THE LIVED EXPERIENCES OF MALE PARTNERS OF WOMEN WHO HAVE PREVIOUSLY BEEN DIAGNOSED WITH POSTPARTUM DEPRESSION

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TO THE DEAN OF THE GRADUATE SCHOOL

I am submitting herewith a dissertation written by Judy Kaye Smith entitled "The Lived Experience of Male Partners of Women Who Have Previously Been Diagnosed with Postpartum Depression." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing Science.

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DEDICATION

I would like to take this opportunity to say thank you to my brother Jerry, my nephew Jason, my nephew Jeff, his wife Estella and their children Xavier, Hailey, and Hannah for your never-ending love and support. But most of all to my best friend Mary Walker who pushed me to pursue a doctorate and who has been by my side throughout my journey my most heartfelt appreciation for all of your love and support.

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ABSTRACT

JUDY KAYE SMITH

THE LIVED EXPERIENCES OF MALE PARTNERS OF WOMEN WHO HAVE PREVIOUSLY BEEN DIAGNOSED WITH POSTPARTUM DEPRESSION

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Postpartum depression (PPD) is a real complication in the postpartum period that affects 50 to 80% of all women giving birth but is not a condition that solely affects women (Beck, 2006). This qualitative descriptive phenomenological study based upon Husserl's (1960, 1970) philosophical underpinnings was designed to gain a broader perspective about the phenomenon of postpartum depression (PPD) and its impact on the family structure through the lived experiences of male partners of women previously diagnosed with the disorder. A sample of seven men recruited through a community hospital participated in face-to-face audio taped interviews that were later transcribed verbatim. The transcripts were rigorously, critically, systematically analyzed and compared to identify common thematic patterns within and between the fathers' individual experiences using a two group analysis and Spiegelberg's (1965, 1975) six step process. The men experienced overarching feelings of being vulnerable when their partners' behavior began to change in such a way that they did not recognize the person their partner had become after the birth of their baby. They began to rationalize the cause for the changes, with feelings ranging from annoyance to wanting a divorce. But as things

changed within their family, fathers felt the overwhelming need to try to make things better for their families. The second major theme was one of being helpless to know what to do or say; but whatever they did was not right or good enough which they attributed to their lack of knowledge about postpartum depression. Given time, the third overall theme of coping emerged in which they were able to identify methods of dealing with the changes that occurred in their lives when their partner was diagnosed with postpartum depression. Suggestions included the need for more one to one education with parents, Also fathers need to be patient and more attuned to the needs of their partner. The foremost clinical implication from the study is the need for healthcare providers to develop better educational methods to relate information about postpartum depression to childbearing couples.

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CHAPTER I

INTRODUCTION

Focus of Inquiry

The postpartum period is filled with extraordinary physiological, psychological, social, economic, and cultural changes in not only the life of the woman but also in the life of the family (Dudley, Roy, Kelk, & Bernard 2001; George 1996; Meighan, Davis, Thomas, & Droppleman 1999; Melrose 2010). Postpartum depression (PPD) is a condition that affects 50 to 80% of all women giving birth but is not a condition that solely affects women (Beck 2006). Fathers and other family members are affected in a variety of ways. Although the issue deserves much attention, research regarding fathers and the phenomenon of postpartum depression has been very limited (Nishimura & Ohashi 2010). By learning more about fathers' perceptions and responses to PPD, better programs may be developed to serve the needs of both women and men during the postpartum period.

Over the past several years much public and private discussion about the phenomenon of postpartum depression and its effects on the structure of the family has occurred. Postpartum depression is a diagnosable psychiatric disorder that may occur following the birth of a baby, and can be divided into three sub classifications: (1) adjustment reaction with depressed mood, formerly known as the baby blues; (2) postpartum major mood disorder, formerly known as postpartum depression; and (3)

psychotic episodes, formerly known as postpartum psychosis which is known to be the severest form of PPD (American Psychiatric Association, 2000). Postpartum depression generally occurs within four weeks to one year after delivery. The cause of postpartum depression is unknown; however, biological, psychological, and situational factors are believed to contribute to the development of the disorder.

Affective mood disorders during the postpartum period result in a wide range of emotions in women. For some women, the symptoms of PPD are mild and transient, but for other women the symptoms can become quite severe. The symptoms can progress to total incapacitation in which the woman may become physically, mentally, and emotionally unable to perform even the simplest activities of daily living. A striking characteristic of postpartum depression is how quietly it can be suffered and, if left unrecognized, in its severest form can result in tragic consequences in which physical or emotional harm to self and to the children can occur. George (1996) suggested in a clinical paper that male partners could influence a woman's ability to recover from postpartum depression but also contended that very few fathers understand the condition or know how to provide support for their depressed partner. For fathers to be able to provide the best support possible for their partners the importance of their role must be acknowledged and their contributions to care actively encouraged (LeTourneau et al., 2012b)

Problem of Study

Little is known about male partners in relationships in which new mothers experienced postpartum depression. Research studies regarding PPD primarily used quantitative research designs (Nishimura & Ohashi 2010; Ramchandani, Stein, Evans, & O'Connor 2005). Using logistic regression analysis quantitative research has shown that paternal depression was associated with employment status, history of psychiatric treatment, and unintended pregnancy (Nishimura & Ohashi 2010). In another quantitative study, logistic regression analysis demonstrated that paternal depression in fathers during the postnatal period was associated with adverse emotional and behavioral problems in children age 3-5 years with an increased risk of conduct problems in boys (Ramchandani, Stein, Evans, & O'Connor 2005). In a qualitative study that addressed fathers' experiences of living with a spouse with PPD, Meighan et al. (1999) found a major disruption in the lives of the fathers and in their relationships with their wives as a result of PPD. The male respondents experienced fear, confusion, and deep concern for their wives' well-being, but suffered from an inability to fix the problem which resulted in the fathers making many sacrifices to keep the relationship and family together (Meighan et al., 1999). The fathers also reported feeling uncertainty about the future with a spouse who seemed very different from the person they had previously known (Meighan et al., 1999). This study was designed to replicate the exploration of lived experiences of fathers whose partners had a diagnosis of postpartum depression with a previous pregnancy. Additionally, this study examined the fathers' level of knowledge about postpartum depression, including signs and symptoms as well as effective ways to support their

partners if they suspect postpartum depression. Based on findings, healthcare providers may be better able to develop educational materials as well as provide adequate support for both men and women during the postpartum period.

Rationale for the Study

Postpartum depression (PPD) is a topic that has received much attention in both public and private sectors locally, nationally, and internationally. Healthy People 2020 (2010) recognized that postpartum depression is a disabling condition for a new mother that can compromise her ability to perform self-care and care for her infant during the postpartum period. Depression can inhibit the woman's ability to relate to her infant and family which can have a profound effect on the total family structure as well as growth and development of the child (Healthy People 2010). In some instances mothers are so overwhelmed by the responsibilities of caring for the child that they begin to wonder if they are crazy; subsequently they may isolate themselves from others for fear someone else may have the same observation (Beck 1995). Their personalities change drastically, which may leave their partners confused and unsettled (Nishimura & Ohashi 2010).

The majority of the research conducted on the subject has been quantitative in nature, primarily dealing with mothers and the resultant effects of PPD on the family structure. The birth of a baby is expected to be a happy, joyous event in the life of the family, but for 50-80% of the female population giving birth, it can be a time of great frustration, anxiety, and stress (Beck 2006). However, it must be kept in mind that postpartum depression not only affects the mother, but can also profoundly affect the total family structure. Probably the most striking characteristic of postpartum depression

is that it is often secretly suffered and if it goes unrecognized, in its severest form can result in tragic consequences in which the mother may contemplate harming herself or her children including the new infant (Beck & Gable 2001; Spinelli 1998). Postpartum depression in mothers has been noted to have adverse lingering effects on the cognitive, psychological, intellectual and emotional development of children and the well-being of the entire family (Beck & Indman, 2005; Tammentie, Tarkka, Astedt-Kurki, & Paavilainen 2002).

Limited attention has been given to studying fathers' perceptions of living with a spouse who has been diagnosed with PPD. Generally the father's role has been viewed as being the provider of social and economic security for the family as well as the provider of emotional support for the mother, but very few qualitative studies have focused on fathers' experiences of living with a spouse who has been diagnosed with postpartum depression (George 1996). This descriptive qualitative phenomenological study explored both the lived experiences of fathers who have a partner previously diagnosed with postpartum depression and the knowledge base of fathers regarding the phenomenon of postpartum depression. Many studies about postpartum depression in mothers have been reported but research regarding fathers and postpartum depression has been very limited (Nishimura & Ohashi 2010). Fathers can be a great source of support for their partners who experience symptoms of postpartum depression but may lack knowledge of how to adequately support their spouse. Research has demonstrated limited knowledge of fathers' roles once their spouse has been diagnosed with postpartum depression.

As a result, this research was designed to determine the impact of the diagnosis on the family as related through the experiences of fathers of partners previously diagnosed with postpartum depression. Learning more about the experiences of fathers who lived with a partner previously diagnosed with postpartum depression, including the general knowledge base about postpartum depression, may enable healthcare providers to develop educational materials as well as provide adequate support for both men and women during the postpartum period. With better education of new parents, earlier assessment and treatment could be initiated and thereby minimize some of the more negative effects of postpartum depression on the total family structure.

Philosophical Underpinnings

Nursing, like phenomenology, seeks to understand the meaning of everyday experiences of individuals, their partners and patients served. Qualitative research is the best means to understand the world perspective of fathers who have lived with someone with postpartum depression.

Descriptive phenomenology as outlined in the writings of Husserl (1960, 1970) served as the philosophical framework for this investigation. Descriptive phenomenology is both a philosophy and a research method that is used to investigate, analyze, and describe a unique perspective of individuals who have firsthand knowledge and experience with a given phenomenon (Spiegelberg 1965, 1975). It enables scholars and clinicians to understand the uniqueness of individuals and their interactions with others and the environment through human responses (Lopez & Willis 2004). Phenomenology

represents a concurrent reflection about the meaning of phenomena and about the meaning of human life (Patocka 1996).

