a family in order to have a clear view of the assessments and interventions necessary to assist them. Appropriate assessment tools will need to be taught to new social workers as well as a how to create a strong alliance between the social worker and the family they are working with in order to prevent and assess paternal depression in the post-partum period. Social work educators should identify the cultural and gender specific characteristics of resilience within each of their families and understand that depression for fathers in the post-natal period can be prevented and treated with alliance, education, and patience.

The biopsychosocial and person-in-environment approaches are a foundation for social work practice with individuals and families. Interviewing clients utilizing a standard biopsychosocial format can help identify risk and protective factors related to parental moods (Boland-Prom & MacMullen, 2012). However, supporting the mother and the developing infant through the post-natal period is stressed during the discussion

of a positive outcome for the family, oftentimes leaving out the pivotal role of the father. Social work education would be best served by a paradigm shift to view depression in the post-natal period as an issue that can affect mothers and fathers equally. Further, this can be both the basis for educating the social work student on conducting a thorough family assessment. This approach can be a platform for instruction in clinical and human development courses. Additionally, it can inform social workers training on conducting assessments and in the prevention of depression in the post-natal period for both parents. It can also make a social work student more attuned to the needs of a new father, the influence of culture on them, and to male expressions of depression.

Also of interest is competency five of the EPAS which compels social workers to engage in policy practice which then directly impacts competency six which pertains to the workers' engagement of individuals, families, groups, organizations and communities (CSWE, 2015). For social workers to take a position on this issue, and most effectively engage in policy practice, the best way to inform policy, social workers must be up to date on where policy is lacking at the local, state and federal levels. Research data should be used as evidence to inform interventions and to evaluate their success. This should in turn inform policy. Assessing and understanding best practices and the laws that have worked become essential in recognizing which subpopulations have shown improvement and *why* they have shown improvement.

Social work curriculum would be greatly benefitted by including the impact of culture and coping skills on fathers who might be experiencing depression in the post-natal period. The dearth of knowledge that can be advanced by upcoming social workers

can make a marked impact on the future of families and the prevention of depression in the post-natal period.

Implications for Social Work Policy

For virtually every developed country in the world, an appreciation of the importance of the first year of parenthood is encouraged and supported through paid leave for mothers; many also provide paid leave for fathers. The United States is a highly visible outlier, offering no national policy on paid leave for mothers or fathers. According to the International Labor Organization (2013), 70 countries had legislated paid maternity leave in 2013. The reasons for extending leave specifically to fathers are numerous, but most often reflect the expression of a few consistent values: greater gender equity, a reflection of the changing roles of men and women at home and in the workplace, and the desire to allow fathers the same rights as of their maternal counterpart (Geva, 2011). Geva (2011) further states that America has a longstanding history of emphasizing motherhood with it policies, specifically with that of the Family Medical Leave Act. And while the FMLA entitles any eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons (US Department of Labor, 2018), it unfairly disadvantages men who oftentimes act as high wage earners and cannot take advantage of being on leave at the same time as their female counterparts.

Policy makers need to construct a policy that impacts not only middle class nuclear families, but view how the policy impacts underserved populations and families from all types of structures, races, genders and social classes. This research advances this view and can aid social workers in being lead advocates for not only fathers but for families. First steps can be to advance this policy away from a gendered approach.

Hobson (1994) encourages a view aligned with our society's most vulnerable population, solo ethnic minority parents, stating "the more difficult and stigmatized solo parenthood is in a society, the greater the barriers to affording the luxury of parental leave" (p. 176). Zlotnik (2012) furthers that social work needs to define itself as the profession that addresses real-world issues that social work research can directly address. Not only can social work research focus on the micro aspect of a father's experience and the benefit of advocating his individual paternity leave as well as the importance of helping ameliorate the cost to families which contributes to the role social workers play at the macro level of influencing policy creation. The social work profession needs to reposition itself as the social justice advocates inherent in our ethical code.

Future Research

Research into depression in fathers in the post-natal period is gaining momentum; however this momentum is minimal in comparison to the large body of work that encompasses maternal post-natal depression studies. Further the link between egalitarianism and coping skills has yet to be identified until this initial inquiry. Further research into this now important identified link is imperative. This study also looked the importance that coping skills play in mitigating depressive symptoms in the post-natal period in fathers. Further inquiry should look at what specific types of coping skills would be helpful in reducing depression during this period. In addition, special attention should be given to how Latino men learn coping skills and which avenues they might they seek to acquire coping skills whether it is from family, society, or professionals. Research should investigate which avenues work best for this specific population as their culture is likely to be masking depressive symptoms.

The challenge for social workers is to shift their focus on the pre and post-natal period to not just mothers, but also fathers. Future research should identify how dominant cultural and gender scripts, like masculinity, may impact a father's ability to identify depression and manage it in a period that is typically accompanied with stress such as the postnatal period. As "ground soldiers" social workers are well positioned to gather information that can both inform this population and gain supports to be able to aid them. In closing, qualitative social work research should also be initiated in this population in an effort to allow these father's voices to be heard.

Conclusion

This researcher found that coping skills and egalitarianism impact depressive symptoms in Latino fathers negatively. More importantly, this research furthers the importance of and the addressing of possible depression in Latino fathers in the post-natal period as well as providing a comprehensive approach to child development, family intervention, and social work practice. In social work, the underlying belief is that every part of the system is fundamental to the community and society. This study addressed a noticeable gap in the social work literature and potentially informed social work practice and treatment in the population of Latino fathers.

References

Adouard, F., N.M.C. Glangeaud-Freudenthal, & Golse, B. (2005). Validation of the Edinburgh postnatal depression scale (EPDS) in a sample of women with high-risk pregnancies in France. *Archives of Women's Mental Health,* 8(2), 89-95.

Addis, M.E., Mahalik, J.R. (2003). Men, masculinity and the contexts of help-seeking. *American Psychologist.* 58(1), 5-14.

Albizu-Garcia, C.E., Alegria, M., Freeman, D., & Vera, M. (2001). Gender and health service use for a mental health problem. *Social Science and Medicine*, 53(7), 865-878.

Alegría, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A. N. (2002). Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services, 53*(12), 1547-1554.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anderson, A.M. (1996a). Factors influencing the father–infant relationship. *Journal of Family Nursing*, 2, 306–324.

Anderson, A.M. (1996b). The father–infant relationship: becoming connected. Journal of the Society of Pediatric Nurses, 1, 83–92.

Añez, L.M., Paris, M., Bedregal, L., Davidson, L., & Grilo, C. (2005). Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *Journal of Psychiatric Research*, 11(4), 221-230.

Antonovsky, A. & Kats, R. (1967). "The Life Crisis History as a Tool in Epidemiologic Research". *Journal of Health and Social Behavior, 8,* 15-20.

Appleby, L., Warner, R., Whitton, A., & Faragher, B. (1997). A controlled study of fluoxetine and cognitive behavioral counseling in the treatment of postnatal depression. *British Medical Journal,* 314, 932-936.

Areias, M.E.G., Kumar, R., Barros, H. & Figueiredo, E. (1996a) Correlates of postnatal depression in mothers and fathers. *British Journal of Psychiatry*, 169, 36-41.

Areias, M.E.G., Kumar, R., Barros, H. & Figueiredo, E. (1996b) Comparative incidence of depression in women and men during pregnancy and after childbirth. Validation of the Edinburg Postnatal Depression Scale in Portuguese mothers, *British Journal of Psychiatry*, 169, 30-35.

Arciniega, G. M., Anderson, T. C., Tovar-Blank, Z. G., & Tracey, T. J. G. (2008). Toward a fuller conception of machismo: Development of a traditional machismo and caballerismo scale. *Journal of Counseling Psychology,55*(1), 19-33.

Armenia, A., & Gerstel, N. (2006). Family leaves, the FMLA, and gender neutrality: The intersection of race and gender. *Social Science Research,* 35, 871-891.

Arnold, M.B. (1960). Emotion and Personality. New York: Columbia University Press.

Ash, S. D., & Byers, E. S. (1996). Understanding the co-occurrence of marital distress and depression in women. *Journal of Social and Personal Relationships*, 13, 537-552.

Ballard, C.G., Davis, R., Cullen, P.C., Mohan, R.N., & Dean, C. (1994). Prevalence of postnatal psychiatric morbidity in mothers and fathers. *British Journal of Psychiatry*, 164, 782-788.

Barclay, L., Donovan, J., & Genovese, A. (1996). Men's experiences during their partner's first pregnancy: A grounded theory analysis. *American Journal of Advanced Nursing, 13*(3), 12-23.

Barn, R. (2008). Ethnicity, gender, and mental health: Social worker perspectives. *International Journal of Social Psychiatry*, 54 (1), 69-82.

Beck, C.T. (1992). The lived experience of post-partum depression: A phenomenological study. *Nursing research*, 41, 166-170.

Beck, C.T. (1993). Teetering on the edge: A substantive theory of postpartum depression. *Nursing research*, 42, 42-48.

Beck, C.T. (2001). Predictors of postpartum depression: An update. *Nursing Research*, 50, 275-285.

Bem, S.L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology*. 42, 155-162.

Bem, S.L. (1981). Gender Schema Theory: A cognitive account of sex typing. *Psychological Review,* 88 (4), 354-364.

Bem, S.L. & Lenney, E. (1976). Sex typing and the avoidance of cross-sex behavior. *Journal of Personality and Social Psychology,* 33, 48-54.

Berger, J. M., Levant, R., McMillan, K. K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward psychological help seeking. *Psychology of Men & Masculinity,6*(1), 73-78.

Berggren-Clive, K. (1998). Out of the darkness and into the light: Women's experiences with depression after childbirth. *Canadian Journal of Community Mental Health*, 17, 103-120.

Berry, J.W., & Sam, D. L. (1996). Acculturation and adaptation. In J.W. Berry, M. A. Segall, & C. Kagitubasi (Eds.), *Handbook of cross-cultural psychology: Social behaviors and application* (Vol. 3, pp. 291-326). Boston: Allyn & Bacon.

Blanco, C., Patel, S., Liu, L., Jiang, H., Lewis-Fernández, R., Schmidt, A. B., Olfson, M. (2007). National trends in ethnic disparities in mental health care. *Medical Care, 45*(11), 1012-1019.

Boath, E.H., Pryce, A.J., & Cox, J.L. (1998). Postnatal Depression: The impact on the family. *Journal of Reproductive and Infant Psychology,* 16, 199-203.

Boland-Prom, K.W. & Macmullen, N. (2012). Expanding the Postpartum Depression Construct Using a Social Work Paradigm. *Journal of Human Behavior in the Social Environment*, 22, 718–732.

Brennan, M., Vega, M., Gartcia, I., Abad, A., & Friedman, M.B. (2005). Meeting the mental health needs of elderly Latinos affected by depression: Implications for outreach and service provision. *Care Management Journals*, 6, 98-106.

Bronte-Tinkew, J., Moore, K.A, Matthews, G., & Carrano, J. (2007). Symptoms of major depression in a sample of fathers of infants: Sociodemographic correlates and links to father involvement. *Journal of Family Issues*, 28, 61-99.

Buck, R., Losow, J. I., Murphy, M. M., & Costanzo, P. (1992). Social facilitation and inhibition of emotional expression and communication. *Journal of Personality and Social Psychology, 63,* 962-968.

Budig, M.J., & England, P. (2001). The wage penalty for motherhood. *American Sociological Review,* 66, 204-25.

Buist, A., Morse, A., & Durkin, S. (2002). Men's adjustment to fatherhood: Implications for obstetric health care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 32 (2), 172-180.

Cabassa, L.J. (2007). Latino immigrant men's perceptions of depression and attitudes towards help seeking. *Hispanic Journal of Behavioral Sciences*, 29 (4), 492-509.

Campos, R. (2008). Considerations for studying father involvement in early childhood among Latino families. *Hispanic Journal of Behavioral Sciences,30* (2), 133-160.

Carro M.G., Grant, K.E., Gotlib, I.H. & Compas, B.E. (1993) Postpartum depression and child development: an investigation of mothers and fathers as sources of risk and resilience. Development and Psychopathology 5, 567–579.

Chesley, N. (2011). Stay at home fathers and breadwinning mothers: Gender, couple dynamics, and social change. *Gender & Society*, 25, 642-664.

Chiang, L., Hunter, C.D., & Yeh, C.J. (2004). Coping attitudes, sources, and practices among Black and Latino college students. *Adolescence*, 39, 793-815.

Chung, P. & Yue, X. (1999). Postpartum depression and social support: A comparative study in Hong Kong. *Psychologia*, 42, 111-121.

Cochran, S. (2001). Assessing and treating depression in men. In G. Brooks & G. Good (Eds.), *The new handbook of psychotherapy and counseling with men* (pp. 229–245). San Francisco: Jossey-Bass.

Cochran, S. V., & Rabinowitz, F. E. (2000). Men and depression: Clinical and empirical perspectives. San Diego, CA: Academic Press.

Cochran, S.V. & Rabinowitz, F.E. (2003). Gender-sensitive recommendation for assessment and treatment of men. *Professional Psychology: Research and Practice*, 34, 132-140.

Coltrane, S. (2000). Research on Household labor: Modeling and measuring the social embeddedness of routine family work. *Journal of Marriage and the Family*, 62, 1208-1233.

Coltrane, S., Parke, R. D., & Adams, M. (2004). Complexity of father involvement in low-income Mexican American families. *Family Relations, 53,* 179–189.

Condon, J.T., Boyce, P., & Corkindale, C.J. (2004). The first-time fathers study: A prospective study of the mental health and wellbeing of men during the transition to fatherhood. *Australia & New Zealand Journal of Psychiatry*, 38, 56–64.

Connell, R.W. (2005). Masculinities. (2nd Ed.). Los Angeles, CA: University of California Press.

Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., et al. (2003). The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients. *Medical Care*, *41*, 479-489.

Coryell, W., Endicott, J., & Keller, M. (1992). Major depression in a non-clinical sample: Demographic and clinical risk factors for first onset. *Archives of General Psychiatry, 49,* 117–125.

Cox, J. Holden. J, & Sagovsky. R, (1987). Detection of postnatal depression. Development of the 10-items Edinburgh Postnatal Depression Scale. Br J Psychiatry, 150, 782–786.

Coyne, J. C., & Benazon, N. R. (2000). Not agent blue: Effects of marital functioning on depression and implications for treatment. In S.R.H. beach (Ed.), Marital and family processes in depression: A scientific foundation for clinical practice (pp. 129-138). Washington, DC: American Psychological Association.

Crouter, A. C., Davis, K. D., Updegraff, K., Delgado, M., & Fortner, M. (2006). Mexican American fathers' occupational conditions: Links to family members' psychological adjustment. *Journal of Marriage and Family, 68,* 843–858.

CSWE (2015). Educational Policy and Accreditation Standards (EPAS). https://cswe.org/Accreditation/Standards-and-Policies/2015-EPAS. Retried on February 3, 2018.

Cummings, S. M., Neff, J. A., & Husaini, B. A. (2003). Functional impairment as a predictor of depressive symptomotology: The role of race, religion, and social support. *Health & Social Work*, 28(1), 23-32.

Dankner, R., Goldberg, R.P., Fisch, R.Z., & DCrum, R.M., (2000). Cultural elements of postpartum depression: A study of 327 Jewish Jerusalem women. *Journal of Reproductive Medicine*, 45, 97-104.

Davey, S.J., Dziurawiec, S. & O'Brien-Malone, A. (2006). Men's voices: Postnatal depression from the perspective of the male partner. *Qualitative Health Research*, 16(2), 206-220.

Davila, Y.R., Reifsnider, E., & Pecina, I. (2011). Familismo: influence on Hispanic health behaviors. *Applied Nursing Research*, 24 (4), 67-72.

Davis, J. M., & Liang, C. T. H. (2015). A test of the mediating role of gender role conflict: Latino masculinities and help-seeking attitudes. *Psychology of Men & Masculinity, 16*(1), 23-32.

Deater-Deckard, K., Pickering, K., Dunn, J.F., & Golding, J. (1998). Family structure and depressive symptoms in men preceding and following the birth of a child. The Avon Longitudinal Study of Pregnancy and Childhood Study Team. *American Journal ofPsychiatry*, 155, 818–823.

Dennis, C.L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth*, 33(4), pp. 323–331.

Dermott, E. (2006). What's parenthood got to do with it? Men's hours of paid work. *British Journal of Sociology*, 57, 619-634.

Deutsch, F. M. (2007). Undoing gender. *Gender & Society*, 21, 106-27.

Diamond J. (2004). *The irritable male syndrome: Managing the four key causes of depression and aggression.* Emmaus, PA: Rodale.

Draper J. (2002). It's the first scientific evidence: Men's experience of pregnancy confirmation. *Journal of Advanced Nursing*, 39(6), 563–570.

Dudley, M., Roy, K., Kelk, N., Bernard, D. (2010). Psychological correlates of depression in fathers and mothers in the first postnatal year. *Journal of Reproductive and Infant Psychology*, 19(3), 187-202.

Dunkel-Schetter, C., Schafer, P., Lanzi, R. G., Clark-Kauffman, E., Raju, T. N. K., Hillemeier, M. M., & Community Child Health Network. (2013). Shedding light on the mechanisms underlying health disparities through community participatory methods: The stress pathway. *Perspectives on Psychological Science, 8*(6), 613-633.

Edmondson, O. Psychogiou, L., Vlachos, H. Netsi, E. Ramchandani, P. (2010). Depression in Fathers in the postnatal period: Assessment of the Edinburgh Postnatal depression scale as a screening measure. *Journal of Affect Disorder*, 125(1-3), 365-368.

Edoka, I.P., Petrou, S., Ramchandani, P.G. (2011). Healthcare costs of paternal depression in the postnatal period. *Journal of Affective Disorders*, 133, pp. 356-360.

Eisler, R.M. & Blalock, J.A. (1991). Masculine Gender Role Stress: Implications for the assessment of men, *Clinical Psychology Review*, 11, 45-60.

Eisler, R.M. & Skidmore, J. (1987). Masculine Gender Role Stress: Scale development and component factors in the appraisal of stressful situations, *Behavior Modification*, 11 (2), 123-136.

Ekman, P. (1992). Facial expression and emotion. *American Psychologist, 48,* 384-392.

Ekman, P., & Friesen, W. V. (1975). *Unmasking the face.* Englewood Cliffs, NJ: Prentice Hall.

Ekman, P., Friesen, W. V., & Ellsworth, P. (1982). Conceptual ambiguities. In P. Ekman (Ed.), *Emotion in the human face* (pp. 7-21). New York: Cambridge University Press.

Epifanio, M.S., Genna, V., DeLuca, C., Roccella, M., & La Grutta, S. (2015). Paternal and maternal transition to parenthood: The risk of post-partum depression and parenting stress. *Pediatric Reports,* 7(2), 38-44.

Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican-Americans in the United States. *Harvard Review of Psychiatry,* 8, 64–72.

Estrada, F., & Arciniega (2015). Positive masculinity among Latino men and the direct and indirect effects on well-being. *Journal of Multicultural Counseling and Development*, 43 (3), 191-205.

Falicov, C.J. (2010). Changing constructions of machismo for Latino men in therapy: The devil never sleeps. *Family Process*, 49(3), 309-329).

Field, A. (2013). *Discovering Statistics Using IBM SPSS Statistics.* (4th Edition): New York, NY: SAGE.

Fincham, F. D., Beach, S. R. H., Harold, G. T., & Osborne, L. N. (1997). Marital satisfaction and depression: Different causal relationships for men and women? *Psychological Science*, 8, 351-357.

Fisher, S., Kopelman, R., & O'Hara, M.W. (2012). Partner report of paternal depression using the Edinburgh Postnatal Depression Scale-Partner. *Arch Women's Health*, 15, 283-288.

Fitzgerald, H.E. & Bocknek, E. L. (2013). Fathers, children, and the risk-resilience continuum. In N.J. Cabrera & C.S. Tamis-LeMonda (Eds.), *Handbook of Father Involvement: Multidisciplinary perspectives* (pp. 168-187). New York, NY: Routledge Press.

Fletcher, R. & St. George, J. (2011). Heading into fatherhood-Nervously: Support for Fathering from online dads. *Qualitative Health Research*, 21(8), 1101-1114.

Frank, E., Carpenter, L., & Kupfer, D. (1988). Sex differences in recurrent depression: Are there any that are significant? *American Journal of Psychiatry, 145*, 41–45.

Franklin, C.W. (1988). *Men and Society*. Chicago: Nelson-Hall.

Friedewald, M., Fletcher, R., & Fairbairn, H. (2005). All male discussion forums for expectant fathers: Evaluation of a model. *Journal of Perinatal Education*, 14, 8-18.

Garcia-Cueto, E., Rodriguez-Diaz, F., Bringas-Molleda, C., Lopez-Cepero, J., Paino-Quesada, S., Rodriguez-Franco, L. (2015). Development of the Gender Role

Attitudes Scale amongst young Spanish people. *International Journal of Clinical and Health Psychology*, 15, 61-68.

Garfield, C.F., Clark-Kauffman, E. & Davis, M.M. (2006). Fatherhood as a component of men's health. *Journal of the American Medical Association*, *296*(19), 2365–2368.

Gaunt, R. (2005). The role of value priorities in paternal and maternal involvement in child care. Journal of Marriage and Family, 67, 643–655.

Genesoni, L. & Talladini, M.A. (2009). Men's psychological transition to fatherhood: An analysis of the literature, 1989-2002. *Birth*, 36(4), 305-318.

Genuchi, M.C., & Mitsunaga, L.K. (2015). Sex differences in masculine depression: Externalizing symptoms as a primary feature of depression in men. *Journal of Men's Studies*, 23 (3), 243-251.

Geva, D. (2011). Not just maternalism: Marriage and fatherhood in American welfare policy. *Social Politics,* 18(1), 24-51.

Gil, R. M., & Vazquez, C. I. (1996). *The Maria paradox*. New York: Perigee Books

Givens, J. L., Houston, T. K., Van Voorhees, B. W., Ford, D. E., & Cooper, L. A. (2007). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry*, *29*, 182-191

Glass, J., & Owen, J. (2010). Latino Fathers: The relationship among machismo, acculturation, ethnic identity, and paternal involvement. *Psychology of Men and Masculinity*. Vol. 11, No. 4, 251–261

Good G.E., Mintz, L.B. (1990). Gender Role Conflict and Depression in College Men: Evidence for Compounded *Risk. Journal of Counselling and Development,* 69(1): 17-21.

Good, G.E., & Wood, P. (1995). Male gender role conflict, depression, and help-seeking: Do college men face double jeopardy? *Journal of Counseling & Development, 74,* 70–75.

Goodman, J.H. (2003). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing*, 45, 26-35.

Grinnell, Jr., R.M. & Unrau, Y.A. (2011). *Social work research and evaluation: Foundations for evidence-based practice.* (9th ed). Oxford: Oxford University Press.

Gross, J. J., & John, O. P. (1997). Revealing feelings: Facets of emotional expressivity in self-reports, peer ratings, and behavior. *Journal of Personality and Social Psychology*, *72,* 435-448.

Hartung C.M., Widiger, T.A. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin 123(3):*260–78.

Harvey, I., & McGrath, G. (1988). Psychiatric morbildity in spouses of women admitted to a mother and baby unit. *British Journal of Psychiatric Care*, 33, 10-18.

Heifner C (1997) The male experience of depression. *Perspectives in Psychiatric Care*, 33(2): 10-8.

Henwood, K., & Procter, J. (2003). The "good father": Reading men's accounts of paternal involvement during the transition to first-time fatherhood. *British Journal of Social Psychology*, 42, 337–355.

Heppner, P. (1995). On gender role conflict in men: Future directions and implications for counselling: Comment on Good et al. (1995) and Cournoyer and Mahalik (1995). *Journal of Counseling Psychology*. 42(1), 20-23.

Hobson, B. (1994). Solo mothers, social policy regimes and the logics of gender. In D. Sainsbury (Ed.), *Gendered welfare states*, (pp.170-187). London, England: Sage.

Hung, C.H. *(2005).* Key stress experienced by new mothers. *Journal of Advanced Nursing;* 27(16), 44-8.

Inglehart, R. & Pippa, N. (2003). *Rising Tide: Gender equality and cultural change around the world*. NY: Cambridge University Press.

International Labour Organization (2013). Maternity and paternity at work. (report). Retrieved June 9, 2014 from: www.ilo.org.

Institutional Review Board (2000). Retrieved June 29, 2015, from http://student.barry.edu.ezproxy.barry.edu/irb/

Ishikawa, R.Z., Cardemil, E.V., & Falmagne, R.J. (2010). Help seeking and help receiving for emotional distress among Latino men and women. *Qualitative Health Research*, 20(11), 1558-1572.

Jacob, T., & Johnson, S. L. (2001). Sequential interactions in the parent-child communications of depressed fathers and depressed mothers. *Journal of Family Psychology*, 15 (1), 38-52.

Jakupcak, M., Salters, K. Gratz, K.L., Roemer, L (2003). Masculinity and emotionality: An investigation of men's primary and secondary emotional responding. *Sex Roles*, 49 (3/4), 111-120.

Jenkins, R. (1985) Sex differences in minor psychiatric morbidity. *Psychological Medicine Monograph Supplement*, 7, 1-53.

Joiner, T. E., Jr, Steer, R. A., Abramson, L. Y., Alloy, L. B., Metalsky, G. I., & Schmidt, N. B. (2001). Hopelessness depression as a distinct dimension of depressive symptoms among clinical and non-clinical samples. *Behaviour Research and Therapy*, 39, 523-536.

Kaplan, M. (1983). A woman's view of DSM-III. *American Psychologist*, 38, 786-92.

Kerlinger, F. N. & Lee, H. B. (2000). *Foundations of behavioral research* (4th ed.). Belmont, CA: Wadsworth.

Kessler, R.C., Berglund, P.A., Demler, O., Jin, R., Walters, E.E. (2003). The epidemiology of major depressive disorder: Results from the national comorbidity

survey replication study. *Journal of the American Medical Association*, 289(23), 3095-3105.

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. *Journal of Men's Health and Gender 2(1):*95–99.

Kim, P., & Swain, J. E. (2007). Sad dads: Paternal postpartum depression. *Psychiatry*, 4(2), 36–47.

King, D.W., & King, L.A. (1983). Measurement precision of the sex role egalitarianism scale: A generalizability analysis. *Educational & Psychological Measurement*, 43(2), 435.

Kockler, M., & Heun, R. (2002). Gender differences of depressive symptoms in depressed and nondepressed elderly persons. *International Journal of Geriatric Psychiatry*, 17(1), 65-72.

Kumar, R. (2011). *Research methodology: A step by step guide for beginners* (3rd ed.). London: SAGE.

Lazarus, R.S. (1991). Emotion and Adaptation. New York: Oxford University Press.

Lazarus, R.S. (1993). Coping theory and research: Past, present, and future. Psychosomatic Medicine, 55, pp. 234–247.

Lazarus, R.S. & Cohen, J.B. (1977). "Environmental Stress". In I. Altman and J.F. Wohlwill (eds.), *Human Behavior and Environment.* (Vol 2) New York: Plenum.

Lazarus, R S and Folkman, S, (1986). Cognitive theories of stress and the issue of circularity. In M H Appley and R Trumbull (Eds), (1986). *Dynamics of Stress. Physiological, Psychologcal, and Social Perspectives* (pp. 63–80). New York, NY: Plenum.

Le, H.N., Perry, D.F., & Ortiz, G. (2010). The Postpartum Depression Screening Scale-Spanish version: Examining the psychometric properties and prevalence of risk for postpartum depression, *Journal of Immigrant and Minority Health*, 12(2), 249 – 258.

Letourneau, N., Duffett-Leger, L., Dennis, C. L. & Stewart, M., & Tryphonopoulos, P. D. (2011). Identifying the support needs of fathers affected by post-partum depression: A pilot study. *Journal of Psychiatric and Mental Health Nursing*, *18*, 41-47.

Levant, R., Majors, R., & Kelley, M. (1998). Masculinity ideology among young African-American and European-American women and men in different regions of the United States. *Cultural Diversity and Mental Health*, *4*, 227– 236.

Lewis-Fernández, R., Das, A. K., Alfonso, C., Weissman, M. M., & Olfson, M. (2005). Depression in US Hispanics: Diagnostic and management considerations in family practice. *Journal of the American Board of Family Practice*, 18, 282-296.

Logsdon, M.C., Wisner, K., & Shanahan, B. (2007). Evidence on post-partum depression: 10 publications to guide nursing practice. *Issues in Mental health Nursing*, 28(5), 445-451.

Lynch J., Kilmartin, C. (1999). *The pain behind the mask: Overcoming masculine depression.* New York: Haworth Press.

Madsen, S.A. (2009). Men's mental health: Fatherhood and psychotherapy. *Journal of Men's Studies*, 17 (1), 15-30.

Madsen, S.A. & Juhl, T. (2007). Paternal depression in the postnatal period. *Journal of men's Health & Gender*, 4 (1), 26-31.

Malin, M. H. (1993). Fathers and Parental leave. *Texas Law Review.* 72, 1047-1095.

Marks, M.R. (1997). Party politics and family policy. *Journal of Family Issues*, 18, 55-70.

Marsiglio, W., Amato, P., Day R.D., & Lamb, M.E. (2000). Scholarship on fatherhood in 1990s and beyond. *Journal of Marriage and Family*, 62 (4), 1173-1191.

Matthey, S., Barnett, B., Kavanagh, D. J., & Howie, P. (2001). Validation of the Edinburgh postnatal depression scale for men, and comparison of item endorsement with their partners. *Journal of Affective Disorders,* 64(2-3), 175-184.

McGill, B.S. (2014). Navigating new norms of involved fatherhood: Employment, fathering attitudes, and father involvement. *Journal of Family Issues*, 35, 1089-1106.

McGuire, T. C., Alegría, M., Cook, B. L., Wells, K. B., & Zaslavsky, A. M. (2006). Implementing the Institute of Medicine definition of disparities: An application to mental health care. *Health Research and Educational Trust, 41*(5), 1979-2005.

Meenaghan, T.M., Kilty, K.M., Long, D.D., McNutt, J.G. (2013). *Policy, Politics, and Ethics: A critical approach, 3rd ed.* Chicago, IL: Lyceum Books, Inc.

Meighan, M., David, M., Thomas, S., & Droppleman, P. (1999). Living with postpartum depression: The father's experience. *MCN: American Journal of Maternal/Child Nursing, 24*(4), 202-208.

Melrose, S. (2010). Paternal postpartum depression: How can nurses begin to help? *Contemporary Nurse*, 34 (2), 199-210.

Merriam-Webster. (2015). *Postpartum*. Retrieved April 15, 2015, from Merriam-Webster.com: http://www.merriam-webster.com/dictionary/postpartum.

Merriam-Webster. (2017) In Merriam-Webster. Retrieved April 26, 2017, from https://www.merriam-webster.com/dictionary/egalitarianism and https://www.merriam-webster.com/dictionary/culture.

Möller-Leimkühler, A.M. *(2002).* Barriers to help seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders* 71, 1–9.

Morgan, M., Matthey, S., Barnett, B., & Richardson, C. (1997) A group program for postnatally distressed women and their partners. *Journal of Advanced Nursing*, 26, 913-920.

Mosher, D.L. (1991). Macho men, machismo, and sexuality. *Annual Review of Sex Research*, 2, 199-247.

Musser, A.K., Ahmed, A.H., Foli, K.J. & Coddington, J.A. (2013). Paternal postnatal depression: What healthcare providers should know. *Journal of Pediatric Health Care*: *Official publication of National Association of Pediatric Nurse Associates & Practioners*, 27 (6), 479-485.

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: NASW Press.

Nayak, S., & Shetty, P.K. (2015). A study on challenges faced by mothers and the coping strategies adopted by them during the postpartum period. *International Journal of Nursing Education*. 7(4), 160-164.

Nazareth, I. (2011). Should men be screened and treated for postnatal depression? *Expert Reviews Ltd*, 11, 1-3.

Noguera, P., Hurtado, A., Fergus, E. (Eds.) 2012. *Invisible no more: Understanding the disenfranchisement of Latino men and boys.* New York, NY: Routledge.

Nomaguchi, K., Brown, S., Leyman, T.M. (2017). Father's participation in parenting and maternal parenting stress: Variation by relationship status. *Journal of Family Issues*, 38(8), 1132-1156.

O'Hara, M.W., & Swain, A.M. (1996). Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry*, 8, 37-54.

O'Neil, J. M. (1981b). Patterns of gender role conflict and strain: Sexism and fear of femininity in men's lives. *Personnel and Guidance Journal, 60*, 203-210.

O'Neil, J. M. (1982). Gender role conflict and strain in men's lives: Implication for psychiatrists, psychologists, and other human service providers. In K. Solomon & N. B. Levy (Eds.), *Men in transition: Changing male roles, theory, and therapy* (pp. 5-44). New York: Plenum.

O'Neil, J., Helms, B., Gable, R., David, L., & Wrightsman, L. (1986). Gender-role conflict scale: College men's fear of femininity. *Sex Roles, 14*(5-6), 335.

Padilla, A. M., & Perez, W. (2003). Acculturation, social identity, and social cognition: A new perspective. *Hispanic Journal of Behavioral Sciences, 25*(1), 35-55.

Pallant, J. (2013). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS*. Maidenhead, Berkshire, England: McGraw Hill.

Patrick, S., & Robertson, S. (2016). Mental health and wellbeing: focus on men's health. *British Journal of Nursing*, 25 (21), 1163-1169.

Paulson, J.F. (2010). Focusing on depression in expectant and new fathers: prenatal and postpartum depression not limited to mothers. *Psychiatric Times*, 27(2), 48-54.

Paulson, J.F. & Bazemore, S.D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression. *Journal of American Medical Association*, 303 (19), pp. 1961–196.

Pilyoung, K. & Swain, J. (2007). Sad dads. *Psychiatry*, 4(2), 35-47.

Pleck, J. (1981). *The myth of masculinity.* Cambridge, Massachusetts: The MIT Press.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men*. New York, NY: Basic Books.

Pollack, W. (1995). Mourning, melancholia, and masculinity: Recognizing and treating depression in men. In R. Levant, & W. Pollack (Eds.), *A new psychology of men* (pp. 147-166). New York: Basic Books.

Prohaska, A. & Zipp, J. (2011). Gender inequality and the Family Medical leave Act. *Journal of Family Issues*. 32(11), 1424-1448.

Psychogiou, L. (2010). Depression in fathers in the postnatal period: Assessment of the Edinburgh Postnatal Depression Scale as a screening measure. *Journal of Affective* Disorder, 125(3), 365.

Radojevic, M. (1994). Mental representations of attachment among prospective Australian fathers. *Australian and New Zealand Journal of Psychiatry, 28*, 505-511.

Ramchandani, P., Stein, A., Evans, J., & O'Connor, T. (2005). Paternal depression in the postnatal period and child development: A prospective population study Elsevier Limited. *The Lancet,* 365(9478), 2201-2205.

Raskin, V.D., Richman, J.A. & Gaines, C. (1990) Patterns of depressive symptoms in expectant and new parents. *American Journal of Psychiatry*, 147, 658-660.

Rastogi, M., Massey-Hastings, N., Wieling, E. (2012). Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. *Journal of Systematic Therapies,* 31 (4), 1-17.

Real, T. (1997). *I don't want to talk about it: Overcoming the legacy of male depression.* New York: Fireside.

Rose, S.J., & Hartmann, H.L. (2004). *Still a man's labor market: The long term earnings gap.* Washington, D.C. Institute for Women's Policy Research. Retrieved June 9, 2014 from: www.iwpr.org.

Rutz, W. (1999). Improvement of care for people suffering from depression: The need for comprehensive education. *International Clinical Psychopharmacology 14*, 27–33.

Saba, R., Kamal, S., Juzer, M. (2017) Emergence of egalitarianism by gender role dynamics in family system. *New Horizons*, 11(1), 1-17.

Saez, P., Casado, A., Wade, J.C. (2009). Factors influencing masculine ideology among Latino men. *The Journal of Men's Studies*, 17(2), 116-128.

Schumacher, M., Zubaran, C., & White, G. (2008). Bringing birth related paternal depression to the fore. *Women and Birth*, 21, 65-70.

Shapiro, J.L. (1987). *When men are pregnant*. San Luis Obispo, CA.: Impact Publishers.

Shepard, D. S. (2002). A negative state of mind: Patterns of depressive symptoms among men with high gender role conflict. Psychology of Men & Masculinity, 3(1), 3-8.

Silverstein, L.B., Auerbach, C.F., & Levant, R.F. (2002). Contemporary fathers reconstructing masculinity: Clinical implications of gender role strain. *Professional Psychology, Research and Practice*, 33 (4), 361-369.

Simpson, H., Nee, J., & Endicott, J. (1997). First-episode major depression: Few sex-differences in course. *Archives of General Psychiatry, 54*, 633–639.

Smith, M., Saklofske, D., Keefer, K., & Tremblay, P. (2016). Coping strategies and psychological outcomes: The moderating effects of personal resiliency. *Journal of Psychology*, 150 (3), 318-332.

Statistics Canada (2011). Retrieved on August 6, 2016 from: www.statcan.gc.ca/eng/start

Strauss R., & Goldberg, W.A. (1999). Self and possible selves during the transition to fatherhood. *Journal of Family Psychology*, 13(2), 244–259.

Stuart, S., & O'Hara, M.W. (1995). Interpersonal psychotherapy for postpartum depression. *Journal of Psychotherapy Practice and Research*, 4, 18-29.

Thompson, A., & Bolger, N. (1999). Emotional transmission in couples under stress. *Journal of Marriage and Family*, 61, 38-48.

Tokar, D.M., Fischer, A.R., Schaub M., & Moradi, B. (2000). Masculine Gender Roles and Counseling-Related Variables: Links With and Mediation by Personality. *Journal of Counseling Psychology*. 47(3), 380-393.

Torres, J. B., Solberg, V. S. H., & Carlstrom, A.H. (2002). The myth of sameness among Latino men and their machismo. *American Journal of Orthopsychiatry, 72*, 163–181.

Townsend, N.W. (2002). *The package deal: Marriage, work and fatherhood in men's lives*. Philadelphia, PA.: Temple University Press.

U.S. Census. (2011) 2010 Census shows America's diversity. Retrieved on July 15, 2014 from: https://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn125.html

U.S. Department of Health and Human Services. (2013). *National healthcare disparities report*. Rockville, MD: Agency for Healthcare Research and Quality.

U.S. Department of Labor. (2018). Family medical leave act. Retrieved on February 3, 2018 from: https://www.dol.gov/whd/fmla/.

Vayreda, A., & Antaki, C. (2009). Social support and unsolicited advice in a bipolar disorder online forum. *Qualitative Health Research,* 19, 931-942.

Vega, W. A., & Amaro, H. (1994). Latino Outlook - Good Health, Uncertain Prognosis. *Annual Review of Public Health, 15,* 39-67.

Walker, L.O., Fleschler, R.G., Heaman M. (1998). Is a healthy lifestyle related to stress, parenting confidence, and health symptoms among new fathers? *Canadian Journal of Nursing Research*, 30(3), 21–36.

Wall, G. & Arnold, S. (2007). How involved is involved fathering? An exploration of the contemporary culture of fatherhood. *Gender and Society,* 21 (4), 508-527.

Ward, E.C. & Besson, D.D (2013). African-American beliefs about mental illness, perceptions of stigma, and heal seeking barriers. *The Counseling Psychologist*, 41, 359-391.

Weissman, M.M., & Jensen, P. (2002). What research suggests for depressed women with children. *Journal of Clinical Psychiatry*, 63, 641-647.

Whisman, M. A. (2001). Marital adjustment and outcome following treatments for depression. *Journal of Consulting and Clinical Psychology*, 69, 125-129.

Wisner, K.L. et al. (2013). Onset timing, thoughts of self-harm, and diagnosis in post-partum women with screen-positive depression findings. *JAMA Psychiatry*, 70(5), 490-498.

Wong, Y.J., Pituch, K.A., & Rochlen, A.B. (2006). Men's restrictive emotionality: An investigation of associations with other emotion-related constructs, anxiety, and underlying dimensions. *Psychology of Men & Masculinity*, 7 (2), 113-126.

World Health Organization. (2008). Mental Health Report. Retrieved on June 1, 2014 from www.who.int/mental_health/maternal-child/maternal_mental_health/en.

Zartaloudi, A. (2011). What is men's experience of depression? *Health Science Journal, 5*(3), 182-187.

Zelkowitz P. & Milet T.H. (1997) Stress and support as related to postpartum paternal mental health and perceptions of the infant. *Infant Mental Health Journal*, 18, 424–435.

Zlotnik, J.L. (2012). Social work research matters. In Hoffler, E.F. & Clark, E.J. (Ed.), Social *work matters*, (pp. 313-317). Washington, DC: NASW Press.

Appendix A: Recruitment Flyer (English)

RESEARCH BEING CONDUCTED ON FACTORS THAT AFFECTS FATHERS IN THE POSTNATAL PERIOD

Barry University School of Social Work is conducting a research study entitled "The Latino father and the role of egalitarianism, coping skills, and depressive symptoms in the post-natal period."

The purpose of this study is to examine factors which may contribute to depression symptoms in Latino fathers.

If you are: 1. a heterosexual man, 2. a Latino man, who was either born in the US from parents born in a Latin American country or you were born in a Latin American country, 3. Have at least one child under the age of 1 year old (12 months), 4. in a relationship with the mother of the child and involved in the caregiving of that

If interested in participating, please call

Tania Paredes, 305-200-8879

Participants will be asked to fill out an assessment battery and short meeting which takes approximately in total 40 minutes to complete. Any questions can be directed to:

Principal Investigator:
Tania Paredes, LCSW
Monday-Friday, 9-6 pm
Telephone: 305-200-8879
1395 Brickell Ave, Suite 800
Miami, Fl 33131
Email: tania.paredes@mymail.barry.edu

Barry University School of Social Work
IRB Contact:

Barbara Cook

Telephone: (305)899-3020

Email: bcook@barry.edu

Appendix B: Recruitment Flyer (Spanish)

PROYECTO DE INVESTIGACION EN FACTORES QUE PUEDEN AFECTAR LOS PADRES EN EL PERIOD DESPUES DE NACER UN BEBE

Se solicita su participación en un proyecto de investigación patrocinado por Barry University, Escuela de Trabajo Social of Social Work que se llamo "El padre Latino, el egalitarianism, y formas de lidiar con problemas, y sintomas de la depression en el period despues de nacer un bebe.'

Los objetivos de la investigación son explorar la manera en que las personas abordan las relaciones, hacen frente a los problemas y lidian con la depresión en el período posterior al nacimiento de un bebé.

Puede participar si usted es: 1. hombre heterosexual; 2. ser hombre latino nacido en Estados Unidos de padres nacidos en un país latinoamericano o haber nacido en un país latinoamericano, 3. tener al menos un hijo de menos de 1 año de edad, 4. estar en una relación con la madre del niño y participa en el cuidado de ese niño, 5. haber participado en el cuidado prenatal de la madre del niño.

Si esta interesado en participar porfavor llame a:

Tania Paredes, 305-200-8879

Si desea participar, se le hace una entrevista corta y se le entregará una encuesta en papel para que la complete, que le tomara en total 40 minutos para completar. Si tiene preguntas por favor llame a:

Investigador Principal:
Tania Paredes, LCSW
Lunes a Viernes 9-6 pm
Telefono: 305-200-8879
1395 Brickell Ave, Suite 800
Miami, Fl 33131
Correo electronico: tania.paredes@mymail.barry.edu

Barry University School of Social Work
IRB Contact:

Barbara Cook

Telefono: (305)899-3020

Correo electronico: bcook@barry.edu

Appendix C: Informed Consent Form (English)

Approved by Barry University IRB
Date: 6/13/17
Signature:

Barry University Informed Consent Form

Your participation in a research project is requested. The research is being conducted by Tania Paredes, a doctoral student in the Social Work department at Barry University, and is seeking information that will be useful in the field of Social Work. The aims of the research are to explore how individuals approach relationships, handle problems and deal with depression in the period after a baby is born. In accordance with these aims, the following procedures will be used: a paper-pencil survey will be provided to you for completion.

If you decide to participate in this research, you will be asked to complete the survey after a short explanation of the study and signing consent forms, which should take about 40 minutes in total to complete. If at any time during the interview you feel uncomfortable answering a question, you may choose to not answer that particular question, leave the session, or withdraw from the study, at any time. The consent to participate in this research is strictly voluntary and if you choose not to do it or should you want to drop out at any time during the study, there will be no negative consequences.

Inclusion criteria for this study is as follows: 1. Are a heterosexual man, 2. you are a Latino man, who was either born in the US from parents born in a Latin American country or you were born in a Latin American country, 3. Have at least one child under the age of 1 year old (12 months), 4. Are in a relationship with the mother of the child and involved in the caregiving of that child, 5. Participated in the prenatal care of the mother of the child.

There are no benefits to you participating. As a research participant, information you provide will be held in confidence to the extent permitted by law. You name and identifying information will not be asked or collected. Data will be kept in a locked file in the researcher's office at 1395 Brickell Avenue, Suite 800, Miami, Fl 33131. Your signed consent form will be kept separate from the data.

Your consent to participate in this research is strictly voluntary and if you choose not to participate or should you want to drop out at any time during the study, there will be no negative consequences. There is minimal risk in participating in this study. Some questions may illicit sensitive content and cause an emotional reaction. Therefore, if you have any needs or if you feel emotional distress resulting from you participation, we will offer you a list of resources to contact. If you have an individual therapist we recommend you contact your private therapist. Although there are no direct benefits to you, your participation in this study may help our understanding of how Latino men cope with depressed feelings after a baby is born.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Tania Paredes at 305-301-2918, or tania.paredes@mymail.barry.edu, my faculty sponsor, Dr. Mark Smith, at 305-899-3900, or msmith@barry.edu, or the Institutional Review Board point of contact, Barbara Cook, at 305-899-3020, bcook@barry.edu. If you are satisfied with the information provided and are willing to participate in this research, please signify your consent by signing this consent form.

Voluntary Consent

I acknowledge that I have been informed of the nature and purposes of this experiment by Tania Paredes and that I have read and understand the information presented above, and that I have received a copy of this form for my records. I give my voluntary consent to participate in

this experiment.

Signature of Participant *Date*

Researcher *Date* *Witness* *Date*

(Witness signature is required only if research involves pregnant women, children, other vulnerable populations, or if more than minimal risk is present.)

Appendix D: Informed Consent Form (Spanish)

Approved by Barry University IRB
Date: 6/13/17
Signature

Formulario de consentimiento informado de la Barry University

Se solicita su participación en un proyecto de investigación. La investigación está siendo realizada por Tania Paredes, estudiante de doctorado en el departamento de Trabajo Social de la Barry University, quien busca obtener información útil para el campo del Trabajo Social. Los objetivos de la investigación son explorar la manera en que las personas abordan las relaciones, hacen frente a los problemas y lidian con la depresión en el periodo posterior al nacimiento de un bebé. De acuerdo con estas metas, se utilizarán los siguientes procedimientos: se le entregará una encuesta en papel para que la complete.

Si decide participar en esta investigación, se le pedirá que complete la encuesta después de explicarle el estudio y firmar el consentimiento para participar, que debe le tomarle 40 minutos en total para completar. Si, durante la entrevista, se siente incómodo ante una pregunta, puede optar por no responderla, por finalizar la entrevista o por retirarse del estudio, en cualquier momento. El consentimiento para participar en esta investigación es estrictamente voluntario y, si decide no participar o si desea retirarse en cualquier momento durante el estudio, no habrá consecuencias negativas.

Los criterios de inclusión para este estudio son los siguientes: 1. ser hombre heterosexual; 2. ser hombre latino nacido en Estados Unidos de padres nacidos en un país latinoamericano o haber nacido en un país latinoamericano, 3. tener al menos un hijo de menos de 1 año de edad, 4. estar en una relación con la madre del niño y participar en el cuidado de ese niño, 5. haber participado en el cuidado prenatal de la madre del niño.

No hay beneficios por su participación. Como participante de la investigación, la información que usted proporcione se mantendrá de forma confidencial, en la medida permitida por ley. No se le pedirá ni se documentará su nombre ni su información de identificación. Los datos serán archivados bajo llave en la oficina del investigador en 1395 Brickell Avenue, Suite 800, Miami, Fl 33131. Su formulario de consentimiento firmado se mantendrá separado de los datos.

Su consentimiento es estrictamente voluntario y puede negarse a participar o retirarse en cualquier momento durante el estudio sin ninguna consecuencia negativa. El riesgo de participar en este estudio es mínimo. Algunas preguntas podrían incluir contenido sensible y causar una reacción emocional. Por lo tanto, si, como consecuencia de su participación, usted tiene alguna necesidad o siente angustia emocional, le vamos a ofrecer una lista de recursos para que contacte. Si usted tiene un terapeuta personal, le recomendamos que se ponga en contacto con él o ella. Aunque no hay beneficios directos para usted, su participación en este estudio puede ayudar a entender cómo los hombres latinos enfrentan los sentimientos depresivos después del nacimiento de un bebé.

Si tiene alguna pregunta o preocupación con respecto al estudio o a su participación, puede comunicarse conmigo, Tania Paredes at 305-301-2918, o tania.paredes@mymail.barry.edu, my faculty sponsor, Dr. Mark Smith, at 305-899-3900, or msmith@barry.edu, o con el punto de contacto de la Junta de Revisión Institucional, Barbara Cook, al 305-899-3020. bcook@barry.edu. Si está satisfecho con la información proporcionada y está dispuesto a participar en esta investigación, por favor, indique su consentimiento firmando este formulario de consentimiento.

Consentimiento voluntario

Ratifico que Tania Paredes me ha informado la naturaleza y los propósitos de este experimento, que he leído y entendido la información presentada anteriormente y que he recibido una copia de este formulario para mis registros. Doy mi consentimiento voluntario para participar en este experimento.

Firma del participante *Fecha*

Investigador *Fecha* *Testigo* *Fecha*

(Solo se requiere la firma de testigos si la investigación involucra mujeres embarazadas, niños, otras poblaciones vulnerables o si hay más que un riesgo mínimo por participar).

Appendix E: Dissertation Survey (English)

Demographic Information Form

Instructions: Please provide a response for each of the following questions:

Participant #:_____ (*to be filled out by researcher*)

1. Your age in years: _____

Your wife/partner's age: _____

2. Are you legally married? Yes _____ No _____

If yes, how many years have you been married? :_____

If no, how many years have you been together in a relationship with your partner?

_____

3. Number of Children: _____

4. Ages of Children: _____

5. With this partner/wife, what is the birth order of this child? _____

6. Is your most recent child: Male: _____ Female: _____

7. Was your youngest child planned? Yes_____ No _____

8. Country of your birth: _____

9. How do you identify? (check all that apply)

Central American

_____Belize _____Costa Rica _____El Salvador _____Guatemala

_____Honduras ____Nicaragua ____Mexico ____Panama

South America

____Argentina _____Bolivia _____Brazil _____Chile _____Colombia

____Ecuador ____Paraguay ____Peru _____Uruguay
_____Venezuela

Caribbean

_____ Cuban

_____ Dominican

_____ Puerto Rican

OR

_____Other _____

10. Were you born in the US:

Yes: _____ No: _____

If you were not born in the US, how many years have you been living in the US? _____

11. What country(ies) was/were your parents born in?

Mother: _____ Father: _____

12. How strongly do you identify with Latino culture (from 1-5, with 1 being not at all to 5 being very much)?

_____

13. What is the highest grade/education you completed?

_____

14. What is your household income: _____ Prefer not to answer _____

15. Has your wife/partner ever been in treatment for postpartum depression?

Yes_____ No_____

Thank you for agreeing to take part in this survey. Please read each statement below carefully and choose the answer that comes closest to how you have felt. Please place an 'X' in the box of your answer.

	This questionnaire asks how you have been feeling after the recent birth of your baby. As you read each item, please place an X in the most appropriate box next to each question.			
	Yes all the time	**Yes most of the time**	**No, not very often**	**No, not at all**
1.I have been able to laugh and see the funny side of things				
2.I have looked forward with enjoyment to things				
3.I have blamed myself unnecessarily when things went wrong				
4.I have been anxious or worried for no good reason				
5.I have felt scared and panicky for no good reason				
6.Things have been getting on top of me				
7.I have been so unhappy that I have had difficulty sleeping				

8.I have felt sad or miserable				
9.I have been so unhappy that I have been crying				
10. The thought of harming myself has occurred to me				

Thank you for agreeing to take part in this survey. Please read each statement below carefully and choose the answer that best describes you.

This short questionnaire asks about how you are coping with feelings of depression since the birth of your child under the age of 12 months (1 year). Please place an X in the most appropriate box next to each question as you answer: During the past year, I have done the following to avoid feelings of sadness since the birth of the baby.

	Never	Almost never	Sometimes	Almost every time	Everytime
1. I have used substances like alcohol or drugs					
2. I have avoided my wife					
3. I have avoided my child					
4. I have spent more time at work					
5. I have done nothing and ignored it					
6. I have turned to faith					
7. I spoke to a mental health professional					

Thank you for agreeing to take part in this survey. Please read each statement below carefully and choose the answer that best describes you. Please place an 'X' in the box of your answer.

	This questionnaire lists various beliefs one may hold about their gender role. As you read each item, please place an X in the most appropriate box next to each question.				
	Totally disagree	**Disagree**	**Neutral**	**Agree**	**Totally agree**
1. People can be aggressive and understanding, regardless of their sex					
2. People should be treated equally, regardless of their sex					
3. Children should be given freedom depending on their age and how mature they are, not depending on their sex					
4. Boys have the same obligations to help with household chores as girls					
5. Household chores should not be allocated by sex					
6. We should stop thinking about whether people are men and women and focus					

on other characteristics					
7.My partner thinking that I am responsible for doing the household chores would cause me stress					
8.The husband is responsible for the family so the wife must obey him					
9.A woman must not contradict her partner					
10. I think it is worse to see a man cry than a woman					
11. Girls should be more clean and tidy than boys					
12. Men should occupy posts of responsibility					
13. I think boys should be brought up differently than girls					
14. I think it is right that in my circles of friends, my future domestic activity is considered more important than my professional activity					

15. A father's main responsibility is to help his children financially					
16. Some jobs are not appropriate for women					
17. I accept that in my circle of friends, my partner's future job is considered more important than mine					
18. Mothers should make most of the decisions on how to bring up their children					
19. Only some kinds of job are equally appropriate for men and women					
20. In many important jobs it is better to contract men than women					

Appendix F: Dissertation Survey (Spanish)

Información Demográfica

Instrucciones: Por favor conteste las siguientes preguntas:

Participante #:_____ (*el estudiante llena este numero*)

1. Su edad: _____

   Edad de su esposa/pareja: _____

2. Ustedes esta legalmente casado? Si _____ No _____

Si esta casado, cuantos anos ha estado casado? _____

Si no esta casado, cuanto anos ha estado en un relacion con su actual pareja? _____

3. Cuantos hijos tiene: _____

4. Edades de sus hijos: _____

5. Con esta pareja/esposa en que orden nacio sú último hijo/a (primero, segundo, etc)?

_____

6. Su hijo/a mas recien es: hembra _____ baron _____

7. Usted planifico para su hijo/a menor? Si_____ No _____

8. País de su nacimiento: _____

9. Como se identifica usted? (coloqué una X en todas que se aplica a usted)

Centro America

_____Belize _____Costa Rica _____El Salvador _____Guatemala

_____Honduras ____Nicaragua ____Mexico ____Panama

Sur America

____Argentina _____Bolivia _____Brasil _____Chile _____Colombia

____Ecuador ____Paraguay ____Peru _____Uruguay _____Venezuela

Caribe

_____ Cuba

_____ Dominica Republica

_____ Puerto Rico

O

_____Otro: _____

10. Nacio usted en los Estados Unidos:

Si: _____ No: _____

Si no nacio en los Estados Unidos, cuantos anos ha vivido en los Estados Unidos? _____

11. En que pais/ses nacieron sus padres?

Madre_____ Padre _____

12. Como usted se identifica con la cultura Latina (Desde el 1-5, con 1 siendo no, en lo absoluto a el 5, si en lo total)? _____

13. Que es el grado/educacion mas alto que usted ha completado? _____

14. Que es el total ingreso de su hogar? _____

Prefiero no contestar _____

15. Su esposa/pareja ha estado en tratamiento para la depression postnatal?

Si _____ No _____

	Este formulario la pregunto sobre como se siente depsues del nacimiento de su bebe. Por favor ponga un 'X' en la respuesta que mejor describe si esta de acuerdo con la declaracion.			
	No, en absoluto	**No, no mucho**	**Si, bastante a menudo**	**Si, casi siempre**
1. He podido reir y ver el lado bueno de las cosas				
2. He mirado al future con placer para hacer cosas				
3. Me he culpado sin necesidad cuando las cosas marchaban mal				
4. He estado ansiosa y preocupado son motive alguno				
5. He sentido miedo o panico sin motive alguno				
6. Las cosas me oprimen o agobian				
7. Me he sentido tan infeliz, que he tenido dificultad para dormir				
8. Me he sentido triste y				

desgraciado				
9. Me he sentido tan infeliz que he estado llorando				
10. He pensado en hacerme dano				

Gracias por participando en este estudio. Por favor complete el siguiente formulario y escoja la respuesta que mejor lo describí a usted: durante el último año, he hecho lo siguiente para evitar la sensación de tristeza desde el nacimiento del bebé.

Este forulario le pregunta como esta lidiando con los sentimientos de la depresion desde que nacio su hijo/a de menos de un ano. Por favor ponga un 'X' en la respuesta que mejor describe si ha participado en ese comportamiento. Durante el ultimo ano yo he hecho lo sigiente para evitar sentimientos de tristeza desde que nacio mi hijo/a:					
	Nunca	**Casi nunca**	**Algunas veces**	**Casi todas las veces**	**Siempre**
1. He consumido sustancias como alcohol o drogas.					
2. He evitado a mi esposa.					
3. He evitado a mi hijo/a.					
4. He pasado más tiempo en el trabajo.					
5. No he hecho nada y lo he ignorado.					
6. He recurrido a la fe					
7. He hablado con un profesional de la salud mental					

	Este forulario le pregunta sobre los actitudes de rol de genero. Por favor ponga un 'X' en la respuesta que mejor describe si esta de acuerdo con la declaracion.				
	Total-mente en de-sacuerdo	**Desacuerdo**	**Neutral**	**De Acuerdo**	**Total-mente de acuerdo**
11. Las personas pueden ser tanto agresivas y comprensivas, independientemente de su sexo.					
12. Se deberia tartar a las personas igual, independientemente del sexo al que pertenezcan.					
13. A los ninos se les deberia dar libertad en function de su edad y nivel de madurez, y no por el sexo de pertenencia.					
14. Los chicos tienen las mismas obligaciones de ayudar en las tareas del hogar que las chicas.					
15. Las tareas domesticas no deberian asignarse por sexo.					
16. Deberiamos dejar de pensar si las personas son hombre o					

muher y centrarnos en otras caracteristicas.					
17. El que mi pareja considere que yo soy la responsible de las tareas domesticas me crearia tension.					
18. El marido es el responsible de la familia por lo que la mujer debe obedecer.					
19. Una mujer no debe llevar la contraria a su parea.					
20. Me parece que es mas lamentable ver a un hombre llorar que a una mujer.					
21. Una chica debe ser mas limpia y ordenada que un chico					
22. Es preferable que los puestos de responsabilidad los ocupen los hombres.					
23. Creo que se debe educar de modo distinto a los ninos que a las ninas.					
24. Considero correcto que en mis circulos de					

amistades se valore mas mi actividad familiar que la profesional.					
25. La principal responsabilidad de un padre es ayudar economicamente a sus hijos.					
26. Algunos trabajos no son apropiados para las mujeres.					
27. Acepto que en mi circulo de amistades el trabajo future de mi pareja se valore mas que el mio.					
28. Las madres deberian tomar la mayor parte de las decisions sobre como educar a los hijos.					
29. Solo agunos tipos de trabajo son apropiados tanto para hombres como para mujeres.					
30. En muchos trabajos importantes es major contratar a hombres que a mujeres.					