

Men's Perspectives on a Spouse's or Partner's Postpartum Depression

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(ABSTRACT)

Men as well as women are affected by the life-changing events of pregnancy and childbirth. The nature of fatherhood and the role of the male in the birthing process have undergone significant changes in the past several decades. While this phenomenon has been well-documented regarding the changes a father experiences during a healthy pregnancy and birth, there is little research that addresses the implications for the man when his spouse or partner is diagnosed with postpartum depression. Approximately 10 to 20% of birth mothers are affected by some form of this disorder (Greenberg & Springen, 2001). The literature on this topic has grown steadily in an effort to better understand the reasons and implications of such a diagnosis for a woman. This researcher's intent was to identify the perspectives of men whose spouses or partners were diagnosed with postpartum depression. Understanding this situation from their perspectives can represent information regarding the effect of postpartum depression on the interpersonal relationship and, secondarily, the family unit. In particular, relationship strains between the men and their spouses or partners and the impact on the adjustment to having an infant to care for were explored. Medical records were reviewed in a medical practice for significant scores on the mother's Edinburgh Postnatal Screening Scale. After a series of elimination steps, seven men were identified and willing to participate in the research. In an hour-long interview, the men discussed their experience with their spouse/partner's postpartum depression. Field notes were taken before, during and

immediately following the interviews to add clarification, using nonverbal responses to the setting and interview questions. The transcripts of the interviews were coded to identify common categories, which in turn generated the themes of emotional deregulation, seeking normalcy, understanding self, and disappointment. Anger was noted by the seven men as a response on several levels to the postpartum depression. In addition to the anger, frustration was experienced with the lack of information received and the lack of response from the medical community as a whole. Several of the men reported surprise at their previous emotions resurfacing so readily when answering the interview questions.

## DEDICATION

I would like to dedicate this work to the seven men who shared their experiences with their spouses or partners postpartum depression. Their voices add to the research on the impact of postpartum depression from a little viewed perspective. Thank you.

I would also like to dedicate this work to my family, my husband Tom and especially my four children, Rebecca, Matthew, Sarah, and Rachel. Rebecca became my eyes post-surgery to keep the process moving. Matthew's humor kept me seeing the brighter side of life. Sarah demonstrated determination in the face of unexpected obstacles. Rachel for your unwavering faith and constant reminder that it is what is inside a person that matters in life. Thank you also to my son-in-law Nick for helping with last minute computer crises. I love you all.

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## Chapter One: Overview of the Research

Pregnancy and childbirth represent major life events for both men and women. Previous research has focused almost exclusively on the transitions a woman makes during the pregnancy and early postpartum. Whatever the response to the birth, there is an underlying assumption that the woman's life has been forever changed by this event. For the man, changes also occur, but these changes are often viewed as being less significant. Men face their own concerns about becoming fathers, as well as the added challenge of having to be an appropriate source of support for their partners. Until recently the experiences of fathers have taken a backseat to their partners with researchers rarely addressing their male perspectives except for that of a nurturing role (Carpenter, 2002). Little attention has been given to the adjustments that men make and the difficult challenges they may face during this period of transition (Chalmers & Meyer, 1996).

Research into postpartum depression and the effects on the mother has received continued analysis. The emotional difficulties are addressed in regard to the three types of postpartum disorders: postpartum blues ("baby blues"), postpartum depression, and post partum psychosis (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006). The importance of a close supportive relationship has been identified as a buffer against postpartum depression (George, 1996; Misri, Kostaras, Fox, & Kostaras, 2000). Comparatively little has been written of the experiences of the fathers when their partners are depressed (Bradley, Mackenzie, & Boath, 2004; Marks, Wieck, Checkley, & Kumar, 1996; Morgan, Matthey, Barnett, & Richardson, 1997). Men are largely unfamiliar with the tasks of childbirth and childcare and look to their partners for support in their transition to first time fatherhood. When this support is unavailable to them due to the partners' own postpartum struggle, men's physical and emotional well-being can be affected (Turan, Nallbant, Bulut, & Sahip, 2001).

Research conducted about the father's experiences during the transition to fatherhood has focused on areas such as the exploration of the "couvade syndrome" (Bogren, 1983, 1989; Masoni, Maio, Trimarchi, de Punzio, & Fioretta, 1994). Couvade is defined as childbearing behavior in a person other than the mother, usually the father (VandenBos, 2007). Couvade can occur during pregnancy and is now recognized as a spectrum disorder that can range from mild physical complaints to psychosis (Shapiro & Nass, 1986).

The transition to fatherhood is a time when many men become highly invested in the role of father and the associated role of provider (Farrell, Rosenberg, & Rosenberg, 1993; Seimyr, Edhborg, Lundh, & Sjogren, 2004). Cowan (1988) found three aspects of a new father's self-concept that changed in the direction of maturity: identity, locus of control, and self-esteem. It is important to know whether experiencing a spouse with postpartum depression changes the fathers' self-concepts in any of these noted areas. The integration of current roles with the long-standing assumptions of paternal roles may distort and possibly even cause regression to unresolved issues when the spouse has postpartum depression.

Previous studies such as one by Rossi (1968) noted that men's self-esteem might suffer in their struggle with the competing demands of work, marriage, and parenting. In the book, *Fatherhood*, consideration was given to a number of important factors concerning the transition to fatherhood, including emotional preparedness and readiness to father (Parke, 1996). Earlier research on the father's perspective of parenting has continued to focus on work demands, financial worries, home responsibilities, being a good father to the infant, and maintaining a spousal relationship (Bianchi, Milkie, Sayer, & Robinson, 2000; Clinton & Kelher, 1993; Glazer, 1989; Ventura, 1987). Another theory explored in research was that expectant fathers may have little exposure to paternal role modeling to develop the process of role making for involved

fatherhood (Daly, 1993; Gage & Christensen, 1991). These studies all make the assumption that the postpartum period for fathers was without complication either physically or emotionally.

What have received limited attention are the implications for the father when all does not go as planned after the birth of the baby. Not every postpartum period proceeds smoothly for mother or father. Statistics have indicated that approximately 10% to 20% of new mothers experience postpartum depression (Greenberg & Springen, 2001). When the mother is depressed and unable to care for the infant, these responsibilities normally shift to the father. Meighan, Davis, Thomas, and Droppleman (1999) noted little research on the effects of postpartum depression on the father during their study of eight men whose partners had experienced postpartum depression.

#### *Background and Significance of the Problem*

The transition to parenthood is one of the most common and most studied developmental transitions (Ahmad & Najam, 1998; Elek, BrageHudson, & Bouffard, 2003). Fatherhood is a common life experience for nearly all men. Almost 90% of men marry, and nearly 90% of these become fathers (Snarey, 1993). This percentage takes into account adoption and other means of reproduction due to infertility.

According to Whitehead and Popenoe (2004) although men are waiting longer to marry; in 1970 average age was 23 in 2004 the average age is 27 most men view marriage as an improvement over being single. Married men represent an important segment of the male population. A study commissioned by the National Marriage Project in 2002 interviewed 1,010 men between the ages of 25 and 34 for their views on marriage and children. Of these men 70% were married and lived in households with children. They reported more child centered attitudes and expressed involvement with their children as an important life experience. The experience of

fatherhood has a transforming effect on men (Hawkins & Dollahite, 1997; Marsiglio, 1998; Palkovitz, 2002).

Over the last two decades there has been a considerable increase in the number of fathers actively participating in the labor room during the birthing process (Draper, 1997). The father's involvement at the birth of his child is seen as a celebration of a significant event (Seal, 1994). It has been suggested that a birth environment in which the father feels free to become involved in the birth process together with his partner can facilitate father-infant attachment (Peterson, Mehl, & Leiderman, 1979). With the cultural definition of fatherhood broadening, men have become more comfortable accepting a nurturing role with their infants.

In an effort to accommodate the changes in societal views concerning father involvement, maternity units have undergone changes in the way maternity care is delivered (Dowswell, Piercy, Hirst, Hewison, & Lilford, 1997). Although these changes have allowed greater freedom in the day-to-day care of the newborn, there is a downside. The emphasis on shorter stays, down from four-to-five days to an average of two-to-three days, has limited the medical community's ability to monitor the emotional well being of the new mother and father. It is normally during this unmonitored period that the new mother may experience what is referred to as the "baby blues."

The baby blues are experienced by an estimated 80% of new mothers (Epperson, 1999). The symptoms include mild depression, irritability, weeping, frustration, and fatigue. The baby blues generally begin the second-to-third day post delivery and may last up to two weeks. The symptoms indicating baby blues gradually dissipate within two weeks for most women as they begin adjusting to the demands of parenting. During this period of "baby blues," the new father may find himself undergoing immense pressure to cope with a partner in distress, a new infant, and his own emotional responses to becoming a parent.

When the new mother is unable to cope with the transition to parenthood and the “baby blues” do not dissipate as expected, the onset of postpartum depression is likely to become a reality. Postpartum depression affects approximately 10-20% of childbearing women and may begin anywhere from two weeks to several months after delivery (Miller, 2002). The incidence increases as much as 25% for women who have had a previous episode of postpartum depression (Wisner, Parry, & Piontek, 2002). The majority of women will resume usual household, social, community and occupational roles within 3-to-6 months postpartum; it is noted that women with postpartum depression have prolonged difficulty with functioning (Gennaro & Fehder, 2000; Logsdon, Wisner, Hanusa & Phillips, 2003). The new father's initial role in nurturing the infant now takes on a greater significance, as the symptoms of depression are manifested in the new mother.

When the expectations of parenting are altered for the couple, as in the case of postpartum depression, the father is expected to adjust and cope with this unexpected complication. Since the early 1970s, there has been an increased desire by men to be part of the early care of the infant. This infant-father bond has been shown in research to be beneficial to the infant (Roggman, Benson, & Boyce, 1999; Von Klitzing, Simoni, Amsler, & Burgin, 1999). However, in a study by Lovestone and Kumar (1993), men commented on the contrast between the excited anticipation of the birth and the reality of trying to cope with work, home, infant, and the care of an emotionally distressed spouse. As a new mother's ability to fulfill important functions is diminished, the father is expected to step in and compensate for his wife's disability (Davila & Beck, 2002; Hickman, 1992; O'Mahen, Beach, & Banawan, 2001).

Although the woman's experience of postpartum depression has been well documented in research (Fowles, 1998; Fox, 1999; Kuhlmann, 1998; Logsdon et al., 2003; Mauthner, 1998; Spinelli, 1998; Wisner, Parry, & Piontek, 2002), there is little or no research, and thus a

commensurate lack of knowledge, on the adjustments made by healthy men in the postpartum period. "Healthy" in this sense means that these men are not themselves experiencing any depression during the postpartum period either by reaction to a spouse who is depressed or due to their own mental health issues. James (1998) argued that male gender role expectations, the ability to manage life stressors, maintain a job and support a family without experiencing personal distress, is operating at both the individual and social level and may be a contributing cause to the relative exclusion of a man's perspective on a spouse or partner diagnosed with postpartum depression.

### *Theoretical Orientation*

The categorical framework of attribution theory is important in understanding the male perspective. Attribution theory examines how persons ascribe causality to the events around them (Kelley, 1973). When the mother develops postpartum depression, the partner seeks to derive meaning from this experience both in how it affects him as well as others. Attribution theory is concerned with the "why" of the questions asked by the partner in order to develop meaning.

Kelley (1973), the leading theorist in the development of attribution theory, related attribution theory to a more general field, which he referred to as "psychological epistemology." The emphasis being on the processes by which people know their world and know that their beliefs and judgments are corresponding with reality or facts. In regard to a man's reactions, responses, judgments, and evaluation of the experience of postpartum depression in his partner, few studies exist. One of these studies by Meighan, Davis, Thomas, and Droppleman in 1999 indicated a framework of loss in regard to the partner relationship experience.

Ambiguous loss is a term used to describe two types of loss (Boss, 1999). One loss occurs when an individual in the system is physically absent but treated by others as if

psychologically present. The other ambiguous loss occurs when a member of the system is physically present but psychologically absent from relating to the other members of the system. This type of loss can be experienced by the family members when a new mother struggles with postpartum depression. Boss (1999) concluded that individuals experiencing ambiguous loss have a difficult time resolving the feelings of grief because the loss is not always clearly defined.

The feelings and experiences of both partners in the transition to parenthood are highly interdependent (Grossman, Eichler, & Winickoff, 1980; Wentzel, 2002). First-time parents experience many new role demands, interrupted sleep, decreased autonomy, and changes in the marital relationship (Leathers, Kelley, & Richman, 1997; Wentzel, 2002). Postpartum depression places an emotional barrier between partners. Although physically present, the depressed spouse or partner is unable to respond to childcare issues and personal care issues in a manner indicating healthy adjustment. As the woman is struggling with feelings of inadequacy, extreme fatigue, and the feeling that no one understands (Beck, 2001), the man often becomes bewildered by the lack of communication and withdrawal from his partner. It is probable that the husband may begin to generate a feeling of resentment at the forced additional role of infant caretaking (Diemer, 1997; Woollett & Parr, 1997).

#### *Statement of the Problem*

The problem to be addressed in this study is the impact of the diagnosis of postpartum depression on a man's relationship with his spouse/partner, the perception of self and the perceived presence of or lack of appropriate assistance. Although women's responses to postpartum depression have been documented in research (Stowe, Landry, & Porter, 1995), questions remain regarding the father's response to a spouse with postpartum depression. For both men and women, parenthood necessitates the adaptation to demanding and unfamiliar roles.

Women who held successful careers outside the home can now find themselves isolated at home with an infant and overwhelmed by unfamiliar responsibilities, as well as cultural expectations to “be happy” as a new mother (Nicolson, 1999). Men find themselves unsure of and unable to “fix” the crying infant or console their formerly competent partners.

Since the 1970s, men have begun to take an active role in the birthing process (Shapiro, Diamond, & Greenberg, 1995). Lemmer (1987) noted that fathers in modern western societies have assumed a more nurturing role with increased involvement in childbirth and childcare. This nurturing role takes on a different connotation when the mother of the baby is diagnosed with postpartum depression.

Postpartum depression and its effects on the mother and on the mother-infant bond have received much research interest (Beck, 1996; Emanuel, 1999; Field 1998; Hay, et al., 2001; Ringler, 1996; Soliday, McCluskey-Fawcett, & O'Brien, 1999; Spinelli, 1997). The father's response to a partner who is diagnosed as having postpartum depression has been studied but only as an aside to the mother's experience (Areias, Kumar, Barros, & Figueirodo, 1996; Locicero, Weiss, & Issokson, 1997; Nieland, & Roger, 1997; Whiffen & Johnson, 1998).

A study conducted by Boath, Pyrcce, and Cox in 1998 listed the implications to the father when a spouse or partner has postpartum depression as ranging from excessive absenteeism from work and losing out on previously enjoyed social and leisure activities to an increase in arguing, worry over the relationship and inability to approach the partner in an acceptable way. Men experience their own concerns about the transition to parenthood and recognizing their experiences provides a completed picture of the family environment. The ability to understand this perspective permits development and implementation of resources to foster a healthy family environment during a difficult time.

*Purpose of the Study*

The purpose of this study was to examine men's experiences in regard to postpartum depression in a spouse or partner. These stories illustrate the day-to-day struggles and responses of the men. The effects on men whose spouses or partners suffer from postpartum depression have not been given priority in research. To date, their collective voices have been largely unheard in regard to their experiences, feelings, thoughts and sense of loss in relation to their experience with a partner who has postpartum depression. This study can assist health care and mental health care workers in gaining a better understanding of the experience of postpartum depression in a spouse or partner. The men's experiences can represent a substantial piece in understanding postpartum depression's effects upon the family unit. The transition to parenthood is recognized as a challenging developmental milestone for both men and women (Benvenuti, Marchetti, Tozzi, & Pazzagli, 1989; Dion, 1985; Dragonas, Thorpe, & Golding, 1992), but when complicated by an unforeseen illness, a sense of loss prevails.

*Research questions.* With this in mind the following research questions were examined:

1. How do men describe their experiences when their spouses or partners are diagnosed with postpartum depression?
2. How do the participants describe the impact on the relationship with their spouses or partners when the spouse or partner is diagnosed with postpartum depression?
3. How do men define themselves when a spouse or partner has postpartum depression?
4. How do the men perceive the help received or offered when their spouses or partners have postpartum depression?

*Delimitations of the study.* The following delimitations will further clarify the boundaries of the research. The first delimitation concerns the use of the Edinburgh Postnatal Depression Scale (EPDS) as the method to determine postpartum depression. The EPDS is a self-report scale

given to a new mother normally at her 6-week postpartum check up. The mother may choose to answer honestly before being seen by the physician or may falsify her response to appear “normal” when in reality she may be having difficulty coping. Thus the risk exists that an accurate assessment for postpartum depression may not occur.

A delimitation of this study is that it does not include individuals who have conceived either by InVitro fertilization or donor sperm. These process of fertilization have their own potential stressors which may effect the postpartum period.

An additional delimitation is the exclusion of non English-speaking populations. The ability to understand the research questions without potential cultural bias has limited the scope of this research to those individuals who have an understanding of the English language.

Another delimitation is the willingness to participate by the spouse or partner. Men use the mental health system less than women and therefore may not see the usefulness in becoming part of related research. Acknowledging their concerns and encouraging participation may still limit the number of men willing to be interviewed.

A delimitation is also noted in the fact that all couples in this study are heterosexual. The implications for lesbian couples were not addressed but are recognized as having their own factors meriting further research.

### *Definition of Terms*

The following terms have been defined below to facilitate consistent understanding of the research. The terms are understood to be defined and utilized as such in the context of this study.

Baby Blues – a mild mood disorder which occurs between the second-to-fourteenth day after delivery and may manifest itself with the following symptoms: mood lability, crying, anxiety, insomnia, poor appetite, and irritability. These symptoms dissipate on their own, usually in two weeks (O’Hara & Engeldinger, 1989).

Cortisol - A hormone, stimulated by the production in the placenta of corticotropin-releasing hormone. With the removal of the placenta following birth, levels of cortisol drop precipitously creating a possible link to sudden onset of depressive symptoms (Hendrick, Altshuler, & Suri, 1998).

Couvade – Abdominal pain or other somatic symptoms appearing in male partners of pregnant women, usually presumed to be psychogenic in origin (VandenBos, 2007).

Diagnostic and Statistical Manual –IV -TR – The manual for classifying mental illness used by the American Psychiatric Association (American Psychiatric Association, 2000).

Edinburgh Postnatal Scale – A measurement scale constructed specifically for use in the postpartum period (Cox, Holden, & Sagovsky, 1987).

Estradiol and estriol – Two biologically active forms of estrogen produced by the placenta during a pregnancy (Hendrick et al., 1998).

Estrogen –A steroid hormone controlling female sexual development (Fink, Sumner, Rosie, Grace, & Quinn, 1996).

Glucocorticoid - Steroid-like compound influencing intermediary metabolism (Hendrick et al., 1998).

Hormones – Chemicals that determine body size, temperature, and activity level (Sichel & Cohen, 1994).

Perinatal – Pertaining to or occurring in the period shortly before and after birth (Swendsen, & Mazure, 2000).

Postpartum – The time following childbirth or delivery (Hendrick, et al., 1998).

Postpartum Depression – Depression associated with the birth of a baby, normally affecting up to 20% of women. Symptoms appear within six weeks postpartum but may be delayed for several months. Symptoms include but are not limited to changes in sleep and

appetite, decrease in libido, fatigue and worry. These are often confused with normal adjustment post birth, making an accurate diagnosis difficult (Susman, 1996).

Postpartum Psychoses – A rare condition occurring in one or two mothers out of every 1000 live births, typically with onset in the first six weeks postpartum. The onset tends to be severe, often requiring hospitalization for the protection of the mother and the infant (Brockington, Winokur, & Dean, 1982).

Progesterone – A hormone whose level drops sharply immediately following birth. It was originally posited to be etiologic in the development of postpartum depression (Nott, Franklin, Armitage, & Gelder, 1976).

Prolactin – A hormone, produced by the pituitary gland, whose levels may remain high post pregnancy for several months. This hormone is associated with milk production and stimulation of the mammary gland in the female (Fava, Fava, & Kellner, 1983).

Puerperal – time after childbirth (Harris, et al., 1996).

Puerperium – Period of about six weeks following childbirth when the reproductive organs are returning to their normal pre-pregnancy state (Harris, et al., 1996).

Thyroiditis – The result of pathological endocrine changes during late pregnancy and puerperium in which the thyroid function is altered, creating a mood disturbance found also in non-pregnant women with thyroid dysfunction (Stowe & Nemeroff 1995).

### *Organization of Study*

Chapter one provides the significance and background of the problem studied, the theoretical orientation, the statement and purpose, research questions, and delimitations used to study the effect of postpartum depression on the participant spouse or partner.

Chapter two focuses on a review of related literature on men's response to postpartum depression in a spouse or partner. Included in this review will be the historical background on the

diagnosis of postpartum depression. Current theories on the possible causes of postpartum depression are addressed including the psychosocial perspective as well as possible medical issues. Relevant research on the experiences of the mother and father will be noted with an emphasis on the man's experience of postpartum depression.

Chapter three includes an overview and justification of a qualitative approach to answer the research questions addressed in this study. An explanation of the qualitative research methodology utilized in answering each of these research questions is presented. In addition the research participant selection, interview protocol, and research procedures are described.

Chapter four presents the results and analysis of data in response to the research questions posed in chapter one. Using the qualitative research method of open-ended interviews, the transcribed interview responses were analyzed using open coding to determine categories that were inclusive of common responses of men relating to their experience of a spouse or partner diagnosed with postpartum depression.

Chapter five addresses the interpretation and significance in the findings of the research. The implications to counselor educators, counseling theory, clinical practice and significance to the field of counseling, as well as the confirmation of knowledge already reported in the research literature, are reviewed. Conclusions and recommendations for further study are presented.

### *Summary*

Chapter one presented the elements of the proposed research on men's experiences with a spouse or partner with postpartum depression. The purpose of this research was to investigate the experiences of the father whose spouse/partner was diagnosed with postpartum depression. More specifically, this researcher investigated men's descriptions of the effects postpartum depression had on them personally and on their relationship with their spouses or partners. Investigating

their thoughts, beliefs, feelings, and questions adds to an understanding of how postpartum depression affects the male in the relationship.

Because research on post-partum depression has been almost exclusively directed at the mother's experience, the impact of this illness on the partner has received limited clinical or academic attention. Extant research explores and categorizes issues surrounding depression and the effects of relationships on its onset and severity. There is also on going study of the impact of fatherhood on men, e.g. self-concept issues surrounding finances, work role, and emotional transformative development as they enter this new role. Little attention, however, has been directed toward the specific intersection of spousal postpartum depression with the normal changes and demands experienced by the father postpartum.

The significance of such study is amplified by the broader social trend of increased participation of fathers in the birthing process, driving changes in hospital protocol and increasing cultural expectations of the father's role during delivery and postpartum. With up to 20% of births involving postpartum depression, the paucity of research, exacerbated by male gender role expectations, leaves a significant void.

This study uses the theoretical orientation of attribution theory, deriving meaning from the "why" questions raised by the postpartum scenario. Preliminary research indicates a promising framework for men's understanding of their experiences of spousal postpartum depression in that of "ambiguous loss," specifically when loss is characterized by physical presence and psychological absence, experienced in different, specific ways by each partner.

During his partner's postpartum depression, focus falls on the experience of the man trying to understand his role supporting his partner cast in the unfamiliar role of dependency and decreased competence. Energy demands, work status, including absenteeism, and resentment at

diminished relational quality is juxtaposed against the positive expectations entering the experience.

Several delimitations of the study include the following: (a) Using the EDPS as a method for determining post-partum depression due to distortions endemic to a self-report scale; (b) participants include only couples who conceived without medical intervention; (c) participants are only English-speaking; (d) reticence to participate in the study due to male pre-disposition against involvement in mental-health services, and (e) participants are only heterosexual couples. Pharmacological, psychological, diagnostic and related technical terms are defined specific to their use in this study, and the organization of the study is five-fold: (a) Accurately stating and contextualizing the problem; (b) a review of related literature; (c) over-view and justification of a qualitative approach; (d) the results and analysis of data, and (e) interpolation and significance of data, along with conclusions and recommendations for further study.

## Chapter Two: Review of the Literature

In this chapter, current literature is reviewed in regard to postpartum mental health issues, specifically postpartum depression. It is noted that the literature contains limited research concerning the fathers' adjustment to parenthood when postpartum depression in the mother has been diagnosed. The historical underpinnings for the actual diagnosis, views as to risk factors and causes are reviewed. In addition, the implications to the mother, father and infant are addressed.

*Historical Perspective of Postpartum Mental Health*

Hippocrates first described postpartum psychiatric illness in the fourth century (Demand, 1994). In the 19th-century, Jean Etienne Dominique Esquirol reported the first systematic study of the phenomenon of postpartum mental illness in his two volume textbook *Des maladies mentales* [Mental Sickness] (Esquirol, 1838). It was Esquirol's study that separated the indices of postpartum mental illness into three groups: (a) those occurring during pregnancy; (b) those occurring soon after childbearing, and (c) those developing several weeks or longer after delivery (Hamilton, 1992). Esquirol suggested in 1838 that the incidence of postpartum illness might be much higher in the general population than was indicated by hospital statistics. He believed that many suffered silently at home, a statement that remains valid today.

Another French physician, Louis Victor Marce, continued the study of postpartum illness. Marce published a textbook *Traite de la folie des femmes enceintes* [Trait of the madness of pregnant women] in 1858 and included hundreds of cases from his own study and that of other hospitals in Paris, France, concerning postpartum illness. He is remembered for the clearly defined and described characteristics of early and late onset postpartum illness.

In the twentieth century, the psychiatric community sought to develop a consistent nomenclature for mental illnesses. In this process the search for the causes of mental illness proved futile.

Without etiology as a basis for classification, the next alternative was to identify psychiatric disorders on the basis of behavior patterns. Hence three categories were developed: (a) Dementia praecox (schizophrenia)- a disorder of thinking; (b) Manic and Depressive syndromes - emotional (affective reactions), and (c) Illnesses in which metabolic agents interfered with the function of the central nervous system neurons--labeled toxic-exhaustive psychoses (later organic psychoses). Some overlapping of characteristics were noted but accepted by the psychiatrists (Hamilton, 1992).

Most of the varieties of identified mental illness could fit into this classification system. There was one exception--postpartum psychiatric illness. The psychiatric community set out to expunge this defined phenomenon because it did not fit into one of the accepted three categories. Through the denouncing of studies previously conducted which identified postpartum illness, misquotes and scathing reviews, the psychiatric community was almost successful in stopping the continued exploration of postpartum psychiatric illness as a diagnosable entity which needed to be included in the manual (Dunnewold, 1997; Hamilton, 1992).

In 1952, the first edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association was published. Despite the increased number of studies on this phenomenon, the inclusion of postpartum mental illness was omitted. The denial of postpartum psychiatric illness continued until 1968 when the DSM-II first included the diagnostic classification of psychosis associated with childbirth. The DSM-III (1980) and DSM-III-R (1987) listed postpartum psychosis simply as an example of an organic psychosis. The DSM-IV (1994) and DSM-IV-TR (2000) utilize postpartum onset as a modifier for brief reactive psychosis and mood disorders.

It is important to note that there is disagreement with *The Diagnostic and Statistical Manual, Fourth Edition-TR* and the current medical literature concerning the standard time

frame for diagnosing the onset of postpartum depression. *The Diagnostic and Statistical Manual, Fourth Edition-TR* allows the specifier, with postpartum onset, under the category of major depressive episode if the diagnosis is made within four weeks postpartum. This is difficult to ascertain when the woman, barring complications or the need for a procedure following birth, is normally not scheduled to see her obstetric physician until six weeks postpartum. The tenth revision of the International Classification of Diseases (ICD-10; World Health Organization, 1992) defines disorders associated with the postpartum period as commencing within six weeks of delivery that do not meet the criteria for mental or behavioral disorders classified elsewhere. Thus the medical diagnosis may occur beyond the “defined” mental health diagnostic window.

#### *Psychosocial Factors of Postpartum Depression*

Despite the commonly positive experience of childbirth and parenthood, a substantial percentage of new mothers will experience postpartum depression (Swendsen & Mazure, 2000). Beck (2001) identified factors which may indicate an increased risk of postpartum depression. These include, but are not limited to, prenatal depression in the mother, lack of social support, life stress, childcare stress, and marital dissatisfaction. Low levels of perceived partner support and partner intimacy have been linked to maternal stress after childbirth (Muslow, Caldera, Pursley, Reifman, & Huston, 2002). Vulnerability factors were also reported in a study conducted by Elliott, et al., (2000) to include the birth event, loss of job, and transition to the social role of mother. Recent literature on postpartum depression identified numerous etiological factors at the cultural, social, psychological and biological levels (Beck, 2001; Forman, Videbeck, Hedegaard, Salvig & Secher, 2000; Robertson, Grace, Wallington, & Stewart, 2004).

*Social relationships.* Social relationships play a central role in the quality of people's lives. A woman's relationships with her partner, family, as well as personal friends are indicative to her psychosocial functioning in the postpartum period (Fisher, Feekery, & Rowe-Murray,

2002). Supportive relationships may enhance feelings of well-being, personal control, and positive affect.

Of particular importance is the primary relationship with her spouse or significant partner (Beck, 2001; Knauth, 2000; Mauthner, 1998; Misri et al., 2000; Paley, Cox, Harter, & Margand, 2002; Robinson & Stewart, 2001). Studies by Brugha, Sharp, and Cooper (1998); Logsdon, BirSamanthaer, and Barbee (1997); and Thorp, Krause, Cukrowicz, and Lynch (2004) indicated that supportive partners played a significant role in reduction of stress levels and improvement of mood in new mothers. Partner support may include balanced involvement in family decision making, emotional support, and assistance with childcare duties (Bost, Cox, Burchinal, & Payne, 2002).

A lack of social support systems increases a new mother's isolation and limits her ability to receive answers to her questions (Hagen, 2000; Hung & Chung, 2001; Lakey & Scoboria, 2005; Swendsen & Mazure, 2000). Dennis and Ross (2006) suggested that deterioration in the marital relationship is linked to maternal mood. In the Australian study reported by Fisher, Feekery & Rowe-Murray (2002) the distress severity of the mothers admitted to a private hospital mother-baby unit was consistently associated with the quality of her relationship with her partner.

*Negative life events.* Negative life events, in conjunction with the postpartum period, often produce greater stress. Recent research indicates that negative life events were significant predictors of postpartum depression (Huizink, Robles de Medina, Mulder, Visser, & Buitelaar, 2002; Lane et al., 1997; Righetti-Veltima, Conne-Perrard, Bousquet, & Manzano, 1998; Sequin, Potvin, St-Denis, & Loiselle, 1999). These events may include occupational changes, either a job loss or expectations by employers for early return to work (Hyde, Essex, Clark, & Klein, 1996).

Women often report depression with the sudden role change from career woman to the categorically different responsibilities of motherhood (Formichelli, 2001; Kuhlmann, 1998).

*Birth experience.* Negative life events can also include unmet expectations of how the delivery of the infant would occur (Dannenbring, Stevens, & House, 1997; Rigletti-Veltema, Conne-Perrard, Bousquet, & Manzano, 1998). The stressors of pregnancy, labor and delivery are experienced only by women and can lead to the emotion of anger and ultimately depression following the actual birth (Graham, Lobel, & DeLuca, 2002). The personal satisfaction in one's ability to maintain control during the labor and delivery process has been noted as a possible source of negative emotion after the birth. In a study conducted by Slade, MacPherson, Hume, and Maresh (1993), women who had maintained self control in regard to the birthing experience were less likely to view the experience as filled with negative emotions against themselves.

Regardless of whether the view of depression is a medical entity or a psycho/social response to environmental factors, the experience of previous depression as well as the experience of depression in pregnancy appears to increase the risk for postpartum depression (Beck, 1995a; Llewellyn, Stowe, & Nemeroff, 1997; Ross, Sellers, Gilbert-Evans, & Romach, 2004). There appears to be both a professional and societal propensity to dismiss depressive symptoms such as change in appetite, sleep, libido, and energy as related solely to the condition of pregnancy (Ugarriza, 2002; Weissman & Olfson, 1995). Also confounding the assessment of major depression during pregnancy is the failure to assess for medical disorders such as anemia, gestational diabetes, and thyroid dysfunction that could potentially contribute to depressive symptoms (Buist, 2002; Pedersen, et al., 1993).

### *Medical Factors*

The other view of causality or risk lies in the hormonal changes experienced by women during pregnancy and the postpartum period. Many hormonal theories have been promulgated

for the cause of postpartum depression (Nappi, et al., 2001; Seyfried & Marcus, 2003; Sichel, Cohen, & Robertson, 1995). Hormones are chemicals that determine our body size, temperature and activity level. They are part of the body's endocrine system and are produced by endocrine glands. Hormones are transported by body fluids, such as blood, to specific organs and tissues to influence their functioning. If the hormonal level changes, so does the functioning of the organ. Early bio-chemical investigations presumed that postpartum depression pathology was related to the rapid decline in gonadal hormones or cortisol and/or the influence of such declines on the neurotransmitter systems (Bloch, et al., 2000; Rubinow, 2000; George & Sandler, 1988).

*Cortisol factor*. As a result of the placenta's production of corticotropin releasing hormone, cortisol levels peak during late pregnancy, and fall abruptly at delivery (O'Hara, Schlechte, Lewis, & Wright 1991). Cortisol is the most abundant gluco-corticoid in humans. The liver can metabolize cortisol into cortisone, a steroid known for the treatment of allergic or inflammatory diseases. The side effects of rapid withdrawal from cortisone can include euphoria, alertness, and insomnia, symptoms often identified in women experiencing postpartum psychosis.

*Estrogen factor*. An additional hypothesis has been that estrogen may play a role in the etiology of postpartum depression. According to Wisner and Stowe (1997) research data demonstrated that estrogen has properties similar to antidepressant medications. Estrogen causes a decrease in cortical B-adrenergic receptor density and in monoamine oxidase (MAO) (Rasmussen, 1991). Estrogen and progesterone are known to influence neurotransmitter function, including serotonin (Kumar, et al., 2003). Low brain levels of serotonin have been associated with depression (Ahokas, Kaukoranta, Wahlbeck, & Aito, 2001; Coyle, Jones, Robertson, Lendon, & Craddock, 2000) and as such may be involved in the etiology of postpartum depressive syndromes. Tryptophan, a precursor to serotonin, is suppressed by cortisol, estrogen,

and progesterone (Maes, Claes, & Schotte, 1992). Estradiol and estriol are biologically active forms of estrogen that are produced by the placenta and rise during pregnancy by 100-fold and 1000-fold respectively. The abrupt decrease in estradiol levels following delivery may theoretically contribute to postpartum depression (Bloch, et al., 2000; Sichel & Cohen, 1994; Wisner & Stowe, 1997).

*Thyroid factor.* The thyroid axis has also been another focus as the biological basis for postpartum depression (Bokhari, Bhatara, Bandettini, & McMillin, 1998; Harris et al., 1996; Joffe & Levitt, 1993; Pedersen et al, 1993). The thyroid gland produces two major hormones, tri-iodothyronine ( $T_3$ ) and tetra-iodothyronine or thyroxine ( $T_4$ ), both of which have wide-ranging stimulatory effects on metabolism in nervous and systemic tissue (George & Sandler, 1988). Diminished thyroid function may affect postpartum mood and its association with diminished central 5-hydroxytryptamine (5-HT [serotonin]) activity (Hendrick et al., 1998).

During pregnancy, as well as at other times in a person's life, thyroid disease has been known to create depression, sluggishness, and exhaustion. In some women, the thyroid is slow in returning to its pre-pregnancy state of functioning, creating the possibility for hypothyroidism. According to O'Hara and Swain, (1996) and Stowe and Nemeroff (1995), regardless of the overlap in symptoms of depression during a lifetime, there is a prevalence rate of 6% to 22% for postpartum thyroid dysfunction recorded in the literature.

As can be noted because of the dramatic biological changes that occur at delivery, postpartum mood disorders have been attributed to a biochemical or hormonal imbalance. What can also be concluded, based upon the studies reviewed, is that while the physiologic changes that occur during and after childbirth may be directly linked to the development of postpartum mood syndromes, the literature does not consistently support a hormonal etiology as the sole cause of postpartum depression (Cott & Wisner, 2003).

*The Impact of Postpartum Depression on the Family*

*The mother's experience.* "Motherhood," is a word that is implied to mean a natural, fulfilling role women assume upon the birth of their babies. It is role defined by the culture the woman lives in, and it is laden with expectations, both spoken and unspoken. As the newborn infant is fussed over by family and friends, and inspected by health care professionals, the mother's psychological and physical condition may be ignored or loosely labeled "baby blues." A generic, harmless sounding phrase, "baby blues" is portrayed in the media and parenting magazines as a possibility, which if it occurs, eventually resolves itself. Despite being common among newly delivered mothers, "baby blues" have no specific diagnostic criteria or assessment scale (Seyfried & Marcus, 2003).

*Transition to motherhood.* The new mother is predictably tired. She has carried a developing baby for nine months and proceeded through the labor and delivery stages when she begins the transition to motherhood. Although typical adjustment falls somewhere between baby blues and depression, typical does not mean easy (Beck, Records, & Rice, 2006). During this time of transition, the woman is faced with on-going stressors related to adjustment of life roles making her more vulnerable to postnatal depression (Edhborg, Seimeyr, Lundh, & Widstrom, 2000).

Clinical and research literature on the transition to motherhood supports the view of pregnancy and the postpartum period as a time when issues of both relatedness and self-definition come to the fore imposing a reassessment for the individual's identity, autonomy, and close interpersonal relationships (Barclay, Everitt, & Rogan, Schmied, & Wyllie 1997; Belsky, Rowine, & Fish, 1989; Dennis, Janssen, & Singer, 2004; Horowitz, Damato, Duffy, & Solon, 2005; Mercer, 2004; Ruble, et al., 1990; Whiffen & Gotlib, 1993).

Early detection of postpartum depression is difficult. Mothers frequently deny that they are depressed, believing that they should be happy and therefore feeling guilty if they are not (Mercer, 2004; Nicolson, 1999). The current standards for good mothering are so formidable, self-denying, elusive, and contradictory that they are unattainable. The contemporary myths heaped upon a new mother about the duties and expectations of motherhood would, if taken seriously, be hazardous to her mental health (Thurer, 1994).

*"Self" as mother.* Research notes that as women verbalize their concerns about their role as a mother recurring categories emerge. Morgan et al. (1997) noted a need for nurturance during the transition phase of motherhood. There is the sense of a loss of an autonomous or personal identity, as relatives, friends and partner identify them as "mother" (Cappuccini & Cochrane, 2000; Lewis & Nicolson, 1998). Beck, Records, and Rice (2006) stated that the basic problem women with postpartum depression have is the loss of control over their emotions, actions, and thought processes.

According to Berggren-Clive (1998), research conducted from a feminist viewpoint revealed stages for women experiencing depression after childbirth. Stage one related to identification and recognition of variables that possibly contributed to the postpartum depression. Stage two was a sense of spiraling downward, not a linear process, but a definite circular motion. Stage three consisted of healing and recovery, a process likened to a roller coaster, with days of ups and other days down.

Beck, Record, and Rice (2006) referred to a four stage process women attempt to navigate through as they walk the fine line between sanity and insanity. The four stages consist of (a) encountering terror as the symptoms hit suddenly and unexpectedly, (b) no longer knowing who they have become as they experience a dying of self as mothers, (c) struggling to survive, and (d) regaining control of their lives.

*Mother's relationship with infant.* In interviews with women experiencing postpartum depression conducted by Woollett and Parr (1997), the discussion focused on the women's feelings about and relations with their babies. These women divulged both positive and negative feelings. Interestingly some women stated they found it difficult to disclose ambivalent feelings about their babies and their relationships with them. Due in part to cultural expectations that the category of mothering and mother-baby relationship was to be "natural," these women felt a risk of being viewed as unnatural if they acknowledged negative feelings (Brown, Small, & Lumley, 1997; Heneghan, Silver, Bauman, & Stein, 2000; Josefsson, et al., 2002; Woollett & Phoenix, 1996).

The belief that her infant was temperamental or difficult has also been a factor in a woman's experience of postpartum depression (Edhborg et al., 2000). The theme of a demanding and difficult-to-satisfy infant has been reported by several researchers as a significant factor in the woman's ability to view herself as competent (Cramer, 1993; Edhborg et al., 2000; Horowitz, et al., 2001; Roberts & Kendler, 1999). The incessant tasks of childcare are exhausting to any mother who is making the transition. However, for the depressed woman, these tasks are overwhelming, reinforcing their ideas that they are indeed inept at mothering. In order not to experience these negative feelings, many mothers will begin to neglect their infant. Recent investigations with postpartum-depressed mothers (Coyl, Roggman, & Newland, 2002; Robertson, Grace, Wallington & Stewart, 2004) suggested a direct association between postpartum depression and the quality of mother-infant relationships.

Postpartum depression has an effect on the woman's adjustment to motherhood and research supports the negative impact on the mother-infant interaction (Edhborg, Seimyr, Lundh, & Sjogren, 2004; Mercer, 2004; Murray, 1992). As the mother experiences postpartum depression, the infant's environment changes on a day-to-day basis. In comparison with mothers

who are not depressed, women experiencing postpartum depression are less affectionate and less responsive to their infants (Beck, 1998; Goodman & Gotlib, 1999). Tronick and Weinberg (1997) noted in their research the infants of mothers diagnosed with postpartum depression tend to be fussier and use more negative facial expressions.

In the infant's first year of life, significant intellectual development occurs. When the mother is depressed, the infant receives less stimulation, verbally, physically, and visually (Beck, 1995b; Righetti-Veltman, Conne-Perreard, Bousquet, & Manzano, 2002; Robertson et al., 2004). Several studies show that children whose mothers experienced postpartum depression display more behavioral problems and cognitive deficits than children with non-depressed mothers during the postpartum period (Burke, 2003; Goodman & Gotlib, 1999; McLennan & Offord, 2002; Rotnem, 1989; Sinclair & Murray, 1998; Teti, & Gelfand, 2007).

*Associated emotions of postpartum depression.* Some mothers experiencing postpartum depression also express feelings of being trapped and begin to fantasize ways to leave the baby and resume their previous life. These feelings are often rooted in the unrealistic expectations about motherhood that the new mother had embraced and now finds unattainable (Burke, 2003; Byrne & Raphael, 1995; Fisher et al., 2002). Beck (2002) noted a pervasive sense of loss of one's former life associated with having a baby as a consistent theme across outcomes of qualitative studies on postpartum depression.

The feelings of women experiencing postpartum depression included anger. The emotion of anger has many faces for the woman with postpartum depression. Anger may be directed at multiple targets, including a woman's partner, family, health care professionals, and friends (Graham, et al., 2002; Wells, Hobfoll, & Lavin, 1999). The anger may also be directed at herself for having to take antidepressant medication or for being unable to meet her own rigid and perfectionist standards (Wood, Thomas, Droppleman, & Meighan, 1997). Anger is often the

result of a particular stressor and therefore understanding where the anger originates can help with appropriate interventions to reduce the aversiveness of childbirth (Graham et al., 2002).

The new mother who has symptoms of depression is often treated in ways that do not take into account the complex factors that are part of her life. "The mother is either seen as a depressed woman who also has a baby, or as a woman with a chronic depressive illness whose current episode was precipitated by giving birth" (Locicero, Weiss, & Issokson, 1997, p.171). The difference between postpartum depression and depression experienced at other times in a woman's life rests in the postpartum mother's feelings of guilt and inadequacy that are centered on being an incompetent and inadequate parent (Fowles, 1998; Tronick, & Weinberg, 1997). Left untreated, postpartum depression has devastating effects on the family unit, including higher risk of suicide and suicidal attempts by the mother. Lindahl, Pearson, and Colpe (2005) have reported that suicides account for up to 20% of maternal deaths during the postpartum period.

There has been an increasing recognition of women's views and experiences in the postpartum period. This recognition has led to the understanding of both the medical and psychological components identified by women as issues to be explored. The role of the father transitioning to parenthood has begun to receive some interest as the fathers take a more active role in labor and delivery. There is however, little exploration of men's feelings and experiences in the postpartum, and how they relate to values, relationships, and stereotypes of fatherhood (Dennis & Ross, 2006; Edley & Wetherell, 1995).

*The father's experience.* "A remarkable transformation occurs when a man becomes a father. Over the course of the pregnancy, fears, anxieties, and concerns generate new sensitivities to relationships, children and the world as a whole" (Shapiro, 1987, p.125). The transition to fatherhood is a time when many men become highly invested in the role of father and the associated role of provider (Carpenter, 2002; Farrel et al., 1993). Fathers today are expected to

take a more active role in pregnancy, childbirth, and childcare than did their predecessors (Hwang & Lamb, 1997).

Patterns of fatherhood have varied throughout history. The strict patriarchal model of the Victorian era has faded. By the end of the twentieth century, the acceptable father was viewed as being softer, one who acknowledged the need to get in touch with his feminine side (Carpenter, 2002). However, the psychological literature that examines the development of children overwhelmingly places the responsibility for child care and behavior on the mother, either excusing or ignoring the role of the father (Bianchi et al., 2000; Bradley et al., 2004).

Until recently the father's role had been largely dismissed or relegated to the delivery room. Although emotional upheaval was seen as a natural process for the mother, what occurred for the new father emotionally was not considered significant (Marsiglio, Amato, Day, & Lamb, 2000; Palkovitz, 2002; Ringler, 1996). It is now understood that fathers who choose to be in the delivery room are also trying to make sense of childbirth (Woollett & Parr, 1997). In addition to being close to and supporting the laboring partner, the father's attendance at the birth is also about being confirmed as the father of the infant (Feinberg, 2002; Palkovitz, 1987; Seal, 1994).

*Transition to fatherhood.* Initial studies indicate that men have their own set of concerns in the transition to parenting (Chalmers & Meyer, 1996). Cowan (1988) studied new fathers and determined that new fathers did not simply "add" this identity. Rather they reorganized aspects of their self in order to become a more coherent self in different roles. The unexpected disruption of this process due to postpartum depression in a spouse or partner may skew the completion of this redefining process (Bradley et al., 2004). In essence, the effect of postpartum depression in a spouse affects the identity of the partner (Boath, Pryce, Cox, 1998; Burke, 2003; Goodman, 2004a, 2004b; Matthey, Barnett, Ungerer, & Waters, 2000; Meighnan, Davis, Thomas, & Droppleman, 1999).

In an early study conducted by May (1982), the idea of being ready to father was investigated. Interviews were conducted intensively with 20 fathers and more informally with 80 more to determine if certain factors were more important than others in regard to becoming a father. Four factors were identified by these men as indicators of readiness to father: the man's desire to become a father; the stability in the couple's relationship; being relatively financially secure, and a sense of closure to the childless period of his life. The transition to fatherhood continues to encompass the four factors listed above. Fathers are increasingly active participants in family life adjusting to and managing work and family commitments (Davey, Dziurawiec, & O'Brien-Malone, 2006; Edhborg et al., 2004; Townsend, 2002).

Transitions, according to Cowan (1991), are long-term processes rather than events, encompassing the reorganization of one's inner psychological sense of self and a reorganization of one's outer roles and relationships. In order for the transition to be complete the internal and external changes must take place. In terms of first-time parenthood, for some, this process of transitioning may take several years to complete, and for others, be completed shortly after the birth (Coltrane, 1996; Knoester, & Eggebeen, 2006).

In a longitudinal study by Barclay and Lupton (1999), 15 first time fathers were interviewed on four occasions from a few days before the birth of their infants until 5-6 months after birth. Their findings included the feeling that the first few weeks and months were more uncomfortable than rewarding. It challenged the men's relationships with their partners, the meaning and place of work in their lives, as well as their sense of self as competent adults. The struggles surrounded the ability to be present to interact with their infant due to work demands, the expectations of a "bonding" experience and the fathers' overall expectation of responsiveness to them by the infant appeared to be initially unrealistic. The authors concluded fathering

required men to be simultaneously provider, guide, household help, and nurturer. Tension in these roles often challenged their relationships to their spouses or partners.

In this process of transitioning into the role of parenthood, an unexpected problem for men may occur when a partner becomes depressed after the birth. Despite all the efforts to have an uncomplicated, stress free pregnancy and delivery, his partner is not happy in her role as mother. The ability to fix the situation is clouded by his lack of understanding of the cause of his partners' depression (Benazon & Coyne, 2000; Burke, 2003). The man is now faced with his own transition issues as well as the stressors of a depressed partner.

Men have been noted to have poorer social supports and to ask for help less often than women, leaving them vulnerable to their own emotions (Bronte-Tinkew, Moore, Matthews, & Carrano, 2007; Smyth, 2003, Wilhelm, Parker, & Dewhurst, 1998). Research suggests that although both women and men can develop the standard symptoms of depression they often have different ways of coping with the symptoms (Bronte-Tinkew et al., 2007; Sagud, Hotujac, Mihaljevic-Peles, & Jakovljevic, 2002). Even if men accept that they are depressed, they tend to be less willing to seek help (Cochran & Rabinowitz, 2000).

*"Self" as Father.* Palkovitz (2002) and Townsend (2002) directed their qualitative studies towards the significance of fatherhood on men. Most current research that focuses on fathers emphasizes the effects that fathers have on their children's outcomes but not their own personal experiences (Marsiglio et al., 2000). There is reason to believe that fatherhood transforms men's lives in ways which are functional for society. Eggebeen and Knoester (2001) note that men who live with their children exhibit more intergenerational and extended family interactions, more involvement in service-oriented activities, and are more dedicated to their work than do nonfathers. It can be implied therefore that fathering behaviors may be important not only for their effects on children but also for their effects on men's lives.

In a study by Strauss and Goldberg (1999), the need to be identified as a competent provider, a supportive spouse, and an interested and active father were all viewed as necessary characteristics for successful transitioning to parenthood by men. In addition to these role characteristics is the man's concept of himself and of any noted discrepancy between the real or ideal parenting self (Eggebeen & Knoester, 2001). This discrepancy may influence the father's role experiences and overall psychological well-being (Bianchi, 2000; Gerson, 1993; Lawton & Coleman, 1983; Presser, 2003; Townsend, 2002).

In his earlier work Cowan (1988) found three aspects of new father's self-concept that changed in the direction of maturity: identity, locus of control, and self-esteem. It is important to know whether experiencing a spouse with postpartum depression changes the fathers' self-concept in any of these noted areas, as well as his interpersonal relationship with his spouse or partner. Regardless if the pregnancy was planned or unplanned, increased tensions negatively impacted the relationship as well as the father's self perception of being competent to cope (Leathers & Kelley, 2000).

Expectant fathers may have little exposure to parental role modeling as they attempt to develop their role as father. In addition, men's identification with their pregnant partners can lead to anxiety, fear, guilt, anger, rivalry, and jealousy, and sexual frustrations (Malnory, 1996; Starn 1993). Other feelings noted in research discussing men and identification with the pregnant partner included feelings of dependency and abandonment (Gelles, Lackner, & Wolfner, 1994; Zelkowitz & Milet, 1996; Zelkowitz & Milet, 2001). The stress resulting from pressure to support and assist the pregnant partner without receiving support for his own needs can create a heightened sense of inadequacy, helplessness, conflict, and anger (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006)

*Father's relationship with infant.* When the birth occurs and the relationship with the infant begins, most men struggle with feeling an essential inadequacy with the role of parent (Matthey, Barnett, & Kavanagh, 2001; Simpson, Rholes, Campbell, Tran, & Wilson, 2003; Zelkowski & Milet, 1997). For first time fathers' tasks related to childbirth and childcare are often unfamiliar. In such circumstances, the father looks to his partner for support to help him make sense of the demands of the infant (Morse, Buist, & Durkin, 2000).

Several researchers noted that fathers represent an important source for infant development (Amato, 1998; Belsky, 1998; Brennan, Hammen, Katz, & Le Brocque, 2002; Flouri & Buchanan, 2002; Lamb, 1997; Sidle-Fulingni & Brooks-Gunn, 2004; Zelkowitz, 2001). Fathers interact with their infants similarly to the mothers, but also in a unique way (Gladstone & Beardslee, 2002; Renk, et al., 2003). This is especially noted in the way fathers play with their infants. By offering a more physically arousing play time for example, the infant develops a sense of exploration and independence (Williamson & McCutcheon, 2004; Yogman, 1982).

An important factor to consider, when assessing the father's role in regard to the care of and interaction with the infant, is the influence of cultural expectations (Deater-Deckard, Pickering, Dunn, & Golding, 1998; Morse et al., 2000; Mortazavi & Karimi, 1992). Researchers agree that there are currently two patterns of fatherhood that predominate. First, there are a growing, but small, proportion of men who are significantly involved in the nurture of their children. Second, there is a dominant mode of fatherhood, which involves minimal or no care taking, with no other connection or contribution to the children (Dowd, 1997; Gerson, 1993). Regardless of cultural and societal roles, the infants remain dependent upon the parents to provide their basic needs. If the most functioning parent, due to postpartum depression, is the father who has worked all day and returned home tired and yet is expected to maintain the home and care for a depressed partner, his relation interactions with the infant may change.

*Postpartum depression and the father.* In conducting a review of the literature concerning postpartum depression it is noted that comparatively little has been written of the experiences of the father when his partner is depressed (Davey et al., 2006; Kowalski & Roberts, 2000; Mark et al., 1996; Morgan et al., 1997). This is of significant concern due to the connection made, in research, of the importance of a close supportive relationship with a partner as a buffer against depression (Alfonso, et al., 1991; Beck, 2001; Bennett & Indman, 2002; Dennis & Ross, 2006; George, 1996; Misri et al., 2000; O'Hara, Neunaber, & Zekoski, 1984; Will & Shiner, 2000). Men have described that their partners' postpartum depression left them feeling overwhelmed, isolated, stigmatized, and extremely frustrated (Davey et al., 2006).

In a qualitative study conducted by Boath, Pryce, and Cox (1998), they reported the respondents need for healthcare services to be extended to partners and family members as well as women. Recognizing that current intervention is primarily focused on the mother, the men responding requested further research for the needs of the partner of the woman diagnosed with postpartum depression. Health care workers play a critical role in promoting help-seeking behaviors or hindering treatment (Dennis, 2004; Webster, Pritchard, & Linnane, 2001). In addition some studies have indicated that health care professionals had a tendency to normalize depressive symptoms and, at times, to dismiss them altogether increasing women's feelings of inadequacy and inability to cope. (Holopainen, 2002; Mauthner, 1997; McIntosh, 1993).

In a study conducted by Lovestone and Kumar (1993), many men noted the marked contrast between the anticipation and excitement of the pregnancy and birth and the reality of coming home from work to an emotionally distraught spouse. Morgan, Matthey, Barnett, and Richardson (1997), in developing a group program for postpartum depressed women and their partners, noted that a discrepancy exists for the father who attempts to assist the depressed spouse and the perceptions of this help. The most consistent theme expressed by the men is that

of trying to help their partners only to get increasingly frustrated by the lack of appreciation verbalized by their partner for the assistance. In a longitudinal study by Lupton and Barclay (1999), those fathers who made the attempt to help in the care of their infants were met with reactions ranging from gratefulness to uncertainty to being refused the opportunity by their partners.

In a recent study conducted by Meighan, Davis, Thomas, and Doppleman (1999), eight men whose spouses had been diagnosed as having postpartum depression were interviewed. The time frame, post diagnosis, was three months to eleven years since the men's experiences with this illness. It was noted that the experience was still vivid in their memories, even after several years. This study has provided insight into the impact postpartum depression has on the spouse or partner and has opened further exploration of the man's perspective of the disorder. The men reported that their partners had changed significantly; they experienced concern for their spouses and recognized they were unable to help her in her recovery from postpartum depression. This inability to "fix it" created frustration, anger, and a sense of hopelessness. All the men in the study reported stress from increased demands and fatigue and some reported feelings of anger and resentment. This study also highlighted the continued perceived stigma of postpartum depression by the men and their reluctance to reach out for help or assistance.

*Paternal postnatal depression.* There is another factor that plays into the father's experience of postpartum depression in his spouse or partner. The father's own psychological makeup may predispose him to experience depression during the postpartum period for reasons similar to his spouse or partner (Ballard & Davies, 1996; Dudley, Ray, Kelk, & Bernard, 2001). In a study by Raskin, Richman, and Gaines (1990), 22% of first-time fathers who were assessed eight weeks postpartum reported dysphoric mood. In research by Jacob and Johnson (2001), they reported that paternal depression has been found to be correlated with functional differences in

marital interactions and the interaction with the infant. First-time fathers reporting elevated depressive symptoms increases when the marital relationship had disharmony during the pregnancy (Coyne & Benazon, 2001). These studies point out the complications which arise when the father's own predisposition to depression is a factor when addressing postpartum mental health needs of the family. The possibility of both parents experiencing depression increases the risk of infant neglect, as well as possible future cognitive impairment of the infant and merits additional research.

### *Summary*

The overall impact of postpartum depression on the mother and, increasingly, on the cognitive development of the infant has been researched in detail from many viewpoints. The father's experiences in this period of time, however, have only been given cursory recognition in the literature. The studies which have been conducted are now viewing this disorder from a relational impact perspective and not solely as a transitional or medical problem for the woman. As the definition of fatherhood continues to be altered by society, the father's voice during this period of transition will need to be understood. When the family or mother is experiencing postpartum depression, the father's voice may be the critical difference when this unexpected and sometimes deadly disorder is manifested in the home.

Despite its ubiquity historically and transculturally, postpartum depression was slow to receive recognition as a diagnosable, and thus treatable, entity. First described in the 4th-century by Hippocrates, it was not until the 19th-century that two French physicians, in separate studies, attempted a systematic formulation of this heretofore anecdotal phenomenon.

Attempts to uncover the etiology of postpartum depression include the psycho-social and the medical. The former involves acknowledgement of predisposing psychological and social contributions to depression which can be triggered or exacerbated by postpartum events,

including prenatal depression, social and/or marital dysfunction, life stresses, and negative life events. The dramatic role change from career to mothering, and the pressure to resume former responsibilities, as well as the self-perception as successful or not in maintaining control in the labor and delivery process are in view. Diagnosis is complicated by a professional and societal propensity to dismiss depressive symptoms and by failure to assess for medical disorders.

Research underscores the need to nurture mothers through the early transition phase. Loss of her autonomous identity to the mothering role is noted, with the basic problem of loss of control of emotions, actions, and thought processes tied to postpartum depression. A new mother's depression is characterized uniquely by feelings of guilt and inadequacy in the parenting role, often leading her to be treated without reference to other complex features in her life. A father's role in support and its effects on the postpartum mother has elicited some study, but not of his specific experiences and perspective.

A man's readiness to be a father, according to studies, is a process of re-defining and re-integration, which varies significantly in length and extent. Readiness to father is marked by four factors: his desire to become a father, the stability of the couple's relationship, financial security, and a sense of closure to singleness, four factors which also mark the transition to fatherhood itself.

More uncomfortable than rewarding is the feeling men expressed concerning the initial weeks and months of fatherhood, challenging their relationship to their respective partners, their work, and their sense of competence. Amidst these adjustments, a depressed spouse increased the extent and stress of men's role and frustrated efforts to make the experience successful. Men typically seek help less often and less effectively, making them more vulnerable to their own emotions. Further, men often rely on their spouses to aid in developing their own parenting skill,

opening them to the potential for conflict and resulting negative emotions, e.g. inadequacy, helplessness, and anger.

Researchers indicated a new father can be a significant buffer against depression for a mother, but that role can be eroded significantly if help is not provided when trying to cope with a depressed spouse. Health-care providers are a potential source of promoting help-seeking behaviors. Men experienced ingratitude and frustration in attempting to cope with depressed spouses and new infants. Another factor is the possible pre-disposition of a man to depression postpartum for reasons similar to that of his partner, increasing the possibility of harm to each family-unit member.

### Chapter Three: Methodology

The purpose of this research was to examine men's experiences in regard to postpartum depression in a spouse or partner. This section will provide a description of the methodology selected to answer the following research questions:

1. How do the participants describe the impact on their relationship, with their spouses or partners, when their spouses or partners are diagnosed with postpartum depression?
2. How do men describe their experiences when their spouses or partners are diagnosed with postpartum depression?
3. How do men define themselves when a spouse or partner has postpartum depression?
4. How do the men perceive the help received or offered when their spouses or partners have postpartum depression?

This chapter also includes the criteria used to select the participants for the study, as well as an overview of the diagnostic tool used in this selection process. The method by which the data was collected from the participants and the process of data analysis is presented. The location in which the research was conducted, along with the role of the researcher is included in this chapter.

Qualitative research methods were chosen as the means to explore the experiences of the men whose spouses or partners were diagnosed with postpartum depression. According to McLeod (2001), "... qualitative inquiry assumes that, at least in human affairs, reality is constructed. There are, therefore, many alternative or complimentary definitions or understandings of reality, reflecting the backgrounds and interests of those involved" (pp.6-7). The utilization of qualitative research methods allowed for the analysis of the experiences reported by men and identified the ways they construct meaning of the realities experienced and expressed when their spouses or partners were diagnosed with postpartum depression. As

Creswell (2007) noted, the qualitative process allows the researcher to be a tool of data collection that gathers information in word or picture format and then focuses analysis on the meaning attributed to the data by the participants.

Wolcott (2001) challenged qualitative researchers, however, to remember the difference in analysis and interpretation. Data analysis provides the standards for observing, measuring, and communicating the phenomenon studied, whereas interpretation provides the sense making of the data in the world of the participants and the researcher. Both are integral parts of qualitative research. Finally the researcher's ability to record and clarify the responses both verbal and nonverbal is essential in understanding the data.

The use of the qualitative paradigm afforded the men the opportunity to include their voice in this phenomenon by describing their experiences with a spouse or partner who has [or had] postpartum depression. McCracken (1988) and Merriam (1998) stated that the use of semi-structured interview questions, allows the researcher to enter the mental world and life of the individual. Moreover, interviewing provides the researcher an avenue to seek answers to the research questions while also allowing for the expansion of ideas presented.

### *Categorical Development*

The four research questions provided the initial categories to examine the men's experiences with postpartum depression in their spouses or partners. The process of analysis began with reading and re-reading the transcribed interviews, reviewing field notes, and listening to the interview tapes to note sounds and pauses. This on-going process provided an immersion into the text increasing the researcher's familiarity with the responses of the seven men selected as participants.

Categories are defined by Rossman and Rallis (2003) to be a word or phrase or sentence describing a segment of the data. Using the process of inductive analysis the researcher used the

men's descriptions to develop categories for each of the research questions. Common categories were noted and continually cross-analyzed with the responses given by the men to the interview questions. Emerging from this continuous analysis the researcher developed four themes.

A theme according to Rossman and Rallis (2003) is a phrase or sentence describing more subtle processes. Four themes, reflective of the four guiding research questions, were developed to represent the experiences of the seven men in the study. Each research question is presented individually and the categories and representative theme developed from the data analysis are presented in the accounts of the men's experiences with a spouse or partner with postpartum depression.

#### *Facility for Research*

The research was conducted at an obstetrical and gynecological practice in the central Virginia area. Founded in the mid nineteen ninety's the practice currently has both physicians and certified nurse midwives on staff as well as a licensed professional counselor who was the researcher for this study. The patient population served includes the central Virginia region. The facility was used to allow for a non-disruptive environment for the interviews to be conducted and taped. All participants were familiar with the location because their spouses were patients of the medical doctors or midwives.

#### *Participants*

The participants were recruited from the center where the researcher serves as a therapist to address the emotional needs of the obstetric and gynecological patients. Permission was granted by the physicians to conduct the research at the medical office (Appendix A), as well as to use the results of the Edinburgh Postnatal Depression Scale (EPDS) (Appendix B) given to mothers during their six week postpartum visit.

The participants were selected to participate if the following criteria were met: (a) This was the first live birth for both individuals, (b) at the postpartum checkup a significant score (12 or greater) was recorded on the EPDS or the woman had already been diagnosed with postpartum depression by a physician or other mental health personnel, and (c) the woman was living with the biological father of the baby.

A review of medical and counseling records from January 2000 through August 2004 was used to identify women who met the criteria of having experienced postpartum depression. A total of 900 deliveries were made during this time period. The office policy is to give each woman the EDPS at her six-week postpartum checkup. When a woman's score was noted to be significant, 12 or greater on the EPDS, a follow up visit with the therapist was made. The initial intervention and stabilization of the woman was the primary concern. Once the woman was stabilized for the postpartum depression, the purpose of the research was presented to her. The woman was contacted in person while at the medical office or by phone call by the researcher in the event the birth had been in a previous year.

Permission was requested of the woman identified with postpartum depression to speak with the spouse and request his participation in the research. A permission form (Appendix C) was signed by the woman granting her agreement for the researcher to contact the spouse or partner. When contact was made with the woman it was made clear to her that her spouse would be asked to voluntarily participate in the research. The spouse or partner was contacted by phone and, upon consent to participate in the study, the informed consent form (Appendix D) was mailed for signature indicating willingness to participate in the study, including permission to audiotape the interview and have the tapes transcribed. Before the interviews each participant completed a brief demographic form. This form is presented in Appendix E.

Each man, his spouse, and their infant were given a pseudonym for the researcher to use as a means to protect everyone's identity. This process was jokingly referred to as the "witness protection" component of the research by one of the participants.

### *Diagnostic Tool*

The Edinburgh Postnatal Depression Scale (EPDS) was used as a primary means of determining postpartum depression in the mother. Cox, Holdren, and Sagovsky developed the EPDS in 1987. It has been widely used throughout Europe and the United States in both research as well as clinical settings. The EPDS is a 10-item self-report questionnaire designed as a screening tool to identify traits of postpartum depression. When used as a screening tool it is recommended that an interview be used to follow-up with the new mother to verify the high scoring items (Cox & Holden, 2003). A score of 12 or 13 is considered significant indicating the presence of postpartum depression symptoms. The researcher briefly interviews anyone with this high score as part of her job responsibilities.

The EPDS has been found to have satisfactory sensitivity and specificity, both in its original validation, as well as in more recent studies involving a large community sample (Cox, Chapman, Murray, & Jones, 1996; Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Samuelsen, 2001). Condon and Corkindale (1997) raised an objection to the validity of the EPDS noting that the EPDS has two items that discern anxiety rather than depression. Although this may have some legitimate diagnostic or research implications (Brouwers, Van Baar, & Pop, 2001), for the purpose of this study it was accepted that anxiety and depression do commonly co-exist during the postnatal period and that the EPDS is essentially sound when used correctly. A copy of the EPDS is presented in Appendix C.

### *Participant Recognition*

A token of appreciation was given to each man participating in the form of a \$10.00 gift card to a local department store. Each infant represented was also given a \$50.00 savings bond. These tokens of appreciation were mailed to the participants following the transcription of the interviews.

### *Role of the Researcher*

The researcher is employed at the medical center where the participants were recruited and the interviews conducted. A current *curriculum vitae* appears after the Appendices. The researcher had many opportunities to see all of the possible study couples throughout pregnancy as the couples check in or out from the prenatal visits. When available, the researcher often discussed the emotional changes of pregnancy with the woman during her required glucose tolerance lab test which occurs at 26 weeks. This contact was usually informal, but at times it was formal.

When the contacts with the couple encouraged discussion of thoughts and feelings in regard to the pregnancy, as well as the future roles as parents, a counseling appointment was an option available to the woman and her spouse or partner. When referred by the physician, the couples could begin counseling before the birth if psycho-social stressors were already present and depression in the women was identified. This previous contact may have been advantageous as men are less likely to enter into a conversation concerning personally troubling issues in a one-time interview (Wester, Vogel, & Archer, 2004).

The previous contact, however, may present a limitation to the woman, for she may desire others in the obstetric office, including the researcher, to think she is adapting to motherhood with no issues. She may also fear her husband's participation may reveal personal issues not previously known to the researcher. The husband may hesitate to express himself

freely in order to portray a smooth personal transition to fatherhood. He may be uncomfortable in talking about himself and his struggles when the emphasis of the visits up to that time had been medical and focused on his spouse or partner.

The researcher respected the decision to participate and assured the couple that there would be no change in the care they would receive should they choose not to participate. The researcher was still available to the couple to answer questions, direct referrals, or engage in a therapeutic relationship. Those who chose to participate were at one time in a counseling relationship with the researcher for postpartum depression. Several who declined participation in the research had also been in counseling for postpartum depression but chose not to revisit that time in their lives as a couple.

### *Design*

Permission to conduct this study was granted by the Institutional Review Board at Virginia State Polytechnic and State University in Blacksburg, Virginia. A copy of the permission to conduct the research is presented in Appendix F. The informed consent includes sections detailing the purpose, procedure, risk/benefits, and confidentiality that are integral to research design. The participants were also informed of their ability to withdraw from the study at any time. Permission was requested of the postpartum women to use the results of the EPDS Scale that was given to them during the postpartum checkup. The permission form is presented in Appendix C.

### *Procedure*

After all permissions were obtained, a one-hour interview was conducted with each father to address the research questions. The use of interview questions and prompts (Appendix G) provided a framework for each interview to be as consistent as possible. The relationship of the research questions to interview prompts is presented in Appendix H. The interviews were held at

the medical center in the sound-proof conference room which is separate from all other offices in the facility. Although qualitative research is preferably done in the field, this location was chosen to allow for limited distractions so the focus could remain on speaking about the experience of postpartum depression in their spouse or partner. The men arrived at the main reception area and were escorted to the conference room by the researcher. The men had the option to exit using a private side door at the conclusion of the interview to enhance privacy if the interview was conducted during regular business hours.

The pre-interview began with some preliminary questions to create a relaxed environment for the men. I requested a pseudonym of each during this time which produced laughter and some joke about being able to tell "the whole truth." This interchange occurred before the taped portion of the interview and served to create a sense of trust with the researcher. The men filled out a demographic form before the taped interview. Every interview began with the same open-ended questions concerning the men's initial response upon being told they were going to have a baby. This question allowed the researcher to transition into the expectations of fatherhood and then the ensuing impact of the postpartum depression experience.

The interviews were audio tape-recorded and process notes were taken during the actual interview to help in understanding the father and record nonverbal responses. Throughout the interview session, notes concerning impressions and observations of the interview process were recorded in the researcher's field journal. These field notes were helpful as an additional means of discerning the meaning of the father's words in the interview when initially unclear with the transcription. According to Rossman and Rallis (2003), observation is an important supplementary technique for research utilizing the interview process.

Immediately upon completion of the interview any information from the field notes taken in the interview that needed clarification were discussed with the participant. The audio tape was

then professionally transcribed. When the researcher received the tapes and transcriptions, the researcher contacted the men by phone to allow them to review their transcripts. Three men agreed to review; the remaining four declined due to work demands and time constraints. The three men who agreed to review their transcripts were mailed copies. The researcher contacted them by phone one week later to ensure correctness of representation and to request any additions. This method of checking credibility is suggested by McLeod (2001) as one way to maintain accuracy within a qualitative research design. No corrections or additions to the transcripts were requested by the men.

Confidentiality was emphasized in all stages of the research. If at any time during the research a man expressed a need for further counseling to cope with his emotions, a referral to the local Mental Health Assessment Center was given.

#### *Data Analysis and Management*

The goal of data analysis was to provide structure and meaning to the information gathered. The main tool of inquiry was the researcher, who, according to McLeod (2001), is continually engaged in the process of finding meaning in the information gathered by the interview, field notes, and transcripts. The first phase of analyzing the data began with listening to the original audio tape of the interview, then reading the transcript of the interviews and utilizing field notes to formulate an understanding of the responses to the research questions.

Of the methods used in qualitative analysis the researcher selected open-coding as recommended by Creswell (2003) as the initial step in identifying codes of information relating to the study by segmenting the content. Using the open-coding method the phenomena under investigation were placed into categories for each meaningful segment or unit presented by the father in the interview. "Open-coding is a process of breaking down, examining, comparing, and categorizing data (Strauss & Corbin, 1990, p. 61)." Categories emerged during the analysis

expressed in the form of the language of the men interviewed. Rossman and Rallis (2003) refer to this process as category generation.

Each interviewee's transcript was printed on a distinct colored paper and several copies were made. A large wall was covered in white paper, and at the top equally spaced were the research questions. The transcripts were coded by hand per interview per research question investigated. Categories were generated on the first analysis and placed under the appropriate question. The analysis of the interviews continued with the emergence of categories from the data. A category, according to Rossman and Rallis (2003), is a word or phrase which describes a particular segment of the data which is explicit. A list of the research questions, main categories and themes developed is listed in Appendix I. The process whereby the categories were generated from the research questions and subsequent themes developed are presented in Appendix J.

Throughout this process, constant comparison was performed with other categories to enhance category refinement when appropriate. By comparing different pieces of data in other categories the researcher continued to refine and clarify the ideas being presented. This also included the identification of the conditions under which categories occurred and what followed or the consequences of their occurrence (McLeod, 2001).

The next stage in the data analysis was the emergence of themes. A theme, according to Van Manen (1990) depicts an aspect of the phenomenon studied as the lived experience. Themes are generated in several ways. The first was to explore the transcripts in their entirety and ask what the significance of the text was as a whole in understanding men's responses to a spouse or partner with postpartum depression. Secondly the transcripts were read in a manner which noted phrases or statements which were revealing about the men's experiences with postpartum

depression and finally by examining one or several sentences which revealed importance to the phenomenon of the men's experiences with a spouse or partner with postpartum depression. Thematic analysis occurs as the researcher becomes increasingly familiar with the data which has been categorized (Rossman & Rallis, 2003).

As the responses to the research questions were examined and placed into categories four themes emerged and are presented in Chapter 4. These four themes, which reflect the research questions guiding this study, represent a more tacit understanding of the phenomenon of the men's experiences of spouses or partners with postpartum depression.

#### *Limitations of the Study*

This study of the man's experience of his spouse or partner's postpartum depression had some limitations. The first limitation was with the selection of the participants. All participants in this study were recruited from one of the obstetrics and gynecologic offices available in the greater central Virginia area. This provided a group of women seeking obstetric care in this geographic area, those individuals who were classified as high risk pregnancies were not part of those served by the medical practice. Higher risk pregnancies have, by their very nature, more intensive medical intervention and may also have more psychosocial stressors, either of which may predispose a woman to postpartum depression dependent upon the pregnancy's outcome (Chaudron, et al., 2001; Warner, Appleby, & Whitton, 1996).

An additional limitation of the study was the relationship that had been already been established between the participants, their spouses, and the researcher who is employed at the obstetric and gynecological medical practice facility where the research was conducted. The researcher consults with pregnant women, and at times the spouses, during the course of the pregnancy on emotional changes the women may experience. The spouses of the seven men who participated in this study were former clients of the researcher for postpartum depression. This

previous relationship prevented three eligible participants from participating in the research. Of these three, one woman stated a concern that she would appear incompetent if her husband told their story. As stated in previous research, a woman may desire healthcare providers and others to view her as adapting successfully to her role as a mother (Heneghan et al., 2000).

The results of this research were limited to noting the common themes reported among men whose spouses or partners had been diagnosed with postpartum depression. According to the literature reviewed these themes may or may not be present in spouses whose partners were not clinically diagnosed with postpartum depression (Burke, 2003; Hendrick, Altshuler, Strouse, & Grosser, 2000). The partners may experience moodiness, anger, and anxiety and resolve these on their own without a diagnosable case of postpartum depression (Beck, 1998).

The themes identified by these men whose spouses or partners had been diagnosed with postpartum depression may or may not be reported by other men whose spouses or partners do not experience a diagnosable case of postpartum depression. Research has indicated that the postpartum experience is unique for every woman and subsequently every man; and although psycho-social stressors increase the risk of developing postpartum depression, this does not mean the event will occur (Barclay, Donovan, & Genovese 1996; Diemer, 1997; Woolett & Parr, 1997). Individuals who have a high score on the EDPS do not necessarily go on to develop a diagnosable case of postpartum depression. They may have the symptoms but are able to process the stressors and prevent the progression of the illness.

The mental health status of the men in this study before the birth of their children is an undetermined factor. Men encounter depression in their lifespan but seek help less often than women (Brooks, & Gilbert 1995; Good, Dell, & Mintz 1989). This researcher did not take this factor into consideration but focused on the man's response to the woman's depression. If in the

course of the interview, the man revealed his own depression the researcher gave the man the phone number of the local Mental Health Assessment Center.

A final limitation was the inability to develop a more cross cultural representation. All men responding were Caucasian. Although attempts were made to have a diverse selection there was no positive response from participants who were of other ethnicities.

### *Summary*

The purpose of this research is to investigate the experiences of the father or a spouse or partner with postpartum depression, specifically:

1. How do the participants describe the impact on the relationship with their spouses or partners when the spouse or partner is diagnosed with postpartum depression?
2. How do men describe their experiences when their spouses or partners are diagnosed with postpartum depression?
3. How do men define themselves when a spouse or partner has postpartum depression?
4. How do the men perceive the help received or offered when their spouses or partners have postpartum depression?

Qualitative methods were used, in order to effectively organize the reporting of the men's experiences involving a spouse with postpartum depression, both for analysis, providing standards for observing, measuring, and communicating, and for interpretation, making sense of the data. The format of semi-structured interview questions established the material for participant observation by the researcher, providing answers to the research questions, as well as expansion of the ideas presented in the interviews.

The responses, of the men, to the research questions were coded and the interview data developed and refined into categories. The categories developed from the men's responses to each research question were compared within each question and between each question.

Categories were refined using transcribed interviews, field notes and interview tapes, ultimately being synthesized into four themes expressing the experiences of the men in this study.

Research was conducted at an obstetric and gynecological office in central Virginia by the researcher, a licensed professional counselor on staff. Research participants were recruited from patients and clients of the practice and met three criteria: (a) Couples having the first live birth for both individuals, (b) the presence of postpartum depression as per an EDPS score or medical diagnosis, and (c) mother and father of the infant were living together. Care was taken not to intrude request for participation in the study into professional care provided. Permission forms and a brief demographic form were completed.

The Edinburgh Postnatal Depression Scale (EDPS) was the primary diagnostic tool, and possible objections to its efficacy were addressed satisfactorily, as were limitations vis-à-vis the counselor/client relationship, including previous contact between researcher and potential participants.

Permission for the study was given by the Institutional Review Board at Virginia Polytechnic Institute and State University, conditioned upon an informed consent form to be developed and signed by the participant. Having signed, each father took part in a one-hour interview in a controlled setting, with attention given to making each interview as confidential and consistent as possible. After preliminary trust-building conversation, the same open-ended question began each interview, which was tape-recorded, and during which field notes were taken by the researcher. These important notes were then reviewed and clarified with the participant, as were the transcribed tapes in order to insure accuracy and comprehensiveness.

The researcher then analyzed the data, first carefully reviewing each of the three data sources: tape, transcript, and field notes. Using open coding, category generation was undertaken, constantly refining and tightening ideas. Next, themes emerged and were analyzed

as a function of the researcher's increased familiarity with categorical data. Limitations of the study included homogeneity of selection racially, culturally, and geographically, previous relationship of potential participants with researcher, and the pre-natal mental health of the men being undetermined.

## Chapter Four: Findings

The purpose of this study was to examine men's experiences in regard to postpartum depression in a spouse or partner. Seven men were interviewed for one hour to investigate their experiences with a spouse or partner diagnosed with postpartum depression. The four research questions posed in chapter one provided a framework, as the initial categories, which guided the direction of the interviews with the intent being the freedom, for the men, to discuss their experiences with postpartum depression. Upon extensive analysis and immersion in the data, the process of which is described in chapter three, categories were formulated and themes emerged.

Two questions were asked of each man as a way to begin the interview process. The initial question addressed the reaction upon knowing their spouse or partner was pregnant. The second question regarded the impact of postpartum depression on their relationship before the diagnosis. Following these two introductory questions, the men's responses to the research questions will be presented.

This chapter details the stories of the men's experiences when their spouses or partners were diagnosed with postpartum depression. The men's responses to the four research questions guiding this investigation were coded and analyzed to denote four corresponding main categories and thirteen sub-categories, from which four summarizing themes emerged (see Appendix I). This chapter begins by introducing the participants to the readers, prior to the men telling their stories.

### *Introducing the Participants*

This section presents the biographies of the seven men who participated in this research, GT, Neil, Ed, Tom, Wayne, Richard, and Allen (all pseudonyms). Their stories will be explored in this research to describe the lived experience of a spouse or partner with postpartum depression. A summary table of the seven men is presented in Table 1 following the narrative

biographies. This table provides a synopsis of the ages, education levels and occupations of the men for a clearer understanding of the background of the participants.

Allen is a Caucasian male who was 35 at the time of his son's birth. Allen has a Bachelor of Science degree in Business. He is part owner in a family operated international corporation.

Ed is a Caucasian male who was 26 years old at the time of his daughter's birth. He is a high school graduate and also has obtained a certificate in engineering graphics from a local community college. He currently works for a machine shop and delivers newspapers to a large geographical area. He and his wife had experienced a miscarriage before this birth. He stated that he was unsure of his ability to remember the details of his experience with his wife's postpartum depression because he was so tired that everything was a blur.

GT is a Caucasian male who was 36 at the time of his son's birth. He is a high school graduate and completed a tour of duty in the United States Navy. He is currently employed as an electrician. He and his wife delayed trying to conceive due to their ages and concerns for genetic issues in regard to his wife. They were both excited but apprehensive when she became pregnant. Unknown to the researcher, GT had a previous child while he served in the military and was deployed at the time of the birth and subsequent year of his baby's life. He divorced following completion of his tour of duty for reasons, of which, he chose not to elaborate with the researcher. The decision was made by the researcher to include his experiences with postpartum depression as a valid experience as he was not present for the majority of the pregnancy, birth, and first year of his first son's life. This time period has the greatest potential in which psychological changes can become apparent in the pregnant and delivered woman.

Neil is a Caucasian male who was 32 at the time of his daughter's birth. He is a high school graduate and has completed two years of college. He is currently employed as a mail

carrier. He and his wife had tried for a few years to conceive and were preparing to begin infertility analysis when his wife became pregnant.

Richard is a Caucasian male who was 27 years old at the time of his daughter's birth. He has a Master's degree and is employed as a manager of marketing. His wife was not diagnosed until they transferred their care following the sudden closing of her Ob/Gyn's office.

Tom is a Caucasian male who was 28 at the time of his daughter's birth. He has a Bachelor of Science degree and is an environmental engineer at a local firm. His wife is expecting their second child which has him greatly concerned due to her past experience with postpartum depression and anxiety. He has already planned to take a three-month paternity leave following the birth.

Wayne is a Caucasian male who was 30 years old at the time of his daughter's birth. He has a high school diploma and is employed as an insurance agent. He and his wife had experienced a miscarriage before this birth. His wife also had other medical conditions which caused concern early in pregnancy.

Table 1

*Demographic Summary of Participants*

Name	Age	Education	Occupation
Allen	35	Bachelor of Science	Co-owner business
Ed	26	Community College	Machine shop
GT	36	High School	Electrician
Neil	32	2 years college	Mail carrier
Richard	27	Master of Science	Marketing manager
Tom	28	Bachelor of Science	Engineer
Wayne	30	High School	Insurance agent

*Introductory Questions*

Acknowledging that this may have been the first time the men spoke to someone about their experiences, the researcher chose to ask two introductory questions to help the men relax and become comfortable speaking on the topic. The two questions asked regarded: (a) the men's thoughts on their spouses or partners becoming pregnant and (b) the men's experiences with their spouses or partners before the postpartum depression was diagnosed. These helped transition the men's thinking toward the topic of postpartum depression. The latter question provided segue to the research questions asked of each participant. The responses to these two questions will be presented before the discussion of the interviews on the four research questions posed in this study.

*On becoming a father.* Each man interviewed was asked to describe the initial response or reaction to being told he would be a father. This transition question was originally designed to break the ice to help the men feel more comfortable speaking about themselves, their relationship with their spouse or partner, and the overall view of pregnancy.

For the men in this study being told they would be a father brought excitement and apprehension. The excitement of what the future would be like as a father and how the child would develop was coupled with the knowledge of the challenges and responsibilities in this new role. The men looked forward to the time when they would be a father.

Apprehension was also reported by some of the men due to previous medical problems and miscarriages. This understanding of the fragility of life made the news of becoming a father mixed with concern for spousal and infant well-being. The following responses address this excitement and apprehension for some of the men.

*Neil.* “Ah, well, we had been trying for a long time, so obviously I felt real happy that I was gonna, she, um-well. . . . I was just real happy and kind of relieved that we were about to go to fertilization process and things like that.”

*Wayne.* “Well, there was [*sic*] two things that, ah, went to my mind. I was very happy, ah, first of all, and secondly, um, kind of worried at the same time because we had, ah, lost a child, ah, while she was still in the womb or he was still in the womb, ah, about a year before. So obviously, um, I had a lot of, ah, feelings of okay, “what’s gonna happen with this one?” Ah, and, um, probably the other--the being happy—I, ah, we wanted a child for over a year now, so you know, we were kind of ecstatic as far as that was concerned.”

The men all expressed a desire to have their partner become pregnant and no indication was expressed during either the pre-interview or the taped portion of the interview that the event

was unplanned or unwanted. Both Richard and Tom shared their reactions about the timing of the news they would be a father.

*Richard.* "... um, it was expected, we had been, um, trying for probably, to get pregnant, for probably about, um, maybe five, six months or so, ah, so it had been planned. Um, of course the timing of when we actually found out was, um, not planned, but that was good too."

*Tom.* "Well, it was pretty exciting, um, especially since that day there had been a series of layoffs at the plant where we were both employed as engineers and we both still had jobs."

Finally, the men all expressed a desire to be a good father. Although references were made to their fathers, both positive and negative, it was their own personal search for the best choices as a parent which was a concern. Tom's initial response to parenting was a mix of laughter and seriousness.

*Tom.* "... what went briefly, [my] mind was raising a hellion. Being a, being a good dad was the main thing. And the one--once the--making sure that the kid is healthy when born, and then after that, it's really just making sure that I was able to be a good parent."

For Ed, the struggle to be a good parent began with the recognition that he does not have a good role model to follow. It is a constant concern for him, and he utilizes his faith as a guide.

*Ed.* "I guess it was a gradual thing for me to realize that 'wow, this is it, I'm a dad.' You know it's sort of a mindset. . . . I would have to say [with the] help of God I was able to--or I'm trying to understand what I need to be, um, what I need to be as far as that that role to be a dad and father."

The purpose of the question on becoming a father was to direct the men's focus back to the time period before the birth and the feelings of anticipation for the event. The uncertainty of what was going on with their spouse or partner was explored in the second question asked of the men.

*Men's Pre-Diagnosis Experiences.* The second question asked of the men was on their lived experiences with their spouses or partners before the diagnosis of postpartum depression was determined. This question focused the men's attention on the phenomenon of postpartum depression. The question provided a foundation to the four research questions and allowed the researcher to enter into the pre-diagnosis world of the men through their descriptions of the events leading up to the formal diagnosis of postpartum depression.

In the days or weeks leading up to an actual diagnosis the men reported a wide range of emotions in regard to their partners' or spouses' behavior. The uncertainty of their roles and responsibilities during this postnatal time frame created an internal re-evaluation of self. As time went on and the partner became more emotionally labile and unavailable to him or the infant, the father became the primary decision maker in regard to infant care issues. This was not a role necessarily embraced with ease by some of the men. The division of roles had been set before the birth in the traditional pattern of the man working and the wife staying at home with the infant, at least for a period of time. For others, this additional role responsibility became a necessity to regain equilibrium of some type in the home environment.

Neil discussed his initial thoughts following the birth and bringing home his daughter as a time when he thought life would go according to plan. He would return to work, his wife would care for the baby, and eventually she would return to work. The transition to parenthood would be relatively easy. He thought his own reaction to his wife's demands as initially justified.

*Neil.* " I was planning to take one week off of work and she asked me to take one more week then another...I sat out of work for three or four weeks. I didn't want to take off work at all. But, um, when I went back, it was frustrating because I was working between 55 and 60 hours a week, and in my mind, you know, I was doing that and she was home all day, and then I would get home, and it was immediately, you know, clean up the house and all this stuff. And I knew

she was watching the baby, and it was like, you know, why can't you do some of this, you know."

The turning point for Neil occurred after a statement his wife made which shocked him into thinking something is wrong. He realized that life was not going to go as planned and that his spouse was not adjusting to motherhood as he had initially believed she would.

*Neil.* "She mentioned I can't take it anymore, I'm gonna just ... I think she was half kidding, but I'm gonna jump off a building or some such. I was worried when she said those things, but I didn't think she'd actually do it, but I just remember I was stunned 'cause usually she'd say something like that and then just kind of storm out of the room. Like I said, I didn't really--it wasn't like a threat or a--I don't remember. . . . I guess I was just so stunned I would sit there for a minute. I guess it kind of, yeah, it kinda paralyzed me, I guess. I didn't know what to do, so I didn't do anything. I didn't want to do the wrong thing. It made me feel powerless at that point."

Tom was aware something was wrong upon bringing his wife and daughter home from the hospital and initially attributed her response to be similar to his, but quickly realized this was not the same reaction to becoming a parent as he had.

*Tom.* "As soon as we got home, I went crazy and started doing all this stuff and gave myself a migraine, and so that kind of set me into settling down. Um, so part of me--when when she was going, I was thinking, you know, she's gonna get this and it's it's just the same thing that I went, and she'll start eating and you know. . . . I lost my appetite for a day or so, so I figured the same thing would happen to her, she--she'd come to the realization that she needed sleep. . . . And the other part of me was scared that she couldn't handle it. Um, I didn't know if she--if I was scared for me or scared for her. Maybe both of us. She never slept. She, um, was continuously, um, crying, um, and worried about, you know, what was gonna happen to her and what was gonna

happen to the baby and if she would be a good parent and if she could--was worthy of taking care of the kid.”

Tom took his wife back to the hospital when her ability to function a couple of days later became severely compromised. The incident which led to the hospitalization scared Tom and he began to accept the fact that his spouse was not going to snap out of it and take on her role as mother.

*Tom.* “It was a continuous “I can’t do this, I can’t do this,” and it was, I guess, just a, ah, climax of, of what she thought she couldn’t do and how she didn’t think she could be a parent--Ah, she, ah, picked up a knife, and, ah, put it to her wrist, didn’t make any cuts or anything, and it was a pretty sharp knife, so. . . . Then at that point, I called her OB-GYN, and they said to take her to the emergency room. I was scared for myself that she couldn’t do it, that I was gonna be taking care of the baby, and so, you know, a little selfishness there and, um, nervous that I guess, yeah, that she wasn’t with us because, you know, she was in the hospital, so it was, ah it was scary--she just couldn’t figure out what to do, and I couldn’t help her figure out what to do.”

Ed struggled to remember his experience during the postpartum period. He remained detached from the interview process and only answered minimally to the prompts and questions posed for further exploration. His uncertainty may have come from the lack of recall of the event or the way he processes information. When asked about the incident of postpartum depression in his wife and how it impacted their relationship he was hesitant in his response.

*Ed.* “Um, I guess I wasn’t, um--maybe didn’t know for sure if--if it was--if she was depressed. I just knew what symptoms she was having. Ah, and just, ah. . . .these symptoms were apparently the, the postpartum depression, and I, I maybe was not, um, thinking of it as in a serious matter. It kind of like, ah, I guess progressively became real. I realized, realized it as time went on. Um, I, I can’t remember precisely, but um, from what I recall. . . . Well--or what makes sense or what

I think may have happened is that if she was going (*pause*) if she was going that then I would not have, um--hopefully I wouldn't have tried to press her too much to, um--like various (*pause*) if there's any issues that I'm not going to not necessarily bring those things up as she was trying to get along herself. So I think that there was probably a redemption in, in our conversation or, ah, sharing heart to heart."

After the taped portion of the interview was over, Ed visibly relaxed. I asked him about the communication piece and he clarified that he tried to minimize any thing which would upset her because she was having her own person struggles, but realized later it was helpful not hurtful to communicate about what she was dealing with (the postpartum depression). He admitted to being nervous (he would give the wrong answer on the tape) and felt self-conscious of the process but wanted to participate in the research. He smiled amicably at the researcher and stated he did not need a mental health referral.

Richard's daughter was born the day after Christmas. Christmas day had been spent with both families, and his wife's family was staying with them when the decision to go to the hospital was made. Richard reported that became a good idea to go on to the hospital after his mother-in-law said it was time. He stated this didn't bother him but found it amusing. When he returned home with his wife and newborn, the in-laws remained for a while. After they left, however, life began to change and he believes it was the beginning of the postpartum depression.

For Richard the change in his wife's usual out-going personality was a troubling sign. Her resistance to others coming over, especially his parents, and her inability to leave the baby with the grandparents increased his anger and frustration at the situation.

*Richard.* "I'd be put in the position of juggling time for my parents and grandparents to see the baby and her mood before, during, and after the visit, if it occurred. I had to be in control and monitor the situation. It was adult relationships that seemed to be the problem. She would get,

um, and it didn't have to be a direct comment, it could be just an observation about, you know, for instance when I was young and, you know, a goofy thing I did, ah, that would kind of set her off into that pattern of later telling me, well, you know, "Why did she do that? Why did she say that?" . . . I don't know, you know, ah, "My mom wouldn't have done that, and I don't want somebody telling me how to, how to do this and that." I became the peacekeeper. A role she would have naturally played. I am, by nature, more confrontational or direct."

For Wayne the issue which made him realize something was not right was a change in his wife's personality.

*Wayne.* "I think the thing that really put me over the edge as far as maybe she . . . she. . . . There's something more seriously wrong is, um, she's very on edge, um, a, a lot more frequently than normal. And she typically, um, is the kind of person when you're having a conversation, she finds a more subtle way of putting things when you have a conversation, but in this instance it wasn't very subtle. She was pretty direct and pretty, you know, this is how--kinda how I feel kind of thing, right there putting emotions on the shoulders, you know, sleeve, you know, that kind of thing, and wearing them on your sleeve."

GT and his wife experienced some medical complications before the birth. An emergency cesarean section was performed, and GT states from that moment on his wife's mood was "not right." His wife had had some mood swings during the pregnancy, but GT was convinced following the birth they would dissipate since they had waited a long time to have their baby. He shakes his head in disbelief as he recounts the events which began a downward spiral of depression for his wife.

*GT.* "The day the baby was born, after they had cleaned him up and everything, I went and got him, and she was in the room and when I brought him to her, she wouldn't hold him, and—I, you know, I was trying to hold him up, and she wouldn't even look at him. And I said well, let me

just lay him beside you, and she didn't want him lying beside her. And I thought--I said to myself, "Something's wrong here," you know? I mean I was excited and she wouldn't even look at him. And this went on for a week, and this went on pretty much the whole time we were there. I had to do everything for him. She wouldn't have anything to do with him."

What scared GT was the nurse at discharge when his wife went into the bathroom: "When my wife went into the bathroom, the nurse pulled me to the side, and she said, 'You need to watch her. So that scared me a little bit. But still I didn't know anything, you know, any specifics about what was going on. I just knew something was not right.'"

So for GT, coming home was full of fear and uncertainty of how this situation would resolve. He recognized that he would be responsible full time for the care of the infant. He also noted that the change in his wife's personality was disconcerting.

*GT.* "My wife's a very, ah, happy, loving person. I mean everybody's always talking about how she's always got a smile on her face, and during that period she was, like I said, almost angry or not. I mean she didn't lash out or anything, but when people would come over, you know, my family or her family, and, ah, try to do something for the baby or whatever, it was like she, she got upset about it. She didn't -- She didn't want them having to do the stuff for the baby, but she didn't want to do it either. And everybody was talking about how much the baby was attached to me. And that's, I guess, it's because I was with, you know, I did everything. And she didn't like that at all."

All the men in the study had experienced, as previously discussed, a change in the relationship with their spouses before the formal diagnosis had been made. The men's comments concerning change of personality was the hallmark sign that all was not as it should be with their spouse or partner. It was not until the formal diagnosis was made that the men understood that their spouse's or partner's personality changes were a direct result of the postpartum depression.

*Research Question One: Describing the Impact of Postpartum Depression on the Relationship*

The first research question explored was: How do men describe the impact on the relationship when their spouse or partner is diagnosed with postpartum depression? The expectations of how it would be as first time parents were changed by the impact of postpartum depression. The men experienced a range of emotional responses. The transcripts of the men's interviews were coded and the following categories were generated: anger, helplessness, frustration, and loss. These four categories will be represented by the men's stories as relayed in the interviews.

*The category of anger.* Anger, was manifested towards the illness, towards the added responsibilities, anger was directed at the spouse's inability to function, and anger was focused at self for not knowing what he was dealing with in regard to the illness. The category of anger permeated all the responses to each of the research questions. Anger in the context of the first research question implies a state of being resentful to the seemingly unjust circumstances which the men encountered in dealing with the impact of postpartum depression on their relationships.

Anger existed pre-diagnosis and once the postpartum depression was identified, it was perceived by the men as the cause of all the issues being experienced by his spouse and himself. Once "it" had a recognizable name the men expressed anger at the illness and its ability to overshadow the joy of the birth of their baby. Integrated with this anger was the acknowledgement that they had not known or somehow had not been prepared for the reality of postpartum depression.

The expression of anger began initially towards the spouse and her inability to adapt to motherhood. Not understanding the reasons for her reluctance the spouse would attempt to

interact but when rejected would pull back and view all the expectations on himself as unreasonable.

Anger impacted the relationship with their spouses as attempts made to be supportive were rejected. The men in this study reported anger at their spouses becoming someone with whom they could not relate. Instead of a team approach to parenting the men realized they would need to do it all for a while and possibly indefinitely. The following statements expressed reveal the category of anger.

*GT.* “. . . before it all happened I really didn't have a clue what was going on. I thought she was mad at me, and I, I was getting ang--[sic] (pause) you know, mad because I felt like I was having to carry the burden for everybody.”

*Tom.* “Anger was in there. I mean I was (pause) I was probably pretty pissed about the fact that she couldn't handle it. You know, in the beginning when she was saying I can't do this; I can't do this; I can't do this--that was probably when I was the angriest, um, in that, you know, I (pause), I know her, and I know she can, and the fact that she wouldn't or couldn't listen to me, you know.

*Wayne.* “I would get it in my head sometimes where I was just—‘deal with it lady.’ You know you kinda get that feeling.”

*The category of helplessness.* Helplessness experienced by the men in their relationship took the form of being rejected by their spouse when trying to be helpful. There was overall uncertainty of what, if anything, to do to try and make the situation better for their spouses. Feeling helpless the men were hesitant to interact with their spouses. The hope of re-engaging into a familiar relationship style previously experienced seemed impossible. For one of the men, part of the feeling of helplessness was derived not only from the change in everyday activities but his perception of the infant creating this feeling of being helpless.

*Allen.* "Before the baby was born, we still had to, I was still on the road, but she was doing her thing, and we kinda got back together, and now it's totally different, you know. Um, because now we have this--this new person that, ah, he's controlling us."

Regardless of the attempts to encourage their wives, some of the men readily acknowledged their own sense of helplessness when this would fail to bring about the desired response from their spouse or partner.

*Wayne.* "It was sometimes very difficult. Um, sometimes I just wanted to get out of the situation. Um, I'm dealing with a crying baby and a person who can't relate to their baby."

*GT.* "It was like everything I said or did upset her."

*Neil.* "Well--why isn't this going better? . . . It might get worse--I thought, you know, maybe it would take her a long time to get out of it. . . ."

*The category of frustration.* Interrelated to the category of helplessness is the category of frustration. It appears to be an outcome of feeling helpless and the inability to fix the situation to bring relief to the spouse or partner, as well as the interactions with the baby. A varying level of frustration was reported in the men that this was a situation which may not end as quickly or smoothly as they initially believed. The frustration was directed at the postpartum depression and the impact it had on their relationships.

The adaptation to parenting was not proceeding as the men had anticipated. As time went on the ideal previously held and anticipated became more and more an illusion as the reality of postpartum depression impacted their relationship with their spouse or partner.

*Wayne.* "I did have some problems with it, um, in fact that, um, occasionally I'd forget, you know, ah cognitively this is not who Barbara is, and I would say, 'Why are you acting this way? Why are you feeling this way?' It's not the way, you know, um, you should be feeling."

For Allen when his wife's crying was brought to his attention by church friends, he noted that he realized that at some level her crying was more complicated than he initially perceived it to be.

*Allen.* "...in the first part, she did do a lot of crying. She was crying, and I just associated that with, I'd be crying too. I mean all these things that are going on, you know. But, but I think it was, um, I think it was a lot more deeper than just, I, you know, I have this, this problem here that I'm having difficult--it was a lot deeper, and I was just looking, I guess, basically, on the surface issues. I guess I had to realize that what your expectations are and what actually happens, um, can sometimes be at the opposite end of the spectrum."

Despite the understanding of medical issues Neil still noted a sense of frustration at the additional tasks expected of him after working all day.

*Neil.* "And I didn't mind doing some things around the house, obviously, but, ah, especially cause she was having--had a c-section, you know, so she couldn't do that much physically, but, ah, I guess for some reason I was just frustrated by that."

*The category of loss.* The category of loss referred to feelings of separation or distance from their spouses or partners. Loss encompassed time, communication, and connection with other people. It also referred to other losses experienced or perceived to be experienced by the spouse or partner. Loss for the men in this study involved not being connected to their spouse or partner on a deep emotional level, not having the freedom to communicate needs and wants and to be able to share in the joys and trials of early parenthood. It entailed losing the ability to socialize as a couple with family and friends.

Richard recounted feeling the loss of time with his wife. He felt unable to suggest they leave the baby with his grandparents for an overnight trip or any time away. He reported feeling

envious of friends who were also having their first babies at the same time and doing couple things without the baby on a regular basis.

*Richard.* “. . .they'd tell us, oh, last night we went out and they did this, or they had an overnight trip without their child, you know, one of the grandparents watched them or something like that. And I thought, well that must be nice to, or interesting to do. I would say we were socially lost. We did not, outside the three of us--we did not do the things with other people. Samantha and I never did anything, um, by ourselves.”

*Wayne.* “ I think the thing that I, I felt lost about was, ah, the loss for her experience of being a new mother...She wasn't able to enjoy it, and I knew that loss was there for her. Um, the loss for me personally probably would be, um, I didn't, I wasn't able to communicate with the Barbara I normally communicate with. I also felt a loss of freedom with the increased of responsibility to care for my daughter.”

*Neil.* “A lot--A lot of the not fighting but bickering. That kind of thing because our expectations of each other were so different. We never really shout at each other or anything like that. But it was a lot of bickering and things like that.”

*GT.* “The way I was thinking, you know, this is the way its gonna be. She can't handle this. I'm gonna have to do it all, which, you know, I love my son and, and I didn't mind doing it, but I needed some help from her, not from everybody else.”

#### *Research Question Two: Describing the Experience of Postpartum Depression*

The second research question asked was: How do the participants describe their experiences when their spouse or partner is diagnosed with postpartum depression? This question allowed the men to share their stories of postpartum depression in a broader context. The experiences ranged from reactions to the threats of a spouse harming herself, the feelings of

rejection with her refusal to participate in mothering, and addressing things which were happening outside their control or understanding.

The transcripts of the men's interviews were coded and the following categories generated: fear, overwhelmed, and control. Each of these categories will be addressed using the men's stories of their experiences with a spouse or partner with postpartum depression.

*The category of fear.* The category of fear presented as the participants' feelings in relation to their partner and to the unknown and unfamiliar dynamics they found themselves dealing with on a day-to-day basis following the birth of their babies. The experience of fear for the men in this study centered on the physical well-being of their babies and spouses when the time came for them to return to work. The strain on the relationship due to the unpredictability of their spouses' moods created a precarious situation. Leaving for work meant temporary relief from the demands of infant and spousal care, however in leaving he recognized he had no way of knowing what was happening at home. Fear became a constant mental companion at work. The men in the study all described feelings of concern for safety of both spouse and baby.

In sharing his experience Tom's honesty about his wife's struggle reveals the underlying fear of safety for her and his daughter after her hospitalization had provided them little help. The hospital was not familiar with postpartum depression and, for the most part, his wife was in group therapy with individuals with depression, alcohol and drug issues, and suicidal ideation. *Tom.* "Um, I was scared about her coming back because she was gonna be at home while I went back to work. So that did scare me. I was nervous about how she was doing and how she was gonna handle being alone. . . . It was nerve-racking, you know, it wasn't comfortable."

For the other men the fear of returning to work was also present. The idea that their spouses or partners may harm themselves or the babies played in the back of their minds during the work day and checking in at home throughout the day was used at times to keep in contact.

*GT.* “Well it caused me to be concerned about the safety of the baby and her safety because she had even said something about, you know, she just felt like killing herself, and, ah, so I, I was, you know, ... the whole time I would be at work, I’m thinking about what’s going on at home.”

*Wayne.* “I (pause) I was a little concerned when I went back to work. Um, even though I knew she told me at times that, you know, I feel like hurting my baby, but I know I won’t. Well obviously, hearing that, that puts thoughts into my mind. So, you know, and I’ve heard the horror stories about postpartum depression, so yeah I was kinda worried, but I also knew God was in control. . . . We didn’t have a whole lot of contact during the day. Um, there was this, this thought of what’s gonna be behind the door after I open it up.”

*The category of being overwhelmed.* This category implied for the men a cumulative effect of the impact postpartum depression had on them and their spouses or partners. As the frustration mounted each man dealt with the issues differently, but with the understanding that they were indeed overwhelmed by the events.

The seemingly endless stream of events, unmet needs and continual demands became overwhelming. The men tried to break the events into segments hoping to manage their own emotions while successfully understanding those of their spouses.

*Allen.* “Goin’ that, you know, not sleeping and, and then, ah, in the afternoons he was really colicky and, and, and I would get home and when I would get home, you know, that both had their hair standin’ on top of their head. So I kinda opened up the door and went—what’s going on, you know, my, what have I walked into? And it was, it was like, wow, um, ah, I can’t believe this is happening.”

*Wayne.* “I didn’t know how to handle the whole entire thing. I (pause) I could handle bits and pieces of it as it came to me, but as a whole there was like--sometimes it was like it seemed like it was very overwhelming.”

Feeling overwhelmed was often accompanied with an understanding that things had to get done regardless of their personal needs. Most of the men reported giving up activities which normally would have been their means to handle stressful situations. The acceptance of help from others was generally seen as a relief, though not always for the spouse.

*GT.* "But it got to where I was doing everything for her and for him and, you know, trying to work, too--that those long hours, and the job I had was a fairly dangerous job, and it, it pretty much got overwhelming for me. And, ah, so when people came to help out, I didn't really mind, but it was . . . it bothered her that those people were there."

*Richard.* "I didn't think much about my needs or desires; I was more tryin' to keep the peace and make sure--I was acting very concerned. I wanted to make sure my household ran well and every, everybody, I was much more concerned that Samantha was happy and okay, 'cause she was, of course, at home with the baby all day...was there by herself."

*The category of control.* The experience of having a spouse or partner with postpartum depression revealed a sense of needing to either be in control or in some cases using a spiritual belief to relinquish control. Decisions were made to regain a sense of normalcy, and in most cases, to attempt to fix or eliminate the problem.

Up until this life experience the men reported being in control of their lives. Making plans, reaching goals, having freedom to enjoy activities with and without their spouse or partner made life good. Life was manageable. As the men recognized control of the events of early parenting were slipping further and further out of their control the impact of postpartum depression became painfully real. At one time, seen as a natural and expected choice, breastfeeding began to add pressure to the new mother. In an effort to remove extra expectations on their spouse or partner, five of the men decided for the mothers that they would not continue to breastfeed.

After his wife's unexpected hospitalization, Tom felt he had no choice but to bottle feed his daughter.

*Tom.* "Um, well, I (pause) I cried for about three hours as soon as I got back from dropping her off, and, um, she had taken care of where all this stuff was, so I didn't know where the formula and the bottles and all that stuff was. Um, so I had to go and buy formula with a five-day-old baby. We were trying to breastfeed of course. It's hard, so I'm sure that didn't aid in the situation, um, but once I started formula, I just told her that you weren't--she wasn't going to start breastfeeding again; we need to figure a way to work this out."

For Allen it was the realization that this issue was fixable and he was not going to wait any longer to try to and resolve the tension it was creating in his distraught wife and child.

*Allen.* "When I came back [from being on the business trip], when I came back, this, this was a real issue. Um, the baby was, was um, seemed like it was crying a lot, ah having problems, ah, feeding. And um, it seemed like, the nurses at the hospital and that, ah, at the classes, almost made you feel guilty if you didn't do that [breastfeed]. And it just wasn't working out too well. We tried, and I think the baby wasn't getting enough nourishment. So I said, "Forget it, we're not gonna do this; let's go to the store, and we're gonna get some milk."

Richard took control of his wife's inability to respond fairly to his parents' and grandparents' or friends' requests to visit. It was not a role he felt comfortable in doing almost feeling deceitful to avoid the real reason for their seclusion.

*Richard.* "It started a pattern of, you know, when, when people would call—"When can we come over?" Well, you know, I'd be put in a position, in a position of, well what do I do? And how do I control things? And I felt like I had to schedule things to not offend people or upset Samantha."

When all the demands became overwhelming there was only one response for Wayne. He noted that when his wife would make some reference to hurting herself or thoughts of hurting their baby, he had to relinquish control over their safety to God when he returned to work. *Wayne*. "I was kinda worried, but I also knew, that, ah, that God was in control. I, I'm a firm believer in God and his sovereignty, and so, I really kind of just left that to God. So I think in this whole process I was able to do a lot of that. Um, I would kinda get a feeling then I would just let it go off my back and just give it to God and just say, you know, "Let you deal with it because I obviously can't. There's too much going on that I can't."

Each man in the study recognized a change in themselves and their beliefs about fatherhood. This transition is addressed in the next research question as the men defined themselves before the diagnosis of postpartum depression and who they became in order to survive this trying time.

*Research Question Three: Defining Self in the Experience of Postpartum Depression*

The third research question asked was how do men define themselves when a spouse or partner has postpartum depression? As a segue into the discussion of defining themselves when their spouses or partners had postpartum depression, the men were asked for their definition of fatherhood. The development of how they define themselves was intertwined with the father or father figure they knew in childhood but was also impacted by the experience of postpartum depression. Although their parental relationship was not always a healthy or close one, they were able to hold onto the good as they became fathers and used the negative as a reminder to be different in regard to involvement with their child. This belief in shaping or forming their identity as father was challenged during the experience of postpartum depression.

*Ed*: "Um, my and his relationship was not as close as we should be, so that example, may not, ah, (pause), I may not have had the best example. And I say that because of, of the situation of me

being, not being close to my dad as I'm growing up, and then my mom and him end up getting a divorce, and they weren't close, and so, um, as far as--to actively scrutinize, ah, being a adult with, with, ah, child and wife, um, I (pause), I would have to say that I, um, the help of God, I was able to or I'm trying to understand what I need to be, um, what I need to be as far as that that role to be a dad and father.

*Wayne.* "I would probably define a father as, first of all, a provider. Ah, I (pause), I, my father passed that down to me. I mean that was major thing for him, I was to be a provider, and I knew I had to do that. I knew that was one of my expectations. I think the thing that, that I wanted as a father was to be an engaged father, um, so that might be God's funny way of how Molly and I became engaged, ah, now that I think about it. Um, but, um, I wanted to be an engaged father. I wanted also to be a father who, ah, had a good balance with, with how they handled and reacted to their child."

*Allen.* ". . . .being a father, Um, I think it just, it compounded more realizing that, you know, my feelings and my ideas about being a father was to take care of both [in regard to his transition to fatherhood]. . . .I guess through that situation, you know, this is a lot of, this'll take a lot of tie [sic], a lot more time than I woulda thought it would."

*Richard.* ". . . .it did change my perception, um, just of family in general. . . . had this idea in my head that all the families would do things together like we did when I was growing up um, that perception was completely demolished . . . so that didn't happen at all."

*Tom.* "I think my dad did pretty well. He worked a lot, but ah, when he was around he was into the family. So I had a pretty good role model to follow."

*Neil.* "Well, I guess my dad, ah, because I had a very good relationship with my father. . . .he worked a lot but was there for us . . . being there with the child and doing things with and for her."

The coding of the responses of the men to the third research question focused on how they described themselves as the postpartum depression became evident after the birth. The following categories will be addressed using the men's stories: need to fix/control, anger, and feeling ashamed/embarrassed.

*The category of trying to fix the problem.* The ability to correct what is wrong or to fix a problem was voiced by all the men in the study in varying degrees. The desire to have a return to normalcy was the driving force to fixing any circumstance which created tension or an emotional reaction from their spouse or partner.

The men in the study sought to uncover the problems faced by their spouses or partners and take the necessary steps to fix the issue or at the very least control any circumstances which were contributing to the situation. This need to fix began initially as a measure to maintain normalcy in the adjustment to parenting but the men soon acknowledged the necessity to fix a situation would be done regardless of their spouses or partners preference.

*Wayne.* "I think for me it was—"I wish I could do something for ya, but I can't. Obviously, there's nothing I can do for ya." Um,"if," you know, "I was able to produce milk I would," you know--that whole thing. Whatever it takes 'cause I'm a fixer. . . . to some degree I felt like I wasn't providing because I wasn't able to fix some of the issues that went on."

*Tom.* "Prior to her hospitalization I was letting her make all the decisions. After it [the hospitalization], I did a 180, and now I was involved in just about every decision. It made her feel uncomfortable, um, but I didn't know how to stop it."

*GT.* "...I really didn't know what to do. And it got to the point where I really just didn't even care if she got upset. I was gonna do what I had to do."

*The category of being angry.* Intertwined with the category of fixing or being in control of situations and outcomes was the category of being angry. This anger was directed not at themselves but towards the inability to please, the inability to understand what was happening, and the frustration with ongoing issues which seemed never to be resolved. Being angry in response to how they defined themselves recognized their indignation at the continual inability to find the workable resolution to the problem. The men in this study examined their own behaviors to discern if anything needed to change in the situation. Upon this self examination they noted that self-blame was not an issue but that the unresolved issues were.

*Neil.* "You know, I just kinda thought, you know, "Wow, maybe I'm not doing enough." I guess I had heard of it; it was like something that a lot of people get and they just get over it, you know, fairly quickly. It was part of the physiology, I guess of, um, it was that, and I guess I didn't realize how, how serious it, it could be. I realized, you know, something's got to be done. This isn't going to go away by itself."

*Tom.* "I snapped out of this, you know, she's gonna, she's gonna hit something and snap out of it, or get so tired from not sleeping that's she's gonna fall asleep and then we'll move on and start working from there. She didn't. [His wife was hospitalized five days post delivery].

*GT.* "And I just remember waking up one night, the baby was crying, and, ah, I went ... all the lights were off. I was like I wonder (pause)--she wasn't in the bed-I was like, I wonder if she's in there with him, so I went in there, he was in his bed just screaming his head off, and I went in the kitchen and she's standing in the kitchen in the dark just crying her eyeballs out. And I said, Well, both of you all crying, I guess I'll just cry with you." I mean I just had then got to the point where I couldn't handle it.

*Allen.* "All I know is that, you know, I had kind of a pretty little picture in my mind of coming home with the baby and everybody's all happy and, you know, happiest time of your life, and

I'm going to be honest with you, it was probably the most miserable time of my life. The, the first six weeks, two-to-three months there, it was (pause) it was miserable, and ah, you know, it's like I almost didn't want to get off of work because I knew what I was gonna have to deal with when I got home."

*Richard.* "I got resentful, but it was usually for the moment because there wasn't enough. I wanted to make sure that I didn't upset Samantha, so *I* would get upset, but then I'd just let it pass 'cause there wasn't anything I could do about it. I don't recall I ever thought "postpartum depression." I mean I knew something was wrong---I just didn't, it's one of those things, you know, it's like when you're sick, you know you feel bad but you can't quite put your finger on what it is. And I didn't know what it was or who to ask."

*The category of being ashamed or embarrassed.* The ability to ask for help or reveal the underlying behaviors they were experiencing produced a feeling of being embarrassed or ashamed – shame for the situation, shame for their spouses' or partners' inability to cope with being a mother, and embarrassed at their own feelings towards their spouses or partners. Sharing what was happening in their homes was not considered a good thing to do by the participants. Employers and fellow work mates were told only about the babies and other questions about their wives or adjustments were skillfully avoided.

*Ed.* "I guess maybe one of my biggest things was not, not realizing that it was as big of an issue that that it actually is and maybe just denying or thinking oh, well, this is not really something, you know, you're--maybe being ashamed for even thinking that, you know, this is like . . . shouldn't consider yourself depressed, you need to be strong, you know, whatever. Maybe thinking that you know . . . you admit that you are depressed, that you are a weak person."

*Tom.* " Um, I told my boss that she had to go back to the hospital 'cause she wasn't eating, which she wasn't. But (pause), but I left out the rest. I steered away from the conversation at work

without a doubt. Um, well, it's embarrassing for me that my wife can't handle it. I didn't tell my dad or my brothers, um, about, you know, the suicide attempt or whatever you want to call it.

Um, I told my mother, but I (pause), I knew she could keep a secret."

*GT.* "Well, I, I know how that (pause) people would ask me every day, you know, "How's things going? How's the baby?" and I'd go, "Oh, its great," you know, and the whole time I'm thinking, Man, I'm dreading going home." I didn't think about going to get help for me. I wouldn't know who to see about it, and I wouldn't, ah, I probably wouldn't want to admit that I had those concerns or problems going on."

*Wayne.* "I felt to some degree I couldn't talk about it a whole lot as it was happening, um, so I intern (pause), internalized a lot of it."

*Allen.* "Probably if it [postpartum depression] was said, I said, "Well, you know, we're not depressed people; we don't have any problems with this." I guess I pretty much dismissed it, the, this is not somethin' that's gonna happen to me. And, um, we're not, we're not those kinda people, and so it's, it's, this can't happen to me."

While struggling to understand their new role as father, support their spouses or partners in the midst of postpartum depression, help of any type whether from medical personnel or family and friends would be welcomed. The men in this study reported a mixed reaction to the help received following the birth of their babies.

#### *Research Question Four: Perceptions of Helpfulness*

The final research question addressed was: How do the men perceive the help received or offered when their spouses or partners have postpartum depression? When this question was asked during the interview, help in varying forms was experienced by all the couples.

The couples represented in these narratives faced life changing events. The time lapse to receiving help for postpartum depression varied with each couple as did the source it was

received from. Many types of help were received by the couples--some helpful, some well-intentioned but misinformed, some not helpful at all. At times the lack of information became as equally frustrating as the postpartum depression.

The majority of the help came from immediate family members, but the presence of church family was also a significant source of assistance to the new parents. The material received at doctor visits and during the actual hospital stay, however, was reported as ineffective by all the men in the study. The men noted a favorable response to initial offerings of meals. This was a tangible expression of help but minimally invasive. The responses to this research question were analyzed to address which of the sources of help offered were or were not helpful to the men. The following categories were developed in regard to the help received: overwhelming, frustration, and the need to know.

*The category of being overwhelmed.* The transition from being pregnant to arriving home from the hospital with a newborn is a daunting task for the new parents. It was perceived as initially helpful when family members were there to assist in the care of the infant or regular household routines. The idea of adjusting slowly to this new role, while originally appealing, began to have an unexpected added pressure to "entertain" the visitors. For new mothers the need to be perceived as competent is an unspoken pressure. The need for help while on one hand expected can also become a pressure to perform as if she had not just given birth but was simply entertaining company.

*Richard.* "Samantha and I both felt very comfortable knowing what we were gonna do and, actually, everybody was great when they were there, and very helpful, and that was great, but it was also, for me, it was a sense of relief that everybody would be gone and we probably, we could do this on our own, and there wouldn't be, you know, ten people at our house or twelve people. So to me it was, it was almost a sense, ah, of relief, ah, you know, eventually we're

gonna have to do this on our own anyway. So, once we can get everybody out, "Thank you for your help. . . ."

*GT.* "We had help. We had almost too much help, but, you know, we had people there constantly, and I think that was, I think that was, I think that was a little bit overwhelming. We had so many, ah, family members and, ah, friends that were in and out, in and out, and all of them wanted to hold the baby.

*The category of frustration.* The medical community, as a whole, was the single most reported source of frustration for the men in this study in relation to the lack of help received or offered. The expectation of the hospital personnel and medical doctors to guide these couples was largely met with more unanswered questions by the men. At times the messages were mixed and left the man to wonder what indeed appropriate behavior was for his spouse or partner. At other times it created anger at the dismissive behavior of medical doctors when questions were asked and concerns expressed. The frustration the men felt was in the perceived lack of accountability in assisting their families in the transition to parenthood by the medical community.

*Tom.* "Looking back with hindsight, um, they were relatively inattentive to my wife's needs in terms of postpartum and talking to her and checking her out, even with any kind of respect to that. Um, you know, the first night she walked down the hall crying going to the nursery to look at her baby for an hour or two, um, so for them to not have realized that it's something couldn't have been completely right."

*Richard.* "I think she did mention something to, ah, our primary care physician, and he was pretty dismissive of, of it. He was more of, you know, eat healthy, exercise, which is fine, but it wasn't gonna make any difference. She went back after being treated for postpartum depression, and he had a problem with the diagnosis. And I told, I told her, I said, "If you've got a problem I

bet you can tell him to call me `cause I can, I can tell the difference between what happened before and what happened now.”

*GT.* “No one talked to me about it at all, you know, and I really wasn’t aware of anything about it, but I could sense something was wrong. I didn’t have a clue what it was. And when she (nurse) told me – The day we left the hospital when she told me you need to watch her, it scared me because, you know, I immediately thought about the stuff you see on the news and everything. Well, I think the nurses at the hospital obviously recognized the situation--if they had said, “Hey,” you know, “This is what you might be looking at” instead of the day I’m going out the door say, “You need to watch her,” and scare me half to death.”

*The category of the need to know.* After the diagnosis had been made, the men felt a series of emotions ranging from relief, because “it” had a name, to anger and frustration at not knowing anything about the signs and symptoms of postpartum depression. Information given in a timely fashion during the pregnancy, the men in the study believed, would have helped them recognize postpartum depression and seek help earlier for their spouse.

*Tom.* “Beforehand, there was really no discussion about it. I didn’t really think about it. I mean I knew it happened, but I didn’t know what level it happened and what exactly it entailed. For me as her helper in the--in the case, it would have been helpful to have somebody explain to me what I can do.”

*Neil.* “On hearing the diagnosis--I guess relief and just, you know, what can we do to end this. Well, I guess I--we didn’t really think about it before. I mean like if it was mentioned in the Lamaze (pause), it was mentioned but not really gone into detail about. It would have been good to know what to look for and that kind of thing. I might have recognized it earlier--or at all--I should say.”

*Ed.* "I believe it was mentioned, but I was probably wasn't in tune with, ah, maybe thoroughly understanding what it was. A man may need to have some kind of training on what to expect."

*Wayne.* "That somebody would have been able to talk to me about it. I, I guess the one thing that you don't know is you don't know it's gonna happen so you don't know you need to prepare for it."

The need to know represented the gathering of information in order to cope more effectively with the changes brought on by postpartum depression. The men readily admitted their ignorance in regard to postpartum depression. The expected source for information was the medical community which was seen by the men as being negligent to their need to know as the father of the baby.

#### *Theme Development*

The four research questions guiding this study were the initial interview questions and analysis categories. The responses by the men to these four research questions provided the framework for analysis. The men's responses to each of the research questions were then continually analyzed to note reoccurring words or thoughts expressed in the replies of the men, generating a total of thirteen categories among the four research questions. From this process four themes corresponding to each of the four research questions were generated that represent the men's responses. The four themes developed were: emotional deregulation, seeking normalcy, understanding self, and disappointment. This development is represented below in Table 2. Each of the four research questions are listed with the corresponding categories and themes that were generated from an analysis of the research.

Table 2

*Theme Development*

Research Question	Categories	Theme
How do the participants describe the impact on the relationship with their spouses or partners when the spouse or partner is diagnosed with postpartum depression?	Anger	Emotional deregulation
	Frustration	
	Helplessness	
	Loss	
How do men describe their experiences when their spouses or partners are diagnosed with postpartum depression?	Fear	Seeking normalcy
	Being overwhelmed	
	Control	
How do men define themselves when a spouse or partner has postpartum depression?	Trying to fix the problem	Understanding self
	Being angry	
	Ashamed/embarrassed	
How do the men perceive the help received or offered as being effective when their spouses or partners have postpartum depression?	Overwhelmed	Disappointment
	Frustration	
	Need to Know	

*Theme of emotional deregulation.* The theme of emotional deregulation is used to describe the overall feelings experienced by the men as they reflected on the impact postpartum depression had on the relationship with their spouse or partner. The uncertainty of the unfolding events coupled with their own expectations resulted in an emotional struggle. The unexpected

feelings generated within themselves toward the spouse or partner resulted in emotions being expressed which were not part of their relationship before postpartum depression. The attempts at trying to help their spouses with the transition to motherhood were at times rejected or ignored. The following are examples of descriptions categorized as emotional deregulation experienced by the men in this study.

*Neil.* "...well, she got so mad at me she said she was going to kick me out of the house, which I didn't take too seriously, but she sounded serious."

*GT.* "I didn't know what to do. It was like everything I said or did upset her. It was like she was mad at me for caring for the baby but she wouldn't do anything."

*Tom.* "Part of me was scared she couldn't handle it. I didn't know if I was scared for her or me-- probably both."

*Ed.* "I shouldn't have, but I started to become judgmental of her and her inability."

*Wayne.* "I wasn't able to communicate with the person I knew. At times I would forget and get frustrated and say: 'Why are you acting this way?' 'What's the matter with you?'"

*Allen.* "What am I doing wrong? I must be doing something wrong."

*Richard.* "I never knew which one I was dealing with--the one who would become paranoid or the one who liked people."

The analysis of the responses to research question one: How do men describe their experiences when their spouses or partners are diagnosed with postpartum depression? indicated to the researcher the various emotions experienced by the men on any given day. The responses previously noted demonstrate how volatile a day may be. During a day decisions and reactions vary from moment to moment. Uncertainty and confusion are viewed as normal and initial expectations of fatherhood were deemed fantasy. Emotional deregulation represented the men's experiences when their spouses or partners have postpartum depression.

*Theme of seeking normalcy.* The categories developed from research question two, how do the participants describe the impact on the relationship with their spouses or partners when the spouse or partner is diagnosed with postpartum depression, were fear, overwhelmed, and control. The theme developed was one of seeking normalcy with the experience of postpartum depression.

The men attempted to seek normalcy in the day-to-day activities of being a new parent. This attempt was often met with trying to fix or control the circumstances being experienced. When the attempts were not met with the desired responses anger at the spouse or partner was experienced coupled then with a feeling of remorse and frustration. The men became increasingly overwhelmed as they re-entered the home after working all day wanting the return home to be as they had expected but fearing the worst. The increased responsibilities and unexpected behavior of their spouses or partners produced an overwhelming desire to control everything and make the decisions to regain a normal environment, while fearing the situation would never be normal as the following remarks illustrate:

*Neil.* “. . . more responsibility than I originally thought. I worked 55-60 hours per week and came home to deal with the household and the baby--I realized something got to be done.”

*GT.* I tried to do everything. But if I went in, and there was one dirty dish on the counter; if I went in to wash it, you know, she would go off, I was gonna wash that you know. It was miserable. I mean, do I leave the dish laying there. Do I wash it? It was like that with everything.

*Tom.* “When we got home, I went crazy doing everything--vacuuming, sweeping, doing the dishes taking care to move this chair and that chair around for comfort, figuring out what we would have for dinner just kinda overdrive on everything.”

*Ed.* “. . . I tried to set limitations for her to help her be a mom. Help her without making more issues.”

*Wayne.* "I would have breastfeed if I could have if it would have helped. It all got to be overwhelming at times. I relied more on my faith to help regain my balance with what was going on around me."

*Richard.* "I took on the role of peacekeeper. Not my natural role, but I had to settle the situation."

*Allen.* "I said, 'Forget it...it's not working; we're going to the store and buy formula.' I made the decision."

The men's responses to research question two describing the impact on their relationships with their spouses or partners demonstrated their experiences were varied but also similar. Their desire to have a positive impact on their spouses and partners was evidenced in their willingness to assume both roles as mother and father while their spouses or partners dealt with the postpartum depression in whatever way necessary for her to heal.

*Theme of understanding self.* The categories developed from research question three, how do the men define themselves when a spouse or partner is diagnosed with postpartum depression, were need to fix or control, anger, and feeling ashamed or embarrassed. Other categories addressed less frequently included: feeling overwhelmed, despair, and withdrawn. At times the men interchanged these categories with the others, for they are all interrelated at some level. The theme developed was one of understanding self because the men described themselves with a spouse or partner with postpartum depression. The men responded to the question of describing themselves in numerous ways. For example, the description of "fixer" included being willing to breastfeed, if he could, if it would help his spouse or partner. To fix the issue of breastfeeding or bottle feeding was the initial task for several men in trying to remove the tension being created.

Compartmentalizing all the responsibilities assisted some of the men in developing plans to control the environment and deal with one issue at a time. Anger became apparent when the fixing or controlling did not produce the expected results. The inability to seek help from others

due to shame for the situation and embarrassment not only for their struggling spouses but also for themselves and their inability to fix the situation created a cycle of helplessness, frustration, and fear. Pretending life was normal to co-workers, bosses and friends added to the secrecy and did nothing to change the circumstances the men revealed.

*Neil.* "I had unrealistic expectations about postpartum. I had a sense of loss for my wife's inability to relate to the baby and myself. I didn't have any friends around here to talk to about it."

*GT.* "I was to a point where I felt, "Is this going to be what the rest of my life is going to be like?" People would ask me everyday about the baby, and I would say the baby's fine and then change the subject, so I didn't have to talk about my wife, and I didn't want to tell them I was dreading going home. "

*Ed.* "I didn't initially think it was serious. I wasn't watchful on what was happening. At times I did get judgmental about her inability to handle things. I relied on God to get me through, but I told few people about her struggles."

*Tom.* " Um I told my boss she went back in the hospital because she wasn't eating, which she wasn't, but that wasn't the whole truth. I didn't tell anybody at work the truth; I was embarrassed she couldn't handle it. I made the decisions more than I initially thought I would in regards to the care of the baby. I had to; she didn't like it so much, but that was too bad I got used to deciding.

*Wayne.* "I felt to some degree I couldn't talk about it a whole lot as it was happening, so internalized a lot of it. I was shamed by what was happening and I couldn't control or fix it."

*Richard.* "I don't mind standing up for things, but in this situation I felt uncomfortable telling my parents what was really going on."

*Allen.* "Well, you know, I thought, 'We're not depressed people, we won't have any problems with this. . . . we're not those kind of people, and so it's--this can't be happening to me.'"

The men's responses to research question three describing how they define themselves revealed a metamorphosis from passive participant to active and in control of decision making regardless of their comfort level. The definition of self changed to include this active role and was not relinquished when their spouses or partners began to heal from the postpartum depression. Recognizing their own emotional response to their spouses or partners postpartum issues revealed areas which they had not been aware of before. Examples included a lack of their own support system, a feeling of judgment towards her inability to cope, or the importance of others believing everything was normal.

*Theme of disappointment.* The categories developed from research question four, how do the men perceive the help received or offered as being effective when their spouses or partners have postpartum depression, were: overwhelmed, frustration, and need to know. These categories are in response to the different types of help received, offered, or the lack of help when their spouses or partners had postpartum depression. The men discussed this help in the context of interpersonal relationships, medical community, and general information. The theme developed was disappointment.

Although all the men acknowledged receiving help in some form from family and friends, they recognized quickly that too much of a good thing was not helpful. And despite the outward appearance of being helpful some family members added to the frustration and anger because of personality conflicts which were already present in the relationships. Angry exchanges between the men and the mothers-in-law resulted. Apologies were stated later after the initial crisis was resolved, and as one man stated, "a truce" was achieved.

The most disappointing issue was with the medical doctors, hospital nurses, lactation specialists and other medical personnel who were part of the pregnancy and labor and delivery process. To have questions or concerns presented and summarily dismissed created anger and

resentment for the men. To be vaguely warned as one left the hospital for home without specific information created fear and uncertainty. To have no printed material to review or read about the postpartum period of time was frustrating. All the men interviewed believed that more information would have helped. They were not all in agreement with the form that information needed to take to be effective.

The men were in agreement to feeling largely ignored by the medical community in educating them about the risks of postpartum depression. The need to know the signs and symptoms of postpartum depression was presented by the men as the single most frustrating piece of the experience. All of the following direct words from the interviews show that the men believed that information shared in a timely manner may have made a difference in seeking help earlier for their spouses or partners.

*Ed.* "I would say, um, that it would be good [to speak to the father about postpartum depression and what to look for]--like maybe two weeks before and two weeks after and--even two weeks after that. I, I mean it wouldn't be a bad thing."

*Tom.* "But beforehand there was really no discussion about it. I didn't really think about it. I mean I knew it happened, but I didn't know what level it happened and what exactly it entailed."

*Neil.* "I didn't really think about it before. I mean if it was mentioned in Lamaze . . . it wasn't really gone into detail."

*GT.* "I feel like, you know, if they had given me some information. I think what would have helped me the most is to have been a little more educated on it."

*Wayne.* "That someone would have been able to sit down and talk to me about it. I guess the one thing that you don't know is you don't that it's gonna happen, so you don't know that you need to prepare for it."

*Richard.* “For me, from my point of view, that should be one of the first things you’re educated about because it’s, now, looking back on it, it’s easy to recognize, if somebody would have said, look for these little things.”

*Allen.* “I think maybe a little more time, ah, should be spent discussing just some of those issues so that you can be more aware of those things. I don’t remember anyone saying a whole lot about this issue.”

The men’s responses to question four and the development of the categories describing how they perceived the help received or offered as being effective developed the theme of disappointment. The help offered by family members or the church community was thought to be the most helpful with the understanding that too much help can also be detrimental to the new parents. The ineffectiveness of the medical community was a significant drawback for the father as he struggled to make sense of postpartum depression and merits further investigation in additional research.

### *Summary*

The purpose of the study was to examine men’s experience in regard to postpartum depression in a spouse of partner. A description is given of the various reactions to the first interview question concerning the initial response of the news of the pregnancy. A mixture of happy anticipation, relief, and concern about fathering skills marked the responses.

The second phase of the interview concerned the period from birth to the time diagnosis of postpartum depression was made. The participants experienced a wide range of emotions, tensions in balancing responsibilities now greatly and unexpectedly increased, worry, anger, being overwhelmed, confusion, fear, fatigue/exhaustion, and helplessness, as well as a dawning awareness of the reality that things were, in some sense, not right with their spouse’s experience and function. A distinct personality change in the spouse or partner was noted as a red flag of

what was later diagnosed as postpartum depression.

The category of anger toward the illness, the added responsibilities, the spouse's inability, and at themselves permeated all the responses. The category of helplessness, both in inability to effect change in the partner and in the sense of being controlled by the infant's demands was present with all. Concomitant frustration grew when things did not improve, responses were not as expected, and the future seemed open-ended.

The category of loss emerged as men acutely experienced separation or distance from their spouses, precipitated by the personality changes exhibited. The category of fear existed in several areas: fear of interacting with the spouse or partner, and/or upsetting her, fear of harm being done to the infant, or of self-inflicted damage to the spouse or partner, and fear of returning to work with the home situation so tenuous. The category of being overwhelmed was a function of the sheer relentlessness of events and the lack of time and energy to relieve stress in what were previously normal methods. All struggled with the category of control, either trying to regain it personally, or entrusting it to God as a spiritual belief.

In the third question concerning the definition of self, three categories emerged: need to fix/control, anger, and feeling ashamed/embarrassed: A drive to re-establish normalcy drove the need to fix/control; anger then grew out of the inability to accomplish normalcy, and embarrassment at the level of difficulty experienced compared with what others had encountered.

Responding to the question of assistance provided or offered, family and church, though not without difficulties, offered the most substantive, timely, and welcomed assistance. All felt underserved and dismissed by medical providers, the single greatest cause of frustration. The need to know, the gathering of information in order to cope more effectively with the changes brought on by postpartum depression, was a category involving relief once informed, anger at

not having been informed sooner and more clearly, and a feeling of being ignored by the medical providers.

After the identification of categories from each question further analysis of the responses was completed and four themes emerged from the respective research questions. The first was emotional deregulation, the second, seeking normalcy, the third, understanding self, and the fourth, disappointment.

## Chapter Five: Conclusions, Discussion, and Implications

The purpose of this study was to examine men's experiences of postpartum depression in a spouse or partner. Their stories illustrated the day-to-day struggles to understand their partners and care for their families. Although previous research has focused on the mother's postpartum issues, few studies have been undertaken which directly address the men's perspective when postpartum depression is diagnosed in their spouses or partners.

The most common complication of childbearing is postpartum depression. It is estimated that between 10%-20% of women will experience some form of postpartum mental illness (Greenberg & Springen, 2001; Swendsen & Mazure, 2000). The DSM-IV-TR notes an episode of depression with a postpartum onset begins within four weeks of delivery. However, previous investigators, on the basis of epidemiologic studies, report the onset within six weeks, three months and one year after delivery (Beck, 2001; Gennaro & Fehder, 2000, World Health Organization, 1992). This disparity can result in a missed diagnosis by health care and mental health workers. The limited education new parents receive on postpartum depression diminishes the probability of early intervention being sought by the spouse for his partner (Bennett & Indman, 2002).

This researcher sought to understand the experiences of the male spouse or partner from the onset of the postpartum depression through the diagnosis and treatment. A discussion of the findings along with conclusions of this study will be presented in this chapter. Then implications for the mental health and medical communities will be addressed, followed by an examination of implications for future research.

Researchers have noted the long-term developmental consequences of postpartum depression on the infant. The impact on the spousal relationship, however, has received only

cursory investigation. The spouse or partner is recognized as a key individual in helping the new mother navigate through the transition to motherhood and assisting her in seeking help when she becomes depressed. What is still unknown is how postpartum depression may impact the man in regard to his sense of self as a man and a father, his ability to effectively interact with his spouse or partner, as well as the impact the experience has on his own adaptation to fatherhood.

The purpose of this research was to examine men's experiences in regard to postpartum depression in a spouse or partner. Once the interviews began all of the men, except for Ed, were relaxed and told their stories with ease. Ed's concern was his ability to remember the event since much time had transpired since his wife's struggle with postpartum depression. The actual experience had become a vague memory due to life circumstances and the birth of additional children into the family unit: "Um, well, I'm starting to get a vague memory of – of what you're saying."

For the other men the retelling of their stories brought back emotions forgotten with the passage of time. The idea that their story could possibly help other men avoid the trauma of postpartum depression was their main reason to be interviewed. For all the men in this study this was the first time anyone had expressed an interest in their experiences.

For the men in this study, their original expectations of transitioning into fatherhood were dramatically altered by their spouses' postpartum depression. Anticipating involvement in the daily care of the newborn, sharing in household responsibilities, and working full time were expected and welcomed responsibilities. The discrepancy between expectation and reality for the men often became overwhelming and confusing.

Fatherhood transforms men's lives (Eggebeen & Knoester, 2001; Marsiglio, 1998). What was not expected by the men in this study was the inability to access their support, their spouses, when the tasks of everyday infant care and household labor became formidable. This inability to

connect with their spouses or partners is presented in the research literature as an issue men face when a spouse or partner develops postpartum depression.(Bronte-Tinkew et al., 2007; Smyth, 2003).

Postpartum depression essentially forced the men to transition to fatherhood in an unexpected way by assuming all the responsibilities of everyday living for everyone in the family. The men in this study reported feeling overwhelmed by the roles placed on them in addition to feeling rejected by their spouses at times. As GT stated: “. . . I didn't know what to do...it was like everything I said or did upset her. .... It was like, I love my son, but I'm going to have to do it all-- was walking on eggshells and didn't know what to do.” Wayne also voiced his frustration: “. . .I knew I wasn't going home after work to relax and take a load off. . . . I was going to be doing a lot more work than I expected when I got home”.

The emotion of anger manifested itself in several ways for the men in this study. When discussing the impact and experiences of postpartum depression in regard to their relationship with their spouses the men reported anger as a cumulative response to the unrelenting demands, the uncertainty of their spouses' moods, and the inability to control or fix the circumstances which were creating the discord.

Additionally the freedoms previously used to release stress were no longer available to the men as their primary focus became caring for their spouse and newborn. In an attempt to manage their emotions some of the men in the study utilized their religious faith as a way to mentally take a break from the pressure created by the postpartum depression. Some reported compartmentalizing the events into manageable segments to be addressed one at a time.

The frustration of not knowing what was happening was a category developed from the men's responses in this study. Frustration presented at two distinct levels. The frustration in relation to the impact postpartum depression had on the relationship with their spouses or

partners as well as the frustration which became evident with the lack of information received. Bennett and Indman (2002) reported that the woman and her spouse or partner often feel confused about the depression and are unsure where to obtain accurate and current information. Lack of prenatal education and training concerning postpartum mental health issues can create a situation of prolonged suffering for the mother and her spouse as they attempt to make sense of the unknown (Dennis & Ross, 2006).

Regardless of the reported help received by the men, this study highlighted a lingering feeling of uncertainty and confusion over what was or was not normal in their spouses' or partners' behaviors. The men reported before the diagnosis was made a behavior change in their spouse or partner's personality. This is consistent with the research on women's response to postpartum depression (Horowitz, Damato, Duffy, & Solon, 2005; Seyfried & Marcus, 2003).

This change in the spouses' personality became the hallmark sign for the men that something was just not right. This is consistent with the literature in which women report that having postpartum depression involves contending with the loss of control over their emotions, thought processes, and actions (Beck et al., 2006).

The personality change left the men uncertain how to approach his spouse to seek out her assistance in everyday care of the infant. The men experienced an increased awareness of her mood volatility and a desire to protect his spouse both from continued emotional stress as well as protecting her physically to circumvent the potential for self-harm.

The concept of fatherhood has been changing since the 1970's and continues to be redefined in the context of the family. Although more men today are involved in the day-to-day experiences of their children, the majority of child care and household responsibilities are still performed by women (Bianchi et al., 2000). The men in this study reported recognizing initially that they did not know where things were in the household. This created a level of anxiety which

the men strived to 'fix' as quickly as possible to regain a sense of being in control. For example, Tom recalled an incident after admitting his wife to the hospital for postpartum depression: ". . . when I came home and cried for about three hours, um, she had taken care of where all this stuff was so I didn't know where the formula and the bottles and all the stuff was--I didn't know what to do, so I called my parents, and they agreed to come down to help me."

Finally, it should be noted that previous research found that health care workers either provide a notable role in promoting help-seeking behaviors or they hinder obtaining treatment (Dennis, 2004; Webster et al., 2001). When health care workers speak openly concerning postpartum depression, the couples perceive the stigma to be lessened, and the desire for help increases (Beck et al., 2006; Mauthner, 1997). The experiences of the men in this study with health care workers revealed that, although information may have been presented in the form of written literature at the time of hospital discharge, the numerous pamphlets on various topics were largely relegated to the trash because, at that time, there was no time to read. The men in this study noted that this information discussed before the birth would be helpful in noting the signs and symptoms of postpartum depression. Although the men stated a desire to have contact with healthcare personnel and be informed on the processes of pregnancy, minimal one-on-one contact was reported.

### *Conclusions*

Postpartum depression is a complex and challenging disorder which often takes families by surprise. The man whose spouse or partner develops postpartum depression is often overlooked in the transition to parenthood. There is little research available that directly addresses the man's perspective of postpartum depression and how it impacts his relationship, his view of self, and his expression of suggestions from his viewpoint on how to help new

parents. This research presented here provided an opportunity to view the lived experience of postpartum depression through the lens of the spouse or partner.

One conclusion drawn from this research is that the men enter into the pregnancy and childbirth experience of their spouse or partner with pre-determined expectations of what their role will be. This pre-determined idea or role expectations are changed with the onset of postpartum depression. Unsure what they were facing in terms of function and duration the men attempted to re-align their expectations to this new reality. Utilizing previous characteristics of self the men attempted to control or fix the circumstances perceived to be the cause of the spouses struggle.

A second conclusion is the recognition of the men's emotional responses to the circumstances they encountered. Dealing with their spouses or partners mood volatility in addition to unrealistic and unrelenting demands created anger in the men. Anger was felt at several levels. Anger towards themselves as they sought to control or fix the circumstances, with the belief the results would change the environment, and the realization that the response was never consistently helpful. Anger felt towards their spouse for her seeming inability to cope with the demands of motherhood. As if her inability was a betrayal of their plans to be a family. If he could handle this transition indeed so should she with some effort. This anger often showed itself in embarrassment and shame the men felt when they returned to work and the questions of bosses and coworkers.

Another conclusion drawn from this research concerns the men in this study reporting only a minimal support group outside of their immediate family. The family was largely not informed of the struggles the new parents were experiencing largely due to the men's embarrassment. The men reported that their spouse had been their sounding board in the past and with her emotionally unavailable to him he internalized his feelings.

The men also concluded, in this study, that utilizing the medical community which had been responsible for the prenatal care and delivery of their child was not an option in seeking out information or help on what was normal for his spouse or partner during the transition to motherhood. The men in this study, for the most part, agreed to feeling largely ignored by the medical providers during the regular prenatal visits. In actuality the men did not recall ever having been asked about their possible concerns or questions during any of these visits. The men in this study did report regularly attending these prenatal visits and desired an improved understanding of the process of pregnancy. The men in this study agreed that having a connection with the medical community would have given them a place to seek out answers earlier and possibly prevent the long term presence of postpartum depression in their families.

The men also concluded that, in addition to a relationship with the medical providers the need for information on postpartum depression before the delivery was also viewed as helpful. Although the method of receiving this information was a personal preference whether verbally or in writing the men all agreed that something was better than nothing. The important piece was the timing of receiving the information. Largely seen as extraneous papers, pamphlets received at hospital discharge were relegated to the trash. The consensus being no one had time to read pamphlets after the birth or after the baby came home. The ideal time to absorb or read and question information, according to the men in this study was a few weeks before the birth. Or as one man commented talk about postpartum throughout the pregnancy to keep thinking how to be prepared.

A conclusion also drawn from this study involved the importance of recognizing the father's role changes in relation to his newborn. It is important to recognize a father's connection with his newborn as equally important to that of the mother. The validation of the father as an

important person in the infant's life strengthened the men's resolve to work through the postpartum issues without setting a time limit on its resolution.

Established in research are the different ways a father plays and interacts with his infant providing stimulation which is different than that which is received from the mother (Gladstone & Beardslee, 2002; Williamson & McCutcheon, 2004). His availability to interact and play with the infant enhances cognition and experiences normally not received from the mother. The availability becomes perfunctory when dealing with a spouse with postpartum depression. The men in this study worked outside the home; some, in excess of 45 hours a week. To return home and work a second shift proved overwhelming and often physically and emotionally exhausting. Thus, the father's interaction with their infant was reduced to basic care, as all other household tasks needed to be completed.

### *Discussion*

As a socio-cultural phenomenon fatherhood is far less studied than motherhood (Bronte-Tinkew, Moore, Matthews, & Carrano, 2007). Most studies have relegated the role of fatherhood to attachment issues with the infant (Brennan, Hammen, Katz, & LeBrocq, 2002; Zelkowitz, 2001). Little has been studied in regard to the relationship with the partner outside the feeding and care of the infant (Seimyr, Edhborg, Lundh, & Sjogren, 2004; Townsend, 2002). The early experiences of fatherhood have been discussed as struggle to re-define self and as a time of stress (Bronte-Tinkew, Moore, Matthews, & Carrano, 2007; Eggebeen & Knoester, 2001). Those studies conducted which addressed the father of the baby as an individual with responses and reactions to their spouse with postpartum depression are limited to a few (Bradley, Mackenzie, & Boath, 2004; Davey, Dziurawiec, O'Brien- Malone, 2006, Meighan, Davis, Thomas, & Droppleman, 1999).

In western society the role of fathers has evolved from primarily 'bread-winner' to simultaneous roles of provider, guide, nurturers, and household helpers (Bradley et al., 2004). Postpartum depression is not only distressing and debilitating for the woman but can affect the development of the infant, have adverse effects on the partner, the couple's relationship dynamic, as well as other family members (Beck et al., 2006). Partners of postnatally depressed women reported less satisfaction with their marriage, dissatisfaction with changes in household routines, increased worry in regard to overall family responsibility, as well as perceived stressors from work, and poor social support (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006).

### *Implications for Counseling*

The findings of this study suggest that it may be advisable to question the couple on their pregnancy and postpartum experience when they present for counseling. Previous research indicated that marital stressors can be a predictor of postpartum depression (Beck, 2001, 2006). The support perceived by the spouse during postpartum depression can impact the marital relationship even after the resolution of the illness (Dennis & Ross, 2006).

The types of support needed by the mother are in the arena of communicating information and affirming the appropriateness of emotions so that she feels cared for and valued regardless of her personal difficulties. Also needed is practical help in the everyday events of parenting (Will & Shinar, 2000). The men in this study indicated an awareness and desire to provide this support for their spouse. At times, however, their support attempts were ignored, questioned, and even generated angry responses and threats from their spouse. Walking on "eggshells," as some of the men described their attempts at help, created tension in the marital relationship.

Men, however, also need of support during the transition to parenthood. Unfortunately for men, social support systems are often few and the ability to feel comfortable in accessing

them is variable. In this study it was noted that a sense of shame and guilt prevented men from initially seeking help from others in regard to their spouses' behavior. As GT commented: ". . . people would ask everyday, 'How are things going?' and I'd say, 'Great,' but the whole time I'm thinking, I'm dreading going home." Similarly Tom admits partially lying to his boss about how things were at home: "I told my boss she had to go back to the hospital because she wasn't eating--she wasn't, but I left out the rest. I mean it was embarrassing for me that my wife can't handle it."

The unresolved feelings generated by postpartum depression can compound as time goes by and the couple's lives take on the demands of parenting. Unresolved emotions from this time period can continue to stretch the ability of the spouses to communicate effectively, trust, and rely on the other in other times of need (Goodman, 2004b). Although all marital difficulties are not the result of postpartum depression enough research exists which would indicate the need to address its potential impact on marital distress in the intake interview.

Evidence is accumulating that the prevalence of postpartum depression is fairly consistent globally (Beck, Records, & Rice, 2006; Dennis, Janssen, & Singer, 2004). Some examples of the international rates of diagnosed postpartum depression include 23% in India (Patel, Rodriques, & DeSouza, 2002), 17% in Japan (Yamashita, Yoshida, Nakano, & Tashiro, 2000), and 15% in Italy (Carpiniello, Pariante, Serri, Costa, & Carta, 1997). Studies conducted to validate the Edinburgh Postnatal Depression Scale have been helpful in understanding that this illness impacts mothers around the world not solely in the United States (Danker, Goldberg, Fisch, & Crum, 2000; Glasser, Barell, & Shoham, 1998; Johnstone, Boyce, & Hickey, 2001; Yamashita, Yoshida, Nakano, & Tashiro, 2000). Researcher in Europe and Australia regularly study this illness to develop a better overall understanding of the impact on the mother, infant

and family unit (Burke, 2003; Clifford, Day, Cox, & Werrett, 1999; Huang, & Mathers, 2001; Williamson & McCutcheon, 2004).

Although studies abroad have noted the role of the father in the postpartum period, there is still an absence of the father's own experiences of having a spouse or partner with postpartum depression. These findings mimic the relative absence of the same in research conducted in the United States. Although every attempt was made to include diverse ethnic groups into this research none of the couples contacted felt comfortable sharing. Counselors would be advised to address this with all couples regardless of ethnicity.

Another area which counselors need to understand is the impact of living in a family where the mother had postpartum depression. And the ramifications this may have on the infant's development both cognitively and physically. Based on the literature reviewed for this present study, therapists, social workers, and health care professionals would be advised to monitor the research to understand the impact on children whose mother had postpartum depression. In addition to the mother, research also indicates that fathers play a significant role in determining child well-being (Flouri & Buchanan, 2002; Sidle-Fulingi & Brooks-Gunn, 2004).

The current research on the impact of the father on an infant's cognitive development is also being examined by attachment and developmental researchers to understand the correlation to behavioral problems in children (Brennan et al., 2002). When a child attends counseling, an in depth family history is taken, largely given by the attending parent. The understanding of the pregnancy and postpartum issues the mother may have experienced, as well as the extent of father involvement, can add another perspective to a child's attachment issues and overall behavior in the social setting.

The postpartum mother entering counseling for her depression may have reservations about expressing her current feelings for a number of reasons. The most significant is the fear her

infant will be taken from her and she will be labeled incompetent to mother. This fear is overwhelming and can keep the mother isolated and her family at continued risk. As has already been established in this study, health care workers can either help or hinder the accessibility to appropriate treatment. By working in sync with the mental health professions, health care providers can direct the couple to receive therapy addressing and eliminating these fears and other concerns. The father, who has access to the health care workers during pre-natal visits and childbirth education classes, should be encouraged to attend and actively develop a relationship with the medical team. The importance of establishing a referral base for him is essential in the postpartum period in the event the mother is not responding appropriately to her new role.

Although not a new concept in therapy, support groups for men have largely focused on correcting specific behaviors such as anger management or addictions. The idea of a support group was presented by all the men in this study as a desire to come together in a communal setting for sharing and support. The men, in this study, reported a limited support group from male friends, excluding relatives, who could provide a sounding board for questions. Also noted was the desire to have more experienced men share in their childbirth and postpartum experiences to provide a sense of hope and guidance.

Those developing a support group would need to explore the preferences of men for information to be presented, locate a central location for the group, and define a time frame. In addition taking into account the various stages of adjustment, the new fathers may present at the group. Future research into the outcome benefits of such a support group would be helpful in the on going development of the family system. Finally, the idea of mentorship or some type of brief support group was suggested, by the men in this study, as a way to help new fathers vent their frustrations, gain information, and, overall, cope effectively with the postpartum depression. The idea of a follow-up support group for new fathers would provide a neutral setting for new fathers

to ask the basic question: "Is this normal?" The support group leader could then guide the discussion to include not only the answer to the question but encourage the other men to share and respond.

A challenge lies in the development of a mental health / healthcare provider liaison. Ongoing marketing and education by the mental health community to the health care professions encourages working together towards a solution for patient/client care that is beneficial for all involved. Postpartum depression is an illness occurring post delivery in some women. The first individuals to assess the new mother are her health care providers, and therefore, the identification of postpartum mental health issues is a topic which merits continued education for them. Speaking to both mother and father is important when reviewing postpartum mental health. The spouse or partner is the one individual who has a relationship with the woman pre-pregnancy and throughout delivery. He is the individual who can note mood or personality changes, frequency of outbursts and intensity of the same.

#### *Implications for the Medical Field*

Although obstetricians, pediatricians, and primary care physicians are encouraged to screen for postpartum depression by their respective professional organizations women may still be reluctant to bring their symptoms to the attention of a caregiver (American Academy of Pediatrics & American College of Obstetricians, 2002; Maternity Center Association, 2002).

The screening and identification of depression during pregnancy and the postpartum period offers physicians an opportunity to impact family health and functioning. Physicians often depend on clinical observation as a means to identify symptoms, whereas standard screening tools may be a more effective way to identify this debilitating condition. The use of the Edinburgh Postnatal Depression Scale in this study, although not fool proof, was an easily administered tool for the detection of postpartum depression symptoms. Screening for

postpartum depression is a brief intervention which can help determine a better overall outcome for mother, infant, and family.

An area in which the medical community needs to improve, according to the men in this study, is the realm of developing a relationship with them as the father of the baby. By engaging the father in a brief personal history the medical provider can gain important insight into his support system as he also makes the transition into fatherhood. In this research the men reported feeling largely ignored by the healthcare providers. Their belief was that a connection with someone responsible for their spouses or partners care may have led them to seek assistance earlier in regard to the postpartum depression.

Including the father in childbirth education classes, as well as routine doctor visits helps develop a relationship which is mutually beneficial. As a result of this relationship with the father the medical provider can ask direct questions concerning the understanding of the process and possibilities of childbirth and the postpartum period. For the men it would allow for the concerns of his spouse's behavior to be discussed in a non-threatening manner to determine if further assessment is required. The men, in this study, unanimously stated the belief that information about postpartum depression would have motivated them to seek help for their spouse or partner earlier.

Listening to his concerns in a respectful and direct manner enhancing his comfort level and reduces any perceived embarrassment or shame over his spouse's struggles. The participants in this study reported shame and embarrassment in regard to how others might perceive their wives' inability to cope with the transition to parenting. A nonjudgmental environment would enhance the likelihood that help would be received.

The internet is increasingly being utilized by individuals is the internet to validate information received from the healthcare provider or unanswered questions from a doctor's visit.

This means of gathering information may or may not be helpful or accurate, and as a whole, the medical community may consider posting several acceptable and reliable web site sources for their patients. Several reliable internet sources are available for postpartum depression and giving this information at the visit may help the family recognize and seek further appropriate care.

The medical community's responsibilities to the new mother and father need not stop at cursory medical attention. The understanding of the long range impact of postpartum depression is crucial to having healthy infants, mothers, and fathers. In conclusion, it is apparent from this study that care providers need to be aware of and responsive to the special needs of fathers as well as mothers during their transition to parenthood. Continued research is recommended which addresses the man's experiences and the overall impact postpartum depression has on his emotional well-being and ability to be a father and a husband.

#### *Research Implications*

Although postpartum depression has been researched extensively for its impact on the mother, its effect on the father has received only cursory investigation. Nevertheless it has emerged from such investigations that an impact on the relationship exists and indeed may continue past the resolution of the illness. To research and understand the nature and extent of the long range implications of postpartum depression for the family unit, a more thorough consideration of the father's voice is essential.

The father of the baby is in a unique position as he has known the mother before pregnancy and has determined through that relationship what her personality characteristics are. He knows her abilities and intellectual capacities. He is familiar with her moods before the pregnancy and throughout the pregnancy as well. He is aware of the subtle and not so subtle shifts of mood, the increased outbursts and the intensity of the same. He provides a lens of these

behaviors and their changes which no one else can for the medical community to determine what may be wrong.

The father, as well, undergoes a change in how he perceives himself upon the birth of his infant. These changes while not inherently physical nevertheless can alter the course of his adjustment to fatherhood. Further research is needed to understand how he assimilates fatherhood into his definition of self. This research would be an important contribution to understanding the role of father. As important, but also under researched, is the changes which, of necessity, are thrust upon him when his spouse or partner experiences postpartum depression. His role expectations change as does his ability to cope with the ongoing and unexplained repercussions of postpartum depression.

Additional research is also needed on how the family unit is challenged during the experience of postpartum depression. As the family dynamics become skewed the reality changes for all involved. The mother's withdrawal from motherhood, the father's attempt to manage work and home, and the infant whose care can be greatly compromised and the necessary stimulation for cognitive development limited due to the primary caregivers postpartum depression. The impact of postpartum depression in the mother on the infant needs continual research. Long standing ramifications can develop from lack of stimulation and appropriate physical care. A small percentage of women commit infanticide every year due to unresolved postpartum mental health issues and an additional number of new mothers attempt or complete suicide.

#### *Recommendations for Counselor Education Programs*

As the counseling profession continues to embrace a holistic view of individuals and the world the integration of therapy and the medical community needs to be opened for examination.

Individuals presenting for counseling often have co-existing medical conditions some of which require medication(s). Counselors unfamiliar with medical terminology could inadvertently miss a contributing factor to the client's presenting issue(s).

The medical community is focused on providing physical healing and oft time does not have the time or resources available to address their patients emotional issues. Both professions would benefit from an understanding of the functions, procedures, and processes of each others specialty. Becoming familiar with the terminology of medical illnesses and the ensuing psychopharmacology enhances the counselor's ability to enter into the client's daily reality.

This research also brings to the forefront the differences in gender when processing information, problem solving, language use, and goal orientation. Becoming comfortable with these differences and assisting the male client to perceive an environment, for example, designed to assist him solve problems, reach goals, and communicate more effectively is a skill developed thru training and an ongoing awareness of men's issues.

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## Appendix A

### Permission to Conduct Study

August 16, 2004

As a doctoral student at The Virginia Polytechnic Institute and State University, hereafter referred to as Virginia Tech, I have chosen for my dissertation topic: The Effects of Postpartum Depression on the Spouse or Partner. In order to gain an understanding of these effects I will be utilizing a qualitative research approach.

I am requesting permission to contact women who at their six-week postpartum checkup were identified as having the characteristics of postpartum depression, either by clinical observation by the physicians or nurses, whereby the mother exhibited signs of weepiness, reports of no sleep, no interaction with newborn if accompanying the mother to her visit, anxiousness, or by assessment from the use of the Edinburgh Postnatal Depression Scale (EPDS). The mothers' permissions would be asked to permit discussion of the results of the EPDS with the spouses or partners. The spouses or partners will then be invited to participate in a one-time 60-minute interview discussing their perceptions of the effects of postpartum depression on spouses or partners, on themselves, on their relationship with the mother of the baby, and on the infant. The interviews will be conducted in the conference room of Forest Women's Center in a manner which will not interfere with daily operations.

A formal research plan will be presented to the Institutional Review Board for Research Involving Human Subjects at Virginia Tech upon completion of the Prospectus Exam. All procedures will be adhered to in regard to respecting participants' confidentiality. If the participants, at any time, have any questions, suggestions, or concerns they will be respectfully addressed.

If you agree to this research being conducted please sign below.

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## Appendix B

### Edinburgh Postnatal Depression Scale (EPDS)

Developed by: J. L. Cox, J.M. Holden, and R. Sagvosky

Department of Psychiatry, University of Edinburgh, 1987

- 1.) I have been able to laugh and see the funny side of things:
  - a. As much as I always could
  - b. Not quite so much now
  - c. Definitely not so much now
  - d. Not at all
- 2.) I have looked forward to the enjoyment of things:
  - a. As much as I always have
  - b. Rather less than I used to
  - c. Definitely less than I used to
  - d. Hardly at all
- 3.) I have blamed myself unnecessarily when things went wrong:
  - a. Yes, most of the time
  - b. Yes, some of the time
  - c. Not very often
  - d. No, never
- 4.) I have felt worried and anxious for no very good reason:
  - a. No, not at all
  - b. Hardly ever
  - c. Yes, sometimes

d. Yes, very often

5.) I have felt scared or panicky for no very good reason:

a. Yes, quite a lot

b. Yes, sometimes

c. No, not much

d. No, not at all

6.) Things have been getting on top of me:

a. Yes, most of the time I haven't been able to cope at all

b. Yes, sometimes I haven't been coping as well as usual

c. No, most of the time I have coped quite well

d. No, I have been coping as well as ever

7.) I have been so unhappy that I have had difficulty sleeping:

a. Yes, most of the time

b. Yes, sometimes

c. Not very often

d. No, not at all

8.) I have felt sad or miserable:

a. Yes, most of the time

b. Yes, quite often

c. Not very often

d. No, not at all

9.) I have been so unhappy that I have been crying:

- a. Yes, most of the time
- b. Yes, quite often
- c. Only occasionally
- d. No, never

10.) The thought of harming myself has occurred to me:

- a. Yes, quite often
- b. Sometimes
- c. Hardly ever
- d. Never

Scoring Key for the Edinburgh:

- 1. a.) = 0; b.) = 1; c.) = 2; d.) = 3
- 2. a.) = 0; b.) = 1; c.) = 2; d.) = 3
- 3. a.) = 3; b.) = 2; c.) = 1; d.) = 0
- 4. a.) = 0; b.) = 1; c.) = 2; d.) = 3
- 5. a.) = 3; b.) = 2; c.) = 1; d.) = 0
- 6. a.) = 3; b.) = 2; c.) = 1; d.) = 0
- 7. a.) = 3; b.) = 2; c.) = 1; d.) = 0
- 8. a.) = 3; b.) = 2; c.) = 1; d.) = 0
- 9. a.) = 3; b.) = 2; c.) = 1; d.) = 0
- 10. a.) = 3; b.) = 2; c.) = 1; d.) = 0

A score of 12 or 13 is considered significant and in need of further evaluation for postpartum depression.

## Appendix C

### Permission to Contact Spouse or Partner

I, \_\_\_\_\_, give my permission to the researcher to discuss my score of 12 or above on the Edinburgh Postnatal Depression Scale. The use of this score is a beginning point to allow my spouse or partner to discuss his experiences with my postpartum depression. This will include an audio taped interview of my spouse or partner on this topic. I have been informed that confidentiality will be emphasized in all stages of the research. I understand my identity will be protected in the reporting of the results.

If at any time during the research there is a need for further counseling, a referral to the local Mental Health Assessment Center will be given.

I understand that this participation is completely voluntary, and there will not be any change to the care I receive should he choose not to participate. I can withdraw my permission at any time during the research. I understand the researcher will be available to us as a couple, as before, to answer questions, give referrals, or engage in a therapeutic relationship.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## Appendix D

### VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

#### Informed Consent for Participants Of Investigative Projects

Title Project: Men's Perspectives on a Spouse's or Partner's Postpartum Depression

Investigator: Susan K. Roehrich, M.S., L.P.C., L.M.F.T.

The purpose of this study is to assess the experiences of men whose partners have been clinically diagnosed as having postpartum depression following the birth of their children.

As part of this study I will be asked to participate in a 60-minute audio-taped interview\_\_\_\_\_ (initial consent). The researcher will use a fictitious name to protect my confidentiality during transcription of the audiotape. I am aware that another individual may also transcribe my interview to provide a check on the interpretation of content. The study will provide data for the completion of a doctoral dissertation in the field of Counselor Education. The study will help medical personnel and clinicians assess the needs of the mother and father when a diagnosis of postpartum depression is made.

My participation in this study is of my own free will, and I may withdraw from this study at anytime. I understand that I will receive a token of appreciation upon completion of the interview in the form of a \$10.00 gift card at a store of my choosing. I also understand that my infant will receive a \$50.00 savings bond to be given when the research is complete.

I understand that every attempt will be made to keep my identity confidential. The only circumstances in which my participation in this study will be disclosed are if I am deemed to be a danger to myself or if I pose a danger to others.

I am free to withdraw from this study at anytime without penalty. I may choose not to answer questions posed to me by the researcher without penalty.

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at the Virginia Polytechnic Institute and State University and by the Department of Educational Leadership and Policy Studies.

I have read and understand this Informed Consent and the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

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Signature of participant

---

Date

## Appendix E

### Demographic Data

The following information is requested as part of this research study. Please fill out all questions.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Current age \_\_\_\_\_ Age at birth of infant \_\_\_\_\_ Spouse/Partners age at infant's birth \_\_\_\_\_

Education (please circle last grade completed) 8, 9, 10, 11, 12

Indicate highest degree earned post high school \_\_\_\_\_

Current Employment \_\_\_\_\_

Salary (annual) \_\_\_\_\_

Do you now have other children? Y or N      Number of children \_\_\_\_\_

Have you ever experienced depression? Y or N

Were you educated concerning postpartum mental health issues during any part of the

pregnancy? (For example: Lamaze class, Physician, OB Nurse) Y or N

Name of MD or other health care professional or therapist who made the diagnosis of postpartum depression \_\_\_\_\_

Appendix F

Institutional Review Board Permission to Conduct Study



**Institutional Review Board**

Dr. David M. Moore  
IRB (Human Subjects) Chair  
Assistant Vice President for Research Compliance  
CVM Phase II- Duckpond Dr., Blacksburg, VA 24061-0442  
Office: 540/231-4991; FAX: 540/231-6033  
email: moored@vt.edu

DATE: January 28, 2005

MEMORANDUM

TO: Hilda M. Getz Educational Leadership & Policy St. 0302  
Penny L. Burge Educational Leadership & Policy St. 0302  
Susan Roehrich

FROM: David Moore 

SUBJECT: **IRB Expedited Approval:** "Men's Perspectives on a spouse or partner's postpartum depression" IRB # 05-041

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective January 27, 2005.

Virginia Tech has an approved Federal Wide Assurance (FWA00000572, exp. 7/20/07) on file with OHRP, and its IRB Registration Number is IRB00000667.

## Appendix G

### Interview Questions and Prompts

1. What were some of your initial concerns when you learned your spouse or partner was pregnant?

(PROMPTS: Finances? Responsibilities? Readiness? Physical well-being of your partner?)

2. What did you know about postpartum depression before your spouse or partner was diagnosed?

(PROMPTS: Definition? Causes? Experience of a friend or relative?)

3. How did experiencing your spouse or partner being diagnosed with postpartum depression change the marital relationship for you?

(PROMPTS: Become Closer? Distant? Supportive? Easily frustrated by behaviors? Equality of relationship?)

4. How did you perceive the losses experienced when your spouse or partner was diagnosed with postpartum depression?

(PROMPTS: Friend? Lover? Confidante? Helpmate?)

5. How did you define yourself as a father when your spouse or partner had postpartum depression?

(PROMPTS: What words would you use to define yourself as a father? Does this definition differ due to the postpartum depression? If so, in what way?)

6. In retrospect what information would have been helpful to know about postpartum depression?

(PROMPTS: Symptoms? Treatment options? What to expect with medications? Resources available?)

7. What types of support were offered to you?

(PROMPTS: Therapy? Medication? Both? Neither?)

8. In what ways were these support mechanisms helpful?

(PROMPTS: Answer your questions? Did they provide a sense of hope or relief? Did you feel more capable to deal with the situation?)

9. In what ways were these support mechanisms unhelpful?

(PROMPTS: No difference in situation? Situation worsened?)

## Appendix H

## Relationship Between Research Questions and Interview Prompts

Research Question	Interview Prompt
<p>How do the participants describe the impact on the relationship with their spouses or partners when the spouse or partner is diagnosed with postpartum depression?</p>	<p>How did experiencing your spouse or partner being diagnosed with postpartum depression change the marital relationship for you? How did your spouse or partner's diagnosis influence your role as a husband or partner? What were some established pre-birth patterns or norms that were altered due to your spouse or partner's condition?</p>
<p>How do the men describe their experiences when their spouses or partners are diagnosed with postpartum depression?</p>	<p>How did you perceive the losses experienced when your spouse or partner was diagnosed with postpartum depression? What was your initial reaction to hearing about the diagnosis? What words or phrases would you associate with your personal experience in dealing</p>

How do men define themselves when a spouse or partner has postpartum depression?

How do the men perceive the help received or offered as being helpful when their spouses or partners have postpartum depression?

with your spouse or partner's diagnosis and why?

How did you define yourself as a father when your spouse or partner had postpartum depression? How did your paternal role change from before the diagnosis?

What types of support were offered to you? In what ways were these support mechanisms helpful? In what ways were these support mechanisms unhelpful?

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## Appendix I

### List of Research Questions, Categories, and Themes

#### Research Question One: Describing the Impact of Postpartum Depression on the Relationship

The Category of Anger

The Category of Helplessness

The Category of Frustration

The Category of Loss

The Theme of Emotional Deregulation

#### Research Question Two: Describing the Experience of Postpartum Depression

The Category of Fear

The Category of Being Overwhelmed

The Category of Control

The Theme of Seeking Normalcy

#### Research Question Three: Defining Self in the Experience of Postpartum Depression

The Category of Trying to Fix the Problem

The Category of Being Angry

The Category of Being Ashamed or Embarrassed

The Theme of Understanding Self

#### Research Question Four: Perceptions of Helpfulness

The Category of Being Overwhelmed

The Category of Frustration

The Category of the Need to Know

The Theme of Disappointment

## Appendix J

## Research Question Codes and Theme Development

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Research Question 1: How do the participants describe the impact on the relationship with their spouses or partners when their spouse or partner is diagnosed with postpartum depression?

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Theme Developed: Emotional Deregulation

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Initial Coding:

Second Coding:

Third Coding:

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Guilty

Anger

Anger

Frustration

Frustration

Frustration

Anger

Helplessness

Helplessness

“Increased bickering”

Withdrawal

Loss

Sarcasm

Loss

Hopelessness

Rejection

Threats to leave (marriage)

Threats to harm self

Paid more attention to baby

than spouse

Judgmental

Limited communication

with each other

Helplessness

Fear

Unequal bonding

Confusion

Loss of connection with her

On-edge moody

Loss of ability to bond (her)

Withdrawal

Lack of readiness to

deal with PPD

Loss of control

Rejected

Compartmentalized

life to cope

Worry

Self-blame

Self-doubt

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Research Question 2: How do the men describe their experiences when their spouses or partners are diagnosed with postpartum depression?

Theme Developed: Seeking Normalcy

Initial Coding:

Second Coding

Third Coding:

Desired to get out of situation

Overwhelmed

Fear

Tried to put wife's needs first

Frustration

Overwhelmed

2<sup>nd</sup> job (home) after working

Need to control

Control

all day

Increased responsibilities

Loss of normalcy (in infant's

Fear

life increased stressors)

Helpless

Increased protectiveness

No freedom

(of wife)

Anger

Panic/nervousness

Relief – "it" had a name

Overwhelmed

Less freedom

More responsibility

Care of infant increased

Anger

Need to control (environment and

decisions)

Relief at diagnosis

Little "fits" by spouse

Personality change of spouse

Inability to please

Working all day and night

(exhaustion)

Fear

Making changes to accommodate

wife

No sleep

Uncertainty

Ability to cope

Deeply involved with care of baby

Frustration

Helplessness

---

Research Question 3: How do men describe themselves when a spouse or partner has postpartum depression?

Theme Developed: Understanding Self

Initial Coding:

Second Coding:

Third Coding:

Loss of control

Worried

Ashamed

Inability to fix

Fixer

Angry

Worried

Shame

Need to control/fix

Shame

Judgmental

Embarrassment

Decision-maker

No role model

Overwhelmed

Judgmental

Guilty

Decision-maker

Anger

Self-confident in role

Frustrated

Overwhelmed

Withdrawal

Expectations changed

Need to control

Reliance on religious faith

Despair

Doubted seriousness of

symptoms

Despair

Compartmentalized

demands

Frustrated

Protective of wife

Misinformed

Process of illness

Loss (communication)

Denial

Withdrawal

No support

---

Research Question 4: How do the men perceive the help received or offered when their spouse or partner has postpartum depression?

Theme Developed: Disappointment

Initial Coding	Second Coding:	Third Coding:
Too much help	Too much	Overwhelmed
Had to ask for help	Overwhelmed	Frustration
Meals	Ignored	Need to know
Dismissed PPD	Fear	
No information given at OB visits	Shame Uninformed	
Nursing staff at hospital no help given	Resentment Too little	
Not enough print material on PPD	Frustration	
Talk with the father		
Lamaze		
Friends		
Advice-giving		
Family secret		



PROFESSIONAL EXPERIENCE

October 1997--current

Licensed Professional Counselor, Licensed Marriage and Family Therapist, and Certified Eating Disorder Specialist in private practice in central Virginia. Mental health counseling provided in the areas of female reproductive issues, infertility, miscarriage, postpartum depression, eating disorders, depression, sexual abuse, career decisions and other issues throughout the lifespan.

March 2005--March 2006

Expert Panel Member--Governor's Task force on peri-natal mood disorders in the Commonwealth of Virginia. Developed an on-line training for medical doctors, nurses and ancillary medical personnel.

March 1999--August 2001

Clinical consultant for the Postpartum Depression Support Group, Lynchburg, VA.

June 1999--August 2003

Virginia State coordinator for Postpartum Support International

PROFESSIONAL PRESENTATIONS RELEVANT TO DOCUMENT

February, 14, 2007 *Diagnosing Postpartum Depression*. University of Virginia Family Practice Residency Training. Lynchburg, VA.

October 25 & 27, 2005 *Lady Sings the Blues--Depression Issues in a Woman's Lifetime*. Virginia Baptist Hospital: Mother Baby Unit Retreat. Lynchburg, VA.

October 13, 2004 *Female Sexual Dysfunction: Biology and Psychology*, University of Virginia Family Practice Residency Training. Presented with M. Semiha Uray, M.D. Lynchburg, VA.

October 12 & 14, 2004 *How to be a Rubber Band in a Paper Clip World: Characteristics of Resiliency*. Virginia Baptist Hospital: Mother/ Baby Unit Retreat, Eagle Eyrie. Lynchburg, VA.

February 13, 2002 *Reproductive Issues for the couple: Postpartum Depression and Understanding Infertility*. Guest lecturer, Liberty University Developmental Psychology Class, Lynchburg, VA.

July 28, 2001 *Postpartum Mental Health Issues*. Presented at the American Mental Health Counselors Association Conference. Chicago, Illinois.

March 17, 2001 *Impact of Postpartum Mental Health Issues on the Family*. Presented at the American Counseling Association Annual Conference. San Antonio, Texas.

November 16, 2000 *When is it more than the blues? (Pt.1)* A workshop discussing the detection and understanding of Postpartum Mental Health Issues. Virginia Counseling Association State Convention.

March 25, 2000 *When is it more than the blues?(Pt1 &2)* Defining, detecting, and treating postpartum mental illness as a caregiver. Association of Women's Health, Obstetric and Neonatal Nurses, Virginia Section Conference; Lynchburg, Virginia.

#### PROFESSIONAL AWARDS

April 2006 *Private Practitioner of the Year*. Lynchburg Counseling Association, Lynchburg, Virginia.

PROFESSIONAL ASSOCIATIONS

American Counseling Association

American College Counseling Association

American Mental Health Counselors Association

Virginia Career Development Association

Virginia Counseling Association

Lynchburg Area Counselors Association

Virginia Association of Marriage and Family Counselors

Virginia Association of Clinical Counselors

International Association of Eating Disorder Professionals

National Association of Anorexia Nervosa and Associated Disorders

Academy of Eating Disorders

Postpartum Support International

Virginia Psychological Association

KAPPA DELTA PI (International Honor Society in Education)