Central to Husserl's (1960, 1970) philosophy is that experience as perceived by human consciousness has value and should be an object of study because human actions and interactions are influenced by what people perceive to be real (Lopez & Willis 2004). Husserl (1960, 1970) believed that the scientific approach of using descriptive phenomenology was needed to bring out the essential components of the lived experiences specific to a group of people (Lopez & Willis 2004). Husserl's (1960, 1970) phenomenology is the study of essences; all problems amount to finding the ideal or true descriptive meanings that lead to a common understanding of the phenomenon under investigation. In any human experience, distinct essential structures make up a phenomenon regardless of how each individual person experiences it. The essential structures or essences emerge both in isolation and in relationship to one another by studying particulars of individual experiences with the phenomenon (Husserl 1962). An understanding of the essences requires what Husserl (1962) referred to as phenomenological reduction. When phenomenological reduction, also known as the act of identifying intentionality, is applied in research, the researcher must strive to temporarily set aside any personal beliefs, assumptions, presuppositions, and biases that may be held about a phenomenon in order to become immersed in the study and really listen to the respondent's individual experiences in order to isolate the pure phenomenon (Speziale & Carpenter 2007). Intentionality is a fundamental aspect of thought processes that reflects how one is conscious of reality. In this instance, reality is the perceived

meaning of the experience of the individual. By recognizing intentionality, Husserl (1960) indicated that researchers could be more creative in the way that they experience or think about the subject at hand.

Husserl (1960, 1970) also used the term eidetic reduction which is a process of returning to the original awareness of the phenomenon. Bracketing is a process where the investigator identifies beliefs, assumptions, presuppositions, and biases they hold about the phenomenon under study. Once biases are identified, the researcher can bracket or separate out of consciousness what they know or believe they know about the topic under investigation based on authority, tradition or positive science in order to more clearly see the true essence (or nucleus) of the experience that the individual respondents describe (Velarde-Mayol 2000). Bracketing requires the researcher to remain neutral in all aspects of the research endeavor.

Intuiting is another aspect of Husserl's (1960, 1970) theoretical framework for descriptive phenomenological study in which the researcher must imaginatively vary the information until a common understanding about the phenomenon emerges. Through imaginative variation, researchers can begin to identify relationships within and between the various descriptions of the phenomenon to define specific themes that universally describe the experiences obtained during data collection (Husserl, 1960, 1970).

Qualitative descriptive phenomenology was selected as the research methodology in order to ascertain more specific, richer data about the lived experiences of fathers whose partners have previously been diagnosed with postpartum depression. Understanding the essences of how fathers perceive their experiences with postpartum

depression may enable healthcare providers in the development of more effective educational materials and in the provision of more adequate emotional support for both men and women during the postpartum period. With better education of both new parents, earlier assessment and treatment could be initiated, which could reduce some of the more negative effects of postpartum depression on the family structure.

Research Questions

The purpose of this study was to describe the lived experiences of fathers whose partners were previously diagnosed with postpartum depression. Also this study examined fathers' knowledge regarding postpartum depression. The focus of the study addressed the following research questions:

1. What are the lived experiences of fathers whose partners were diagnosed with postpartum depression after previous pregnancies and are now experiencing subsequent pregnancies?
2. What is the level of knowledge of postpartum depression amongst fathers whose partners were diagnosed with postpartum depression after previous pregnancies and are now experiencing subsequent pregnancies?

Orienting Definitions

These definitions were used to clarify terms in this study.

1. History of postpartum depression with a previous pregnancy was documented on prenatal records of women coming into the hospital for a subsequent pregnancy.

   Women who reported taking antidepressant medications required further

evaluation of the history by the admitting nurse to confirm the presence of PPD after a previous delivery.

2. Level of knowledge about PPD was assessed through the face to face interviews with the fathers.

   Non directive questions determined what fathers knew about the common signs and symptoms of the disorder.

   Non directive questions determined what the fathers knew about effective ways to support their partners if they suspected development of postpartum depression.

   Non directive questions identified what available resources exist should she experience PPD after the current pregnancy.

3. The most common and mildest form of postpartum depression is called adjustment reaction with depressed mood, formerly known as the "baby blues." Baby blues usually occurs in 50 to 80% of new mothers following delivery (Beck 2006).

   Baby blues is usually short lived and can occur within days after delivery.

   It may last for a few hours up to1 to 2 weeks postpartum.

   Baby blues are characterized by emotional instability, but functioning is usually not impaired (Ugarriza & Robinson 1997; Beck 2006).

4. Moderate depression, also known as postpartum major mood disorder or depression without psychotic features, affects one in ten women.

   Moderate depression usually begins with the baby blues but progresses rapidly, characterized as intense and pervasive sadness with severe and labile

mood swings that are more serious and persistent than the baby blues but does not involve loss of touch with reality (Urgarriza & Robinson 1997; Beck 2006). The mother may experience anxiety, feelings of panic, and failure as well as unreasonable thoughts, pointless fears and indifferent feelings toward the new baby.

Professional treatment is required and may include counseling and medication (Ugarriza & Robinson 1997; Beck 2006).

5. Depression with psychotic episodes previously known as postpartum psychosis is the severest form of the disorder and affects one in 1,000 mothers.

   Women who are affected by psychotic episodes manifest symptoms of extreme confusion, agitation, delusions, hallucinations, total loss of touch with reality, grossly disorganized behaviors and possibly contemplation of harm to self or their infant.

   Women are usually unable to care for themselves or the infant.

   Postpartum psychosis requires immediate referral to a professional psychiatric counselor, hospitalization, and anti-psychotic medications (Ugarriza & Robinson 1997; Beck 2006)

Assumptions

Assumptions of this study included:

1. Fathers were able to fully and completely relate their experiences of living with a partner who has been previously diagnosed with postpartum depression.
2. It is culturally acceptable and/or expected that fathers in the United States want

to know about PPD and feel it is their responsibility to provide care and support to their partner if they experience PPD.

3. Fathers may not be able to describe what they know about the phenomenon of postpartum depression.

Summary

Postpartum depression can be a debilitating disorder that can significantly affect women from 4 weeks to one year after the birth of a baby. Not only does it affect the woman but it can also profoundly affect the general family structure. Research has shown that fathers can have a positive effect in facilitating their partners' recovery from postpartum depression, but fathers often do not have a clear understanding of how to do so (George 1996). The purpose of this descriptive phenomenological study was to identify the lived experiences of fathers whose partner had been previously diagnosed with postpartum depression as well as fathers' general knowledge base regarding the phenomenon of postpartum depression in order to identify possible gaps in nursing knowledge about postpartum depression that can be addressed.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this descriptive phenomenological study was to examine the experiences of fathers with a partner experiencing postpartum depression and to determine the fathers' knowledge level regarding postpartum depression. A comprehensive literature review exploring sources of *CINAHL* and Medline was undertaken. Articles deemed to be potentially relevant were retrieved using keywords, phrases, and Boolean operators of postpartum depression and fathers in an effort to determine completed research studies involving fathers with partners diagnosed with postpartum depression. Search dates were originally set from January 2007-January 2012. The selected articles were limited to those written in English that specifically dealt with both factors under study, i.e., postpartum depression and fathers. Some earlier resources dated prior to 2007 were deemed to be classic articles that have a definite bearing on the history and background of the study of postpartum depression and form a basis for the introduction of the subject. The review of the literature presents information regarding the negative impact of PPD on family structure, adverse effects of PPD on children's growth and development, PPD in fathers, effect of paternal PPD on family structure, support intervention preferences of mothers and fathers, and experience of living with a partner with PPD.

Negative Impact of Postpartum Depression on Family Structure

When dealing with PPD, one of the greatest difficulties is determining the impact of PPD on families. While investigators have found marital discord and other problems, the nature of the studies makes it difficult to categorically state that these were a result of PPD or were significant in the development of PPD. Two research studies and a meta-analysis have focused on the negative impact of PPD on the total family structure.

Boyce (1994) studied 100 mothers and fathers at six weeks, six months, and twelve months following childbirth using Cox, Holden, and Sagovsky's (1987) Edinburg Postnatal Depression Scale (EPDS). Boyce (1994) noted that a positive correlation existed between postpartum depression and marital dysfunction. Whether the identified marital dysfunction was the cause or result of postpartum depression remains unknown; however, women in this study frequently described their spouses as being uncaring and controlling while fathers often recounted difficulty understanding what their partners were experiencing (Boyce 1994).

Tammentie et al. (2002) conducted a survey study of 1000 Finnish families to investigate the prevalence of postpartum depressive symptoms as well as ascertaining their relationship to certain socio-demographic factors in mothers. At 2 months postpartum investigators administered the Edinburgh Postnatal Depression Scale (EPDS) to mothers and a questionnaire on demographic characteristics
to both mothers and fathers. The data were examined using frequency and percentage distributions as well as using Spearman Correlation Coefficient and analysis of variance to determine connections between socio-demographic factors and postpartum depression

(Tammentie et al., 2002). The study demonstrated that neither the number of pregnancies, deliveries, or children, the mode of delivery nor the age of the mother were associated with the development of postpartum depression. However, mothers with depressive symptoms that scored 13 or greater on the EPDS had fewer years of education ($r = -0.15$, $P < 0.01$), shorter duration of breastfeeding or did not breastfeed at all ($P = 0.05$), and were more dissatisfied with family life than mothers who had no symptoms of depression ($P < 0.001$). The study also demonstrated that families in which the mother had depression generally had more problems, changes, or illnesses that have a profound effect on the family; however, the result was not statistically significant (Tammentie et al., 2002).

LeTourneau et al. (2012a) performed a meta-analysis of research studies that focused on re-conceptualizing PPD as a mental health condition that not only affects the mother but also affects the whole family. An initial meta-analysis of 28 studies demonstrated that postpartum depression or major depression with postpartum onset has an overall prevalence of 15% and mothers affected by PPD are 300 times more likely to experience a reoccurrence of depression during subsequent pregnancies and two times more likely to have a relapse of major depression within five years of giving birth (LeTourneau et al., 2012a). Mothers relied heavily on their partners for support which placed additional strain on intimate relationships causing marital problems, possible separation and in some cases divorce (LeTourneau et al., 2012a).

LeTourneau et al. (2012a) performed a secondary meta-analysis of 43 studies that demonstrated 24-50% of partners also experience depression. While onset in women

usually occurs early in the postpartum period, the onset of depression in men begins later and is more gradual, often following the onset in women (Goodman 2004; LeTourneau et al., 2012a). Mothers and fathers suffering depression simultaneously reported marital difficulties as a result of poor communication and less than optimal interactions with their children; additionally, they experienced feelings of being overwhelmed, isolated, stigmatized, and frustrated (LeTourneau et al., 2012a). Other conditions associated with paternal depression included paternal aggression, intimate partner violence, substance abuse, and economic stress (LeTourneau et al., 2012a; Roberts, Bushnell, Collings, & Purdie 2006). Changes in cortisol levels and vasopressin along with environmental stressors were identified as biological risks for both maternal and paternal depression (LeTourneau et al., 2012a). Psychosocial stress in women is associated with lack of social support, low self-esteem, inability to cope, feelings of incompetence and social isolation while in men it is more related to social expectations, increased responsibilities during the postpartum period and increased emphasis on the man's role as a financial provider (LeTourneau et al., 2012a; Meighan et al., 1999).

Evidence also suggests that maternal and paternal PPD have negative consequences on parenting cognition and parent-child relationships. Depressed mothers are more likely to engage in risky parenting behaviors such as the use of corporal punishment, failure to follow up on child well-health visits, and minimization of the importance of safety in the home. They lack knowledge regarding infant development and age appropriate nurturing and are less likely to participate in literacy enrichment activities (LeTourneau et al., 2012a). Depressed fathers demonstrated less warmth and

more psychological control and are also disengaged in literacy building activities with their children (LeTourneau et al,. 2012a).

Studies further demonstrated that maternal PPD has negative consequences on infant and child development that result in more difficult child temperament, poor health, sleep related disorders, abuse or neglect, failure to thrive, decreased intellectual and social-emotional development, delayed motor development and less secure attachment to their mothers as well as lower levels of self-esteem and long-term behavioral problems (LeTourneau et al., 2012a; Ramchandani et al., 2005). Paternal PPD seemed to have more impact on children's social competencies. However, the meta-analysis failed to reveal any other domains of father-child interactions relative to paternal PPD or research that specifically demonstrated the effects of PPD on siblings within the family unit (LeTourneau et al., 2012a).

Based on this meta-analysis, the negative effects of maternal and/or paternal PPD have serious, long-term implications for the whole family; consequently mental health interventions need to follow a family centered approach rather than focusing solely on the mother. Thorough screening is believed to be a key component in identifying and diagnosing maternal and paternal PPD. While the literature abounds with information that focuses on the treatment of maternal PPD, there has been little intervention research specifically designed to target male partners of mothers with PPD (LeTourneau, et al., 2012a).

Adverse Effects of Postpartum Depression on Children's Growth and Development

There is growing evidence that maternal postpartum depression can also have adverse lingering effects on the cognitive, psychological, intellectual, and emotional development of children. Two studies have discussed the relationship between postpartum depression and adverse effects on children's growth and development. In a descriptive study, Kersten-Alvarez et al., (2012) compared the growth and development of children of 29 mothers with a diagnosis of postpartum depression with the growth and development of 113 community children whose mothers did not experience postpartum depression in the Netherlands. Mothers with PPD who had an infant up to twelve months of age were recruited from eight mental health centers (Kersten-Alvarez et al., 2012). Inclusion criteria were a diagnosis of major depressive episodes postpartum based on the DSM-IV criteria and/or a score of greater than 14 on the Beck Depression Inventory, fluency in Dutch, and receipt of professional outpatient treatment for their depression (Kersten-Alvarez et al., 2012). Mothers excluded from the study were those with psychotic episodes, manic depression and/or substance abuse history. During the early school age period the children were tested using several instruments including a Dutch translation of the California Q-set to measure the children's ego resiliency which relates to the child's ability to cope with stress and regulate emotions, a subscale of the Stress Response scale to measure how the children adjusted to stress in their school settings, and the Puppert Interview adapted for 5-7 year olds to measure self-esteem (Kersten-Alvarez et al., 2012). In addition, a Dutch translation of the Peabody Picture Vocabulary Test Revised was used to measure verbal intelligence; peer social competence was assessed

with the Preschool Social Behavior Questionnaire; and, behavior problems were assessed using the Achenback forms (Kersten-Alvarez et al., 2012). One way ANOVAs and Chi Square Tests were used to examine differences between the sample groups in terms of demographics as well as to identify potential risk factors that may be associated with depression. Results demonstrated that children whose mothers had postpartum depression had lower ego resiliency ($F = 4.74$, $p < .05$, $n^2_p = 0.04$); did not cope as well with stress, regulate emotions as well, or interact with peers as well in early school ($F = 8.74$, $p < .01$, $n^2_p = 0.08$); had lower peer competence ($F = 9.48$, $p < .01$, $n^2_p = 0.08$); and, had lower school adjustment ($F = 4.80$, $p < .05$, $n^2_p = 0.04$) than the community sample children. Girls whose mothers had postpartum depression also demonstrated lower verbal intelligence ($F = 6.50$, $p < .05$, $n^2_p = 0.12$) (Kersten-Alvarez et al., 2012).

Gress-Smith, Luecken, Lemery-Chalfant, and Howe (2012) investigated postpartum depression prevalence in relation to its impact on infant health, weight gain, and sleep patterns in 132 low-income predominantly Hispanic women and infant pairs. The mothers were interviewed in person at 24-48 hours after delivery and then by phone at 5 and 9 months postpartum. Higher depressive symptoms in women at 5 months significantly correlated with less weight gain in the infant from 5-9 months ($p = .002$), increased infant physical health concerns ($p = .05$), and increased nighttime awakening of the infant at 9 months ($p = .001$) (Gress-Smith et al., 2012). Results suggested a striking prevalence of clinical depression symptoms through 9 months postpartum in low-income Hispanic women. The researchers further concluded that postpartum depression has significant ramifications that affect infant physical growth and health as evidenced by

less weight gain, increased physical health issues, and increased night awakening of the infants (Gress-Smith et al., 2012).

As indicated by these research studies, both short and long term physical, cognitive, psychological, intellectual, and emotional issues can affect children when their mothers have been diagnosed with PPD. Some factors that affect the children were readily apparent during the first year postpartum such as failure to thrive, multiple illnesses and delayed growth and development. Other factors such as ego resiliency, failure to cope with stress or regulate emotions, inability to interact with other children appropriately, lower peer competence and lower school adjustment were found to be long term effects of having a mother diagnosed with PPD. Lower verbal intelligence was also noted with female children when their mothers were previously diagnosed with PPD.

Postpartum Depression in Fathers

While postpartum depression is generally associated with mothers, research studies have revealed that a significant number of male partners may also experience postpartum depression after the birth of a child and that paternal depression is significantly linked to living with a women suffering from the PPD. Ballard, Davis, Cullen, Mohan, and Dean (1994) used Cox, Holden, and Sagovsky's (1987) Edinburgh Postnatal Depression Scale (EPDS) to study 200 postpartum couples in England. They performed the surveys using the EPDS tool at 6 weeks postpartum and again at 6 months postpartum and demonstrated that 27.7% of mothers and 9% of fathers screened positively for depression at 6 weeks postpartum. At 6 months postpartum, 25.7%

of mothers and 5.7% of fathers were depressed (Ballard et al., 1994). They concluded that postpartum fathers are more likely to have depression at both 6 weeks and 6 months postpartum if their partner also had postpartum depression.

Goodman (2004) performed an integrative review of twenty research articles from 1980 to 2002 noting that the incidence of paternal depression ranged from 24-50% of men whose partners were also experiencing postpartum depression. The presence of maternal depression was found to be a significant indicator in predicting the development of paternal depression during the postpartum period in many articles.

Lovestone and Kumar (1993) studied three groups of men. The participants were divided as follows: one group was comprised of men whose wives had been diagnosed with postpartum induced psychiatric disorders; the second group had wives who had a long term psychiatric history; and the third was a control group of men whose wives did not have diagnosed depressive symptoms. Out of the 24 spouses of women with postpartum psychiatric issues admitted to a mother-baby unit over the first 12 months following the birth of the baby, one-half of the men manifested psychiatric illness as defined by DSM-III criteria (Lovestone & Kumar 1993). Other associations with psychiatric illness in these men included a history of chronic social problems, previous psychiatric illnesses, and poor relationships with their own father (Lovestone & Kumar 1993). As noted, the incidence of psychiatric illness was higher in the men whose wives had been diagnosed with postpartum induced psychiatric disorders than those whose wives comprised the long term psychiatric history group and the group that did not have depressive symptoms (Lovestone & Kumar 1993).

Pinheiro et al. (2006) performed a population based study in Brazil to determine if paternal postpartum depression was associated with maternal postpartum depression. A total of 386 couples were assessed from the sixth to the twelfth week postpartum for demographic characteristics, alcohol misuse and for depressive symptoms using the Beck Depression Inventory. The results of the study showed a significant correlation (Spearman's Correlation: $p < 0.01$) between paternal postpartum depression and both alcohol related disorders as well as the severity of the mother's depression. The authors concluded that depressed fathers who are living with depressed mothers both struggle in their relationship at a very vulnerable time in the life of the family (Pinheiro et al., 2006).

Roberts et al. (2006) used a cross sectional survey of a group of men with partners who had postpartum depression and a control group of men whose partners did not have PPD. The study was conducted in the greater Wellington region of New Zealand that included the capital city and its surrounding area (Roberts et al., 2006). The study group consisted of 58 men who had a partner with PPD and a control group of 116 men whose wives did not have PPD for an effect size of 0.56. The researchers used six measures of psychological health. The group of men that had a partner with postpartum depression reached pre-determined thresholds indicating psychological disturbance during the postpartum period. The statistical results using the Beck Depression Inventory-II (BDI-II) had a significance of ($p = 0.049$) and the Beck Anxiety Inventory (BAI) with a significance of ($p = 0.36$). The General Health Questionnaire – 28 (GHQ –28) demonstrated a significance of ($p = 0.027$), and the Somatic and Psychological Health Report (SPHERE) somatic and sleep disorders tool had a $p = 0.043$. Symptoms of

depression and anxiety demonstrated a significance of ($p = 0.28$) and all combined scores had a significance of ($p=0.38$). Alcohol use was assessed using the Alcohol Use Disorders Identification Test (AUDIT) ($p = 0.9$). Symptoms of aggression were measured with the Aggression Questionnaire (AQ) which included subscales for anger, hostility, physical aggression, and verbal aggression (Roberts et al., 2006). Men who had wives diagnosed with postpartum depression had poorer psychological health as evidenced by the presence of more symptoms of depression, non-specific psychological impairment, fatigue and aggression (Roberts et al., 2006). Men in this group were also more likely to have three or more co-morbid psychological disturbances. No discernible difference in anxiety and alcohol use between the study group and the control group were noted.

Paulson and Bazemore (2010) performed a meta-analysis of 43 articles originating in 16 countries published between January 1980 and October 2009 that assessed depression in fathers during pregnancy, the first year postpartum or both. Rates of paternal depression were higher during 3-6 months postpartum and demonstrated a moderately positive correlation with maternal depression ($r = 0.308$; 95% CI, 0.228-0.384). Paternal depression was identified as a significant public health concern with the highest rates of prenatal and postpartal depression occurring in the United States (14.1% versus 8.2% internationally) (Paulson & Bazemore 2010). The study further elaborated that prevalence, risk factors, and effects of depression among new fathers is poorly understood and has until recently been ignored by researchers (Paulson & Bazemore 2010).

The aforementioned studies suggest paternal depression associated with having a partner who was diagnosed with postpartum depression was a significant public health concern in the United States at a rate of 14.1% as opposed to the international rate of 8.2%. The incidence of paternal depression identified through these research studies ranged from 24-50% of men whose partners were also experiencing postpartum depression. The presence of maternal depression was found to be a significant indicator in predicting the development of paternal depression during the postpartum period in many studies. Based on these studies, the development of paternal postpartum depression transcends different cultures and significantly correlates with living with a spouse who has been diagnosed with postpartum depression. Therefore, the development of paternal postpartum depression could be a barrier to the father in being able to adequately support and positively affect the recovery of a partner who has been diagnosed with postpartum depression.

Effect of Paternal Postpartum Depression on Family Structure

Attention has also turned to researching paternal postpartum depression and its effect on the family structure with or without a partner suffering from the disorder. Ramchandani et al. (2005) conducted a longitudinal study in England to determine the effects of maternal and paternal postpartum depression on the growth and development of the children using the Edinburgh Postpartum Depression Scale (EPDS). Assessments were carried out at 8 weeks postpartum with both mothers and fathers and again at 21 months with only the fathers. The Rutter Revised Preschool Scales were used at ages 3-5 years to assess for children's behavioral and emotional problems as reported by the

mother (Ramchandani et al., 2005). A total of 8,431 fathers, 11,833 mothers, and 10,024 children participated in the study. Scores greater than 12 on the EPDS for mothers and fathers were significantly correlated (Pearson Correlation 0.27, $p < 0.001$). Paternal depression was strongly associated with an increased risk of behavioral problems at age 3-5 years on the Rutter Revised Preschool Scales (OR 2 - 19, 95% CI 1.55-3.08) which suggested that paternal depression during the early months of an infant's life might be a risk factor for adverse development in children (Ramchandani et al., 2005). Maternal depression was significantly associated with high problem scores across all domains of child psychological functioning tests with an odds ratio of (3.10 (2.32-4.14) (Ramchandani et al., 2005). They also concluded that the association between paternal depression and child behavior problems was stronger in boys than in girls (likelihood ratio test 5.26, p=0.22) (Ramchandani et al., 2005).

Support Intervention Preferences of Mothers and Fathers

This research study included the determination of components of fathers' knowledge with regard to PPD as well as improved support for both mothers and fathers in the postpartum period. Doucet, LeTourneau, and Blackmore (2012) conducted a multisite, exploratory, qualitative descriptive research study to explore the perceived support needs and preferences of women diagnosed with postpartum psychosis (PP) and their partners. The respondents consisted of 7 mothers from Canada, 2 mothers from the United States, 7 fathers from Canada and 1 father from the United States. One to one semi structured in depth interviews over the telephone, in person, or in a mutually agreed upon setting were conducted. The audiotaped interviews lasted approximately 45 minutes

to 2 hours with the verbatim transcription of the tapes occurring as soon as possible after the interviews. Mothers identified that they needed instrumental or physical help with basic care needs, informational, emotional and affirmation support as well as help with generic parenting skills and serious mental illness (Doucet et al., 2012). Mothers were most interested in knowing about treatment options, medication safety when breastfeeding, long-term prognosis, risk of relapse with future pregnancies, birth control methods, and community support (Doucet et al., 2012). All mothers preferred to have one to one support from professionals and their partners immediately after symptoms of postpartum psychosis started and group support once their symptoms improved. All mothers and fathers expressed the desire for more information about postpartum psychosis. The study also demonstrated that fathers played a significant role in supporting their partners experiencing postpartum psychosis (Doucet et al., 2012). Fathers conversely felt they needed more information on the best methods to support their partners as well as ways to deal with stress from being the primary support person for their partner, their infant, and in some cases the other children at home (Doucet et al., 2012). Doucet et al. (2012) concluded that health care providers need to be proactive in providing both mothers and fathers with information regarding potential causes of postpartum psychosis, early symptoms, general course of illness, and rates of reoccurrence with subsequent pregnancies as well as spending adequate time and keeping them both involved in every stage of treatment.

LeTourneau, Duffett-Leger, Dennis, Stewart, and Tryphonopoulos (2011) conducted a qualitative pilot study with seven fathers from the New Brunswick and four

fathers from the Alberta provinces of Canada. One to one phone interviews lasting approximately one to two hours were conducted using a semi-structured interview guide to collect demographic and exploratory data on fathers' experiences, support needs, and available resources as well as barriers in accessing resources, support and support intervention preferences (LeTourneau et al., 2011). During the interviews fathers described experiencing a wide range of emotions including self-doubt, helplessness, worry, depression, anxiety, sleep disturbances, fatigue, irritability, sadness, changes in appetite, and thoughts of harming themselves or their babies when their partners were experiencing postpartum depression (LeTourneau et al., 2011). Many voiced uncertainty about their ability to help their partner and felt that they were ill prepared for the possibility of PPD developing. The most common barriers to accessing support were fathers' lack of awareness and understanding about the phenomenon of PPD as well as helplessness in doing anything about their partners' PPD, knowledge about PPD resources, difficulty reaching out to others, and fear of the stigma associated with PPD (LeTourneau et al., 2011). LeTourneau et al. (2011) concluded that their study contributed to the understanding of the impact of PPD on fathers but that more research was needed with an expanded emphasis on the fathers' views of preferred supportive interventions for both fathers and mothers.

In a follow up study LeTourneau et al. (2012b) performed a qualitative, community based research study throughout Canada in order to describe the support needs and preferences for support of fathers whose partners had PPD. One to one phone interviews were conducted with 40 fathers between 2009 and 2011. The interviews were

audiotaped followed by verbatim transcription. Each transcript was reviewed by a minimum of two team members and themes were identified. Group meetings of the team were also held at regular intervals to review the data and determine if more themes emerged from the comprehensive reviews of the transcripts. To ensure adequate rigor, an audit trail was created by recording decisions as they occurred. From the interviews, fathers unanimously agreed that the primary barrier to early diagnosis and treatment of PPD in their partners was due to inadequate public knowledge and awareness about PPD (LeTourneau et al., 2012b). It was further concluded that fathers regarded themselves as an important source of support for the partner suffering from PPD but they also desired informational, emotional, objective, nonjudgmental, and sympathetic support of professionals as well as friends and family (LeTourneau et al., 2012b). Support preferences included interventions of sharing information about PPD and practical tips on how to cope with their partners' PPD. Postpartum depression intervention programs should be designed to reach a broad spectrum of parents as well as being multifaceted, accessible, and flexible (LeTourneau et al., 2012b). Examples of resources that would be beneficial included face to face offerings as well as information through telephone support lines or through the internet.

In summary, fathers recognized that a primary barrier to early diagnosis and treatment of PPD in their partners was due to inadequate public knowledge and awareness about PPD. In order to minimize the devastating effects of PPD on the family structure, mothers and fathers need more informational, emotional, objective, nonjudgmental, and sympathetic support of professionals as well as friends and family

during the first year following the birth of a baby. The articles further defined a need for more education to the public that fosters intervention programs that are multifaceted, accessible, and flexible. Such programs may include having face to face group sessions, telephone information, and the use of the internet to reach a broad spectrum of the public.

Experiences of Living with a Partner with Postpartum Depression

As noted from prior articles reviewed, the greatest majority of research on postpartum depression and fathers has been quantitative in nature. Minimal attention has been given to conducting qualitative research on the subject. One qualitative study focused on fathers living with someone diagnosed with postpartum depression (Meighan et al., 1999). The phenomenological study involved audiotaped, nondirective face to face interviews that lasted 1-2 hours with 8 men who described their fears, confusion, and concern for their wives who had been diagnosed with postpartum depression. Some of the respondents were recruited through their wives who had been involved in a previous study and others were recruited through health professionals or by word of mouth (Meighan et al., 1999). The following themes emerged from the interviews: she becomes an alien; he attempts to fix the problem; he makes sacrifices; his world collapses; and he experiences losses that include lost control, lost intimacy, and altered relationships (Meighan et al., 1999).

She becomes an alien was described as the wife's personality suddenly and drastically changing in such a way that the fathers had difficulty in both recognizing and relating to this new person (Meighan et al., 1999). Another theme that emerged was *he attempts to fix the problem*, to find the cause of the problem, and help his spouse to

recover. However, most of the respondents also shared that nothing they did seemed to help (Meighan et al., 1999).

Eventually the men realized that they could not fix the problem, so then *he makes sacrifices* of his own needs in order to help the family get through this crisis. The men assumed increased responsibilities in caring for their wives and children while continuing to work (Meighan et al., 1999). After prolonged periods of stress *his world collapses* around him. The fathers felt angry and resentful over the situation but often felt guilty for feeling that way (Meighan et al., 1999).

Respondents described their losses as *loss of control* over the situation in which they felt helpless, frustrated, angry, alone, anxious and fearful she might harm herself or the children (Meighan et al., 1999). The respondents further described a *loss of intimacy* with their spouse during the period of time she was experiencing postpartum depression. Even when the spouse recovered from PPD, the fathers reported that their relationship with their wife had drastically changed and was never quite the same as it was before PPD (Meighan et al., 1999). The study also reported that more than 50% of the respondents felt that health care professionals and other people would tend to minimize the problem and ignore the couples' concerns which left them feeling isolated and alone when postpartum depression is indeed a very real problem and a crisis for the family (Meighan et al., 1999).

Summary

Collectively from the studies cited in this review of the literature, postpartum depression is a debilitating condition that transcends gender, age, ethnic backgrounds,

cultural boundaries, and economic groups of people. The literature review has documented the fact that postpartum depression can have a negative impact on family structure resulting in marital dysfunction. Mothers with depressive symptoms tend to have fewer years of education, a shorter duration of breastfeeding or no breastfeeding at all and more dissatisfaction with family life than mothers who had no symptoms of depression. Mothers with depression generally had more problems, lifestyle changes, or illnesses that also had a profound effect on the family.

Other studies noted that maternal postpartum depression had an adverse effect on the cognitive, psychological, intellectual, and emotional growth and development of their children. Results demonstrated that children whose mothers had postpartum depression had lower ego resiliency, did not cope well with stress, regulate emotions well, or interact with peers in early school, had lower peer competence and lower school adjustment than the community control sample children. Girls whose mothers had postpartum depression also demonstrated lower verbal intelligence. Postpartum depression can have significant ramifications that affect the physical growth and health of infants as evidenced by less weight gain, increased physical health issues, and increased night awakening in infants.

While postpartum depression is generally associated with mothers, research studies now document that a significant number of male partners (approximately 24-50%) also experience postpartum depression after the birth of a child and that paternal depression is significantly linked to living with a women suffering from the disorder. Mothers and fathers who suffered from depression simultaneously reported more marital difficulties as a result of poor communication and less than optimal interactions with their

children. Additionally, they experienced feelings of being overwhelmed, isolated, stigmatized, and frustrated. Conditions frequently associated with paternal depression included paternal aggression, intimate partner violence, substance abuse, and economic stress. Paternal postpartum depression hinders the father's ability to adequately support and positively affect the recovery of a partner who has also been diagnosed with postpartum depression. A strong positive correlation between paternal depression during the early postpartum period and child behavioral problems especially in boys between the ages of 3 and 5 were also demonstrated in the review of the literature.

From the articles that have been reviewed it has been noted that a primary barrier that fathers face to early diagnosis and treatment of PPD in their partners was due to inadequate public knowledge and awareness about PPD. It is also clear that health care providers need to be much more proactive in providing both mothers and fathers with information regarding potential causes of PPD, early symptoms, general course of illness, and rates of reoccurrence with subsequent pregnancies as well as spending adequate time and keeping them both involved in every stage of treatment.

In conclusion, the majority of research on postpartum depression and fathers has been quantitative in nature. Minimal attention has been given to conducting qualitative research that describes the lived experiences of fathers whose partner has been diagnosed with postpartum depression. Fathers have often been overlooked and underestimated in research regarding postpartum depression. Therefore, this descriptive, phenomenological study sought to describe the lived experiences of fathers whose partners have previously been diagnosed with postpartum depression as well as to determine the knowledge base

that fathers had about PPD including common signs and symptoms of the disorder, and effective ways to support their partners if they suspected development of PPD. By conducting more research about the general knowledge base that fathers have about PPD, healthcare providers may be better able to develop educational materials as well as provide adequate support for both men and women during the postpartum period. With better education of new parents, earlier assessment and treatment could be initiated and thereby minimize some of the more negative effects that postpartum depression has been shown to have on the total family structure.

CHAPTER III

PRODEDURE FOR COLLECTION AND TREATMENT OF DATA

Qualitative descriptive phenomenological studies are conducted when little is known about an area of study (Burns & Grove 2005) Descriptive phenomenology as a research method involves rigorous, critical, systematic investigation of a specific phenomenon that is free of bias for the purpose of deriving the structure or essence of the actual day to day experiences of persons who have firsthand knowledge about the phenomenon under study. This descriptive phenomenological study was designed to describe the experiences of fathers who have lived with a partner with a prior diagnosis of postpartum depression. This study also explored the father's general knowledge base regarding the phenomenon of postpartum depression in order to identify possible gaps in patient education that need to be addressed.

Postpartum depression has been a problem of concern for women for a number of years. Little research has been published on the subject of fathers' actual experiences of living with a partner diagnosed with postpartum depression that explores the richness, breadth, and depth of these experiences. This chapter contains a detailed description of the methodology that was employed in the conduct of the study that was congruent with the philosophical underpinnings**.**

Setting

The setting for the study encompassed the labor/delivery/postpartum units of a 285 bed facility in southeast Texas that averages approximately 1500 births per year. Approximately 10% of pregnant woman present to the facility with a history of postpartum depression and/or taking antidepressant medications. The structured audio taped, face to face interviews with the fathers took place as soon as possible post-delivery in secluded private rooms adjacent to the nursing units. Privacy and quiet were maintained while allowing the respondent the opportunity to comfortably relax in order to honestly relate their previous experiences with the phenomenon. Female partners were not present during the interview process since the major focus of the study was on the fathers' firsthand experiences of living with a partner who has had PPD and on their knowledge base of PPD.

Sample

The sample for this descriptive phenomenological research study included fathers ages 18 and above whose partners recently delivered and had been diagnosed with postpartum depression following a previous pregnancy. It was anticipated that 20 fathers would be interviewed, but the final sample size for the study was determined by saturation of developing themes. In the study by Meighan et al. (1999), a total of seven fathers were interviewed in order to reach saturation. When the interviews failed to reveal any new pertinent information based on the stories related by the respondents, the final sample size of this study was determined and ultimately reinforced as being appropriate at seven respondents.

Inclusion criteria included: (a) fathers who were ages 18 and above and their partner had recently delivered a baby and had been previously diagnosed with postpartum depression; (b) active involvement by the father in the family structure at the time the diagnosis of PPD was made; and (c) ability to understand, speak, read, and write in English. Purposive sampling was used to ensure that a diverse, representative sample was obtained. Criteria of exclusion included fathers: (a) whose partners had a complicated previous or current pregnancy, labor and/or delivery; (b) whose infants required neonatal intensive care or intermediate nursery care on oxygen; (c) whose partners were previously diagnosed with psychotic episodes, manic depression, and/or substance abuse disorders; and (d) with a family history of depression or who take anti-depressant medications themselves.

Sampling Method

The sampling method utilized in this descriptive phenomenological research study was purposeful and criterion related (Creswell 1998). Events, incidents, and experiences of people rather than the people themselves are the substance of purposeful sampling in qualitative research (Sandelowski 1995). Utilizing descriptive phenomenological research methods, structured face to face audio taped interviews were conducted in a non-directive manner. The respondents were encouraged to describe their experiences as well as their perceptions about the experiences of living with a spouse who had previously been diagnosed with postpartum depression. Repeated analysis of verbatim transcripts of the audio tapes compiled during the interview process were used to describe the phenomenon

as experienced by the respondents without theories, unexamined preconceptions, conjecture or presuppositions as to the cause of the phenomenon.

Protection of Human Subjects

Prior to data collection, approval from the Institutional Review Boards (IRB) of the Texas Woman's University and the healthcare facility were obtained. (See Appendix A.) Participation in the study was strictly voluntary. All respondent names and personal information were coded with pseudonyms and maintained in a private locked file in the researcher's office. As soon as IRB approval was received from both the University and the healthcare facility, data collection began. None of the interviews elicited negative, sad, or distressing emotions for the respondents, so no interview had to be terminated prematurely. Each participant was provided with information about postpartum depression that included a list of available resources for additional information following each interview.

Recruitment of Participants

Prenatal records were reviewed and flagged when there was a history of postpartum depression. Nurses on the nursing unit also assisted in identifying maternity patients with PPD history based on the hospital admission screening process. The Health Insurance Portability and Privacy Act (HIPPA) release form was explained to the respondents and signed. The nurses then notified the researcher of the patient's admission. As soon as possible after the delivery, the researcher approached the patient and spouse to explain the study, including the process for data collection and to determine eligibility of the father to participate in the study. In some instances the mother

delivered and had progressed through the system before the researcher was notified of their presence. In those cases, phone follow-up calls by staff nurses were conducted post discharge to check on their status post discharge and to elicit interest in participating in the study. If the father was eligible and willing to participate in the study, an appointment was made with the father at which time a combined informed consent for participation and consent to record interviews was explained and signed. A Demographic Data Sheet was also completed on each respondent from which generalizable information about the respondents was correlated with age, race, educational level, income, number of children, type of delivery, types of complications, family history of depression and antidepressant therapy of partner (Appendix B).

Data Collection

The study was conducted over a six month period. Data collection involved the use of an Interview Protocol that included several open-ended nondirective interview questions designed to elicit specific descriptive information about the father's experiences of living with a partner who had a prior diagnosis of postpartum depression (Appendix C).

Data collection during the interview process took approximately sixty minutes. Two audio tape recorders were utilized during the data collection process to minimize the risk of equipment malfunction during the interview process. In this phenomenological study, active reflective listening was employed during the interview process and verbatim transcription of the audio taped interviews were completed as soon as possible after the

conclusion of each interview to confirm common themes or patterns in the respondents' stories.

Data Analysis

Spiegelberg's (1965, 1975) six processes for descriptive phenomenology was utilized for its compatibility with the theoretical framework described by Husserl (1962). Like Husserl (1960), Spiegelberg's (1965, 1975) methodology gives attention not only to relationships between but also essences within the phenomenon. Based on descriptive phenomenological research principles, the interviews were conducted in a nondirective manner and the respondents were encouraged to describe their experiences as well as their perceptions about the experience in their own words. The first step in the process involved the researcher becoming totally immersed in the phenomenon. Much like Husserl's (1960) bracketing of the phenomenon, Spiegelberg's (1965, 1975) first process, known as intuiting, occurred when the researcher began to know more about the phenomenon as it was described by the respondents, without theories, criticism, evaluation, unexamined preconceptions, conjecture or presuppositions as to the cause of the phenomenon (Spiegelberg 1965, 1975). Active listening skills were employed during each individual interview process in order to develop reflective inquiry that allowed for a more thorough understanding of the respondent's point of view. By utilizing reflective listening skills during the interviews, confirmation of the accuracy of the information obtained was determined immediately. Phenomenology of appearances gave attention to identifying the different ways the phenomena appeared and determining if there was a

particular order in which the phenomenon was described by the respondents (Speziale & Carpenter 2007).

In Spiegelberg's (1965, 1975) third step, the researcher did phenomenological analyzing to isolate the essence of the phenomenon being studied and to look for relationships of components that relate to the phenomenon. Phenomenological analyzing and phenomenology of essences involved repeatedly probing through verbatim transcripts of interviews to identify common essences or themes while seeking to establish patterns of relationship shared within the phenomenon. In this core concept of Spiegelberg (1965, 1975), the use of imagination and freely varying the data helped to determine what was essential information from what may have been accidental information. Such variation promoted the attainment of richness, breadth, and depth of the information. In this step, the researcher read the transcribed data from interviews and repeatedly reviewed what the respondents had described. The multiple perspectives derived from the individual interviews created multiple realities by which descriptive phenomenology was employed to analyze the derived essences in order to develop an understanding of what actually constituted the phenomenon (Shellman 2004). The process involved repeatedly probing through the verbatim transcripts of the recorded interviews to identify common essences or themes that established patterns of relationship shared within the phenomenon. As the researcher began to identify the components of the phenomenon, relationships within and between common themes or essences began to emerge. However, Spiegelberg (1965, 1975) cautioned researchers to avoid making premature attempts to describe the phenomenon, which is a common

problem associated with this type of research. The researcher also had to pay particular attention to the different ways in which essences appeared within and between the respondent interviews. Phenomenological analyzing necessitated that the researcher become immersed in the generated data and dwell with the data as long as necessary to ensure a pure accurate description of the phenomenon, (Speziale & Carpenter 2007).

Constitutive phenomenology was the process in which the phenomenon evolved from first impressions into a more global perspective of the phenomenon. Initially identified thoughts about the data were limited to two to three rather general ideas but gradually evolved into three distinct themes with each one having between two and four associated subthemes. As a result of the on-continuing analysis of the data, the phenomenon actually began to take shape in the researcher's consciousness.

Reductive phenomenology occurred concurrently throughout the research study; the researcher continually confronted and set aside personal biases, assumptions, and presuppositions in order to obtain the purest description of the phenomenon being investigated. This process like Husserl's bracketing was critical in order to preserve the researcher's objectivity during phenomenological studies.

Spiegelberg's (1965, 1975) phenomenological describing is the process in which the primary focus is to communicate the critical elements of the phenomenon to others through journal articles, oral, and poster presentations. The description of the phenomenon is based on the generated elements, essences, or themes derived from extensive analysis of the data obtained during the interview process. The elements,

essences and/or themes are described singularly and then within the context of their relationship to one another (Speziale & Carpenter 2007).

Data analysis was a continual on-going process as each interview was completed. The tapes were transcribed verbatim and were repeatedly analyzed in an attempt to isolate common emerging thematic statements. Themes identified from the line by line analysis were written and re-written to develop a more holistic interpretation of the meaning of the data obtained during the interviews that would truly describe the lived experiences of fathers whose partners had previously diagnosed with postpartum depression as well as the knowledge base of the fathers with regard to PPD.

Methodological rigor was maintained through the establishment of credibility, transferability, dependability, and confirmability (Lincoln & Guba 1985). Credibility was established through prolonged engagement, persistent observation, and triangulation. Prolonged engagement involved taking sufficient time to learn the culture of respondents, testing for misinformation introduced by distortions either of the self or of the respondents that might alter the data, and to provide the investigator the opportunity to build trust (Lincoln & Guba 1985).

The investigator has worked at the healthcare facility for 16 years and was familiar with the culture of the institution as well as the various cultures of the clients who were admitted to the facility on a regular basis. Building trust was a time consuming process that involved ensuring that confidentiality of each respondent was maintained through the use of pseudonyms, as well as coding of each interview and audio tape. Files and audio tapes created during the interview process were maintained in a locked file in

the investigator's office. Biases and hidden agendas had to be laid aside to ensure that the truest essences of the information supplied by the respondents would become evident during the analysis process. The interests of the respondents were honored and the respondents had input into influencing the inquiry process through the use of reflective listening skills in which the investigator fed information obtained during the interview back to the respondent to ensure that the information was what the respondent intended to convey. Persistent observation involved sorting out irrelevant information from atypical information that may indeed have relevancy to the study.

Triangulation enhanced credibility. During the interviews, the researcher fed back information to the participants to confirm the meanings and intent of the statements each father made as they answered the non-directive questions. Each interview was audio taped for further review of information and validation of the stories related by the respondents during verbatim transcription of the tapes. The verbatim transcripts were reviewed by the researcher and outside observers to determine consistency of the information and to confirm the respondents' views on the subject. The use of a two-group line-by-line analysis of the transcripts was the primary method that provided triangulation. One group consisted of two researchers familiar with descriptive qualitative phenomenology as a research method and the second group consisted of two nurse researchers familiar with the phenomenon of postpartum depression. Significant statements were extracted from each description. The statements were formulated into meanings and clustered into global themes for comparison. During this phase of analysis large post it note pads as well as individual post it notes were employed to ensure that the

statements would be categorized under the best overall global theme identified. If a new theme was identified from the statements, the small post it notes with key descriptions of experiences was moved around until the best possible fit was found. The completed thematic diagrams were presented back to the expert researcher groups for feedback and validation of accuracy. Such a process was not designed to seek a compromise among the group members but rather it strived to develop the most correct interpretation of the information based on the actual words of the respondents. The process involved using evidence obtained from the interviews, the audio tapes, the verbatim transcripts and the two group analysis to shed light on the specific themes or perspectives identified (Lincoln & Guba, 1985).

Decisions regarding transferability were enhanced through rich, thick description of the participants, the setting, the process for recruitment, and the analysis of the data. Such descriptions enable readers to transfer the information to other settings and ultimately determine whether the findings of the study are transferrable based on common shared characteristics (Creswell 1998).

Dependability and confirmability were determined through an audit process using an outside person not associated with the study. The auditor asked the researcher hard questions about methods, meanings and interpretations. Meetings with the auditor helped the researcher to look at the data honestly and openly to prevent personal biases from entering into the research (Creswell 1998). The auditor also examined the process of the inquiry, data, findings, interpretations and recommendations to determine their acceptability. Ultimately, this established the extent to which the data and interpretations

in the study were grounded in reality rather than the researchers' personal constructs or biases thereby establishing both dependability and confirmability (Lincoln & Guba 1985).

Summary

The use of group analysis and an outside auditor strengthened the process in providing checks and balances that helped to clarify the specific meaning of what each respondent said as well as preventing words of respondents from being taken out of context. As a result of utilizing these methods during the analysis phase trustworthiness, credibility, transferability, dependability, and confirm ability was assured (Creswell 1998).

CHAPTER IV

ANALYSIS OF DATA

This qualitative, descriptive phenomenological research study was designed to provide information for healthcare providers that would facilitate the development of better educational materials for parents as well as encouraging adequate support for both men and women during the postpartum period. The study explored the lived experiences of male partners of women who had previously been diagnosed with postpartum depression. The stories related during the interview process by the respondents were rigorously, critically, systematically analyzed and compared to identify common themes within and between their individual experiences. Additionally, this study was designed to examine the fathers' level of knowledge about postpartum depression, including signs and symptoms as well as effective ways to support a partner if they suspected that partner was developing postpartum depression.

Data analyses were completed utilizing Speigelberg's (1965, 1975) methodology that gives attention not only to relationships between but also essences within the phenomenon. The methodology was chosen for its congruency with the theoretical framework from the classic works of Husserl (1960, 1970) outlined in chapter one.

This chapter presents the findings obtained from the face to face audio taped interviews with respondents. The tapes were transcribed verbatim and reviewed utilizing a two group analysis process in order to assure trustworthiness, credibility, transferability,

dependability, and confirmability. One group consisted of two doctoral prepared persons familiar with qualitative research and the other group consisted of two doctoral prepared persons familiar with the psychiatric components of postpartum depression. One member of this team also had knowledge related to the medical aspects of childbearing women. The usage of two groups with extensive background knowledge of qualitative research and psychiatric aspects strengthened the analysis process through a consensus of agreement between the members and the researcher in identifying the major themes and subthemes gleaned from each of the interviews. The groups assisted in identifying the point at which saturation of data was achieved that re-enforced the sample population of seven respondents. They further assisted in categorizing supporting statements by the respondents that re-enforced the identified themes or patterns within and between each of the respondents.

This chapter describes the sample. Next, themes and subthemes about the phenomenon of living with a partner diagnosed with postpartum depression as derived from the information in the verbatim transcripts are highlighted with statements by respondents that re-enforced the identified themes. Finally, a summary discussion of each of the themes and subthemes conclude the chapter.

Description of the Sample

The respondents included seven males ranging in age from 22-52 with an average age of 31. While it was hoped there would be representation from various cultural groups, all of the respondents who voluntarily agreed to participate in the study were Caucasian. Incomes ranged from $15,000 to greater than $60,000 with an average income of

$43,000.00 per year. Educational backgrounds of respondents included four college graduates, one with some college, and two who were high school graduates at the time of the interviews. Three of the respondents and their significant others had their second child while three had their third child. One other respondent and his significant other had their fourth child. Four of the infants were delivered vaginally and the remaining three were delivered via an uncomplicated repeat cesarean section. All of the respondents but one were legally married to their significant others and had been married for a range of five to ten years. The unmarried respondent had been with his significant other for over seven years and she had delivered their third child. Based on the descriptions given by the respondents, the partners of each of these men previously experienced symptoms of mild to moderate depression as opposed to severe depression with psychotic episodes.

Findings

While the experiences related by the respondents were somewhat different and unique to the individual, many similarities among the stories resulted in the identification of three major thematic patterns. The first overarching theme that emerged was the father's sense of vulnerability when his partner began to experience postpartum depression following the birth of the previous baby. Father's feelings of *vulnerability* were manifested through a lack of recognition of partner behaviors. Fathers rationalized the cause and became annoyed to the point of wanting a divorce. Eventually fathers tried to fix things. As time progressed and the symptoms of the partner's postpartum depression did not subside, a second theme of *helplessness* to know what to do also emerged. *Helplessness* manifested itself in two ways: I couldn't do anything right and I

didn't know. Finally, a third theme of coping emerged when the fathers began to identify things that may alleviate some of the more negative effects of postpartum depression. During this phase, fathers identified that more education was needed, and that fathers need to be patient and be more attentive to their partners needs when they are experiencing symptoms of postpartum depression.

Experiencing Vulnerability

Vulnerability implies that one has an inability to withstand the effects of a hostile environment. When the fathers' partners began displaying symptoms of postpartum depression following the birth of a previous baby, the fathers' lives changed unexpectedly in ways they had never imagined. Each of the fathers in this study identified in very specific terms the ways in which his partner changed when she began to experience symptoms of postpartum depression as well as what she felt and did. They openly described their feelings of being emotionally hurt, frustrated, and at a loss to know how to help their partners during this difficult time.

He didn't recognize her. Each of the respondents had been with his respective partner for a significant number of years, ranging from five to ten years. As a result respondents were accustomed to seeing their partners' responses in a variety of situations which formed the basis for an expected pattern of behavior following the birth of their babies. When the expected pattern of behavior deviated following the birth of a previous baby, each respondent was able to differentiate normal from abnormal patterns of behavior.

> A 32 year old father of three stated, "She just wasn't herself, just very gloomy attitude. Sometimes she would be perfectly normal and other times no reasoning with her. She was doing irrational things that didn't make any sense like telling the baby to stop crying."
>
> A 24 year old father of three noted, "Right after birth you know she didn't really have a lot to do with the child … which I found it kind a strange...when I left to go to work, she'd be sitting on the couch…and when I came home, she'd be sitting on the couch. I don't care-like that was her response to everything you know. She just really didn't have a lot of passion towards anything."

Partners with postpartum depression were saying and doing things the respondents often found irrational and erratic, things that did not make sense to them. These fathers had planned for the birth of their baby and yet, their partners demonstrated detachment to the infant and had a lack of interest in things in general. In fact their overall demeanor changed drastically. Many of the women were described as not wanting to leave the house and sat or laid down often. Some had obvious difficulty with making decisions or completing common household tasks. It was quite evident from the respondents' descriptions that as the woman began to display symptoms of depression, the fathers did not recognize the person she became.

He rationalized the cause. As it became more obvious to the respondents that something was definitely different about their partners, they began to rationalize the cause for the changes they were noticing. Two of the respondents felt the changes in behavior were the result of a chemical imbalance while others attributed it to a lack of sleep or other physical and emotional issues.

> A 32 year old respondent said, "I just chalked it up to hormones alone because she got a lot of stuff going on breastfeeding the baby and her hormones were just totally out of whack. I knew that was what it was."

> A 22 year old respondent echoed what the 32 year old father had said when he noted, "My thought, it was like … a chemical imbalance due to childbirth which is correct in some instances but it's very diverse because that's not the only thing, there are lots of different causes. I think that was probably her … cause of it…a chemical imbalance of being pregnant or childbirth. So that's what caused hers because of the medications fixing it so easily."

However, some fathers thought the differences in behavior were due to lack of sleep. The 32 year old father who chalked it up to hormones also added, "She wasn't getting a lot of sleep. Not sleeping like that, it's your brain I thought was kind a just playing tricks on her." A 33 year old respondent said, "I assumed it was lack of sleep." Other ways in which the fathers rationalized the changes included:

> A 26 year old who stated, "I mean she seemed down and you know I think it was directly due to … she just felt bad."
>
> Conversely, the 52 year old respondent felt, "There were situational circumstances leading up to the birth of the baby that I thought, maybe...contributed to it a little bit. She had a very adversarial relationship with my mother and the fact that my parents came for the delivery irritated her quite a bit."

From the interviews, the respondents made it clear that their significant other was not demonstrating a normal behavioral pattern and as a result several of the respondents tried to rationalize the cause in order for them to be able to deal with the emotional changes that they saw occurring within their partners. The changes had to be occurring for a reason. Some of the rationalizations were: chemical imbalance; hormonal changes associated with pregnancy and childbirth; a lack of sleep or other emotional issues. Depression was not noted as a cause of the changes they had observed.

He was annoyed to the point of wanting a divorce. After the respondents realized there really was a problem, they expressed their feelings and emotions on a

continuum from being annoyed and frustrated to wanting a divorce. They expressed their emotions about how the change in their partners' behavior was affecting their family and personal relationships in a number of ways.

A 24 year old father of three summarized his experiences in just a few words, "Annoyed. I just thought she was being lazy." Another father summarized his emotions as "…I'd get frustrated with her…I am not going to lie, it was a difficult time. You already had a crying baby but your wife's at the end of her rope." A 52 year old father of two similarly described his experiences in the following manner, "I would get... mad cause it was you know every day. It was pretty rough…affected me, affected our relationship…we almost didn't make it." A 22 year old father of two elaborated, "I wanted a divorce is the way I felt."

These key statements emphasize the degree of disruption to their lives that the respondents experienced during the time period when their partners were going through postpartum depression. It was identified as being very rough, tough, miserable, emotional experience that almost resulted in them separating from their significant other. One father also noted that, "….it kind of actually made me depressed."

He tried to fix things. As time went on fathers began to realize that there were definite problems and issues that needed to be addressed. So despite their feelings of hurt, anger and frustration, the respondents began to figure out ways to try and fix things. They felt an overwhelming need to try to do something that would make things better somehow for themselves, their partners, and their families.

> One father summarized the experience by stating, "It would be 2:00 in the morning that's usually when it is the worst. I'd say…let me have him for a little bit and you just kind of calm down a little bit. And she would kind a gain her senses a little bit." I've learned what babies [do that] kind of trigger her and what I can do to help so I tried to help as best as I could."
>
> Another father noted, "I tried to sit down and talk…but she wasn't always open to it. She'd get mad so I would just let her chill out and relax, let her do her thing and eventually most of the time when she did that she would come back and want to talk later."

Each of the above examples demonstrates an interrelated subtheme that despite their feelings of frustration and vulnerability, each of the fathers tried to fix things to make them better for their partner, their family, and themselves. They tried to communicate with their partners as well as sacrificing time and energy to care for the new baby, other children, and maintain the home while trying to keep the situation with their significant other from escalating out of control. They made concessions that were aimed at keeping their partner calm and rational. During the time period when their partners were experiencing symptoms of postpartum depression, the fathers felt emotionally wounded, hurt and had a great deal of difficulty withstanding the hostile environment that their home had turned into.

The respondents uniquely described their experiences of living with a partner who had previously been diagnosed with postpartum depression. And, yet, despite each story being slightly different, the subthemes emerged that produced overarching evidence of the respondents' *vulnerability* when their partners were diagnosed with postpartum depression. The respondents first did not understand why their partner's behavior suddenly changed in drastic ways from what they had expected. Then they had to find a

rational explanation that would help them understand why the changes were occurring. As time passed, the respondents felt annoyed and frustrated. The respondents described their lives as becoming rough, tough, miserable, and emotional experience that almost resulted in them separating from their significant other. Finally, despite their negative feelings of vulnerability at that time, they saw a need to try to fix things to make them better. Some of the fathers had begun to think that their partners were possibly experiencing postpartum depression during this period of time.

Experiencing Helplessness

The second overarching theme gleaned from the interviews was the sense of *helplessness*. Fathers did not feel like they could do anything right and in essence were just biding their time, like weathering a storm until the symptoms of postpartum depression passed. Part of the problem, as they viewed it, was simply the fact they did not know that much about postpartum depression at the time their partner was experiencing symptoms. Despite current educational programs, the topic being discussed on national television talk shows, and current literature on the subject, many of their comments emphasized the fact that they still had little information about this subject at the time of the interview.

I couldn't do anything right: Weathering the storm. Although these men were trying to do whatever it took to keep the family going and tried to support their partner through the frustrating experience of having postpartum depression, many of them felt like nothing they ever did was quite good enough. Two fathers readily identified that they were "….Kind of helpless…." to know what to do.

> The 32 year old father of three elaborated further, "If you said something it made it worse so if you didn't say something; only made it worse. So it's just, just like weathering a storm. Just buckle down cause it was going to get bad." He further noted, "God forbid you mention postpartum depression. If you even just say the word postpartum depression a bomb goes off…it was like World War II."
>
> A 22 year old father of two perhaps summarized the overall experience of all fathers best when he stated, "I think, you know you give them exactly what you think they ask for and that's not right. They tell you what they want and, uh, you give em that and, uh, that's not right…Damned if you do, and damned if you don't."

Many of the respondents' statements expressed similar thoughts that were very profound and illustrated the fact that nothing they did seemed to make things better and in some cases only made things worse. In many cases the fathers thought they were doing or saying exactly what they thought their partner wanted them to do or say only to discover nothing they did or said was right.

I didn't know. A prominent component of the interview process centered on the knowledge the respondents had about postpartum depression. The responses ranged from little or no knowledge to misconceptions about what the term postpartum depression truly represents.

> A 26 year old father of two aptly stated, "Well, I mean, I think, me as a husband and just being a male we really don't know what it is supposed to look like….I wasn't really knowledgeable about the thing. I'm just oblivious to it like most dads are I would imagine." He further noted that his perspective of what postpartum depression involved was, "[the mother] doesn't… maybe … want to be around the baby… doesn't have the bond with it and she just kind of doesn't want anything to do with the baby..."
>
> The 52 year old father echoed feelings of, "I really didn't know anything, you know I heard of baby blues but I mean other than that term, I really didn't know anything."

> The 24 year old father of three noted, "My views at the time … on postpartum was if you had postpartum you were going to hurt the baby."
>
> A 22 year old father of two recounted, "I didn't really know anything about it…like I said, I still don't know a whole lot about it."

As noted in these statements, the knowledge level of all of the respondents was minimal at the time their partner was experiencing postpartum depression but unfortunately, it also became obvious that they did not know much more about the postpartum depression during the interview. It seemed like nothing they said or did was right because of their lack of knowledge and as a result they were helpless to know how to proceed.

Better Ways of Coping

Though the respondents in the study described feelings of vulnerability and helplessness, they also were able to identify ways in which they and other fathers could perhaps better cope with the devastating effects of postpartum depression. Their advice for coping formed the basis for three subcategory themes: more education is needed, be patient, and be more attentive.

More education is needed: They could have told me. It was evident from interviewing these fathers that education about postpartum depression continues to be inadequate in many instances.

> A father of two adequately summed up this theme, when he stated, "They could have informed me a little bit more about this."
> Educational recommendations proposed by a 26 year old father was, "Maybe somebody…talking on a one to one basis, if you see some of these symptoms you might want to … let somebody know and get some help for your wife."

> A 24 year old father elaborated, " I think if would have been beneficial to have like a class…for the fathers to go to at the hospital you are going to be at or something like just saying these are like the identifying traits of a woman with depression."

Two other fathers mentioned the use of media as a resource for better educating the public about postpartum depression.

> The 32 year old father noted, "Maybe like a little survey … you read in magazines asking ten questions. Maybe a few questions to answer and after you answer say you might show symptoms of postpartum depression or something like that set in stone her rationale would have understood."

> A 33 year old father added, "I think we need some kind of a media … like in a commercial you know during times that women…are watching at that time…"

As noted above their responses ranged from wanting a one to one discussion with the dads to having specific classes that would inform both the moms and dads that postpartum depression is a possibility after delivery and how to manage it if symptoms occur. They further noted that media campaigns at peak viewing times as well as ad campaigns in newspapers and magazines could also be beneficial in better educating the public.

Be patient. The second subtheme under coping provided a way in which these fathers and fathers who might in the future have a partner experiencing postpartum depression; be patient with your partner.

> A 52 year old father of two stated, "…patience, I guess, I mean…it could take a while …talk to her and have understanding, [fathers] don't get frustrated and make it worse."

> A 28 year old father of three added, "To be patient…help out all you can…try not to be contentious, see that she gets everything she needs, and encourage her. Just speak to her doctor about it."

> But a 33 year old father of four perhaps made the most profound statement when he noted, "Have a lot of patience when your significant other is going through something like that cause it's not, it's not their choice that they're choosing to be that way."

The common subtheme of be patient with your partner when they are experiencing postpartum depression became quite evident throughout the remarks made by this group of respondents. The advice they gave for other fathers who might go through a similar experience in the future was also highly applicable to their relationships with their partners. They emphasized that getting upset with their partner often made things worse. The fathers further noted that by being patient and allowing their partner time to work through the effects of postpartum depression, their partners were often able to pull out of the depressive state given time. They began to recognize that their partner did not choose to have postpartum depression, but they needed support, understanding and encouragement to work through its effects.

Be more attentive. These fathers also had advice for new fathers who might in the future have a partner experiencing postpartum depression. The majority of the respondents noted that fathers need to be more attuned and attentive to the needs of their partners if they begin to experience symptoms of postpartum depression.

> A 22 year old emphasized that fathers need to give their partners more positive reinforcement, "pay more attention to your wife maybe try to make her feel really good and … make her see that she is awesome…bring her flowers or a gift"
> A 32 year old father of three discussed the need to be as helpful as you can to your partner and not to "say or do things that can make it worse or compound it, like blaming her or telling her she's depressed. Avoid arguments. Try to relieve the …. triggers so she's not feeling like that."
>
> The 24 year old father of three eloquently acknowledged the importance of talking to their partner when he noted, "You don't know what's goin on inside

> their head unless you talk to them about it…you can't just lose your temper about it or anything like that. Encourage her….Encourage her to speak to her doctor about it."
>
> The 33 year old father of four stated, "Ask a lot of questions. Don't be afraid to tell someone else that you believe that your partner is [having postpartum depression]…get a referral somewhere to talk to someone."

As these fathers struggled to understand what their partners were going through they clearly identified the importance of encouraging their partner, bringing her gifts, and avoiding arguments. Being attuned and attentive to their partners' needs also requires that fathers communicate openly and frequently with their partners and healthcare professionals in order to get their partners the help they need in a timely manner.

Summary

The birth of a new baby is expected to be a happy, joyous event in the life of a family. But for some families the experience becomes something quite different from what they had anticipated. This qualitative, descriptive, phenomenological study explored the many ways in which families were profoundly affected by the diagnosis of postpartum depression. The fathers in this study richly described the unexpected ways in which their lives were altered as a result of changes they had observed in their partners' behavior following the birth of a previous baby resulting in feelings of *Vulnerability.* The fathers had difficulty recognizing the person their partners became and found themselves living in a volatile, hostile environment. In addition, the fathers described a wide range of emotions and issues that confronted the family when their partners were experiencing symptoms of the disorder. The family structure was shaken in such a way that the fathers actually contemplated separation from or divorcing their partners. But despite the turmoil

that their lives were in, the fathers tried to do everything they possibly could to make things better for their partners, their families, and themselves. However, despite their best efforts, the fathers felt *Helplessness* that they were unable to do anything right because they simply did not know that much about the condition. Ultimately, the fathers were able to work through the frustrations they had experienced and were able to identify specific ways they could better help and support their partners should they experience postpartum depression again. The fathers also identified ways of *Coping* that may help other fathers with a partner who develops postpartum depression.

CHAPTER V

SUMMARY OF STUDY

Postpartum depression is a condition that affects 50-80% of all women following the birth of a baby (Beck 2006). It is a condition that has been shown to not only affect the mother, but also can have profound effects on the total family structure. Generally, the father's role within the family following the birth of a new baby has been viewed as being the provider of social and economic security for the family as well as the provider of emotional support for the mother. However, very few qualitative research studies have been conducted that focused on fathers' experiences of living with a partner who had previously been diagnosed with postpartum depression. This descriptive qualitative phenomenological study was designed to replicate a research study conducted by Meighan et al. (1999). Like the aforementioned study, the primary focus of this study was to determine the impact of postpartum depression on the day to day lives of the family as related through the firsthand lived experiences of fathers. In addition, this study also focused on learning more about the fathers' general knowledge base with regard to the phenomenon of postpartum depression. By studying the first hand experiences of fathers who have lived with a partner that was previously diagnosed with postpartum depression and focusing on learning more about the general knowledge level with regard to the phenomenon of postpartum depression, healthcare providers may be better able to develop more effective educational methods and materials on the subject. With better

education of new parents, earlier assessment and treatment could be initiated and thereby minimize some of the more negative effects of postpartum depression on the total family structure. This chapter presents a summary of the research study, a discussion of the findings resulting from the research, conclusions from the findings, implications of the findings, and recommendations for further research.

Summary

Husserl's (1960, 1970) descriptive phenomenological design was chosen to explore the day to day lived experiences of male partners of women who had previously been diagnosed with postpartum depression. Speigelberg's (1965, 1975) six step methodology of data analysis were utilized in the review of the verbatim transcripts from semi-structured interviews conducted with seven men recruited through a hospital in the southern United States. The transcripts were continuously and repeatedly reviewed individually and collectively in order to identify common thematic patterns that emerged within and between each of the interviews. Personal biases, assumptions, and presuppositions were set aside in order to obtain the purest description of the phenomenon being investigated. In addition to the researcher reviewing each transcript, a two group analysis process was employed to provide trustworthiness, credibility, transferability, dependability, and confirmability of the data (Creswell 1998). The groups consisted of two doctoral prepared professionals who had qualitative research experience and two doctoral prepared professionals who had psychiatric knowledge of the phenomenon of postpartum depression. One professional also had knowledge of medical aspects of postpartum care.

Through continuous, on-going analysis of the transcripts from each interview, the stories related by the male partners participating in this study yielded a panoramic view of *the journey* each man took on a day to day basis when their partners were previously diagnosed with postpartum depression. The collective snapshot that the fathers presented regarding their experiences produced three pathways in which their lives were detoured on their *journey*. Having a new baby is similar to going on a *journey*: you may not know exactly where the journey will take you but you have certain expectations of how the journey will progress. As a result of their partner developing postpartum depression, the respondents started out on their journey expecting to have a happy, joyous experience with their partner and new baby only to discover unexpected, highly distressing detours that threatened to destroy their relationships and the life they were building for their family. Based on a consensus between the group members and the researcher the major deviations in their life's pathway produced three major themes of *vulnerability, helplessness,* and *coping*. Sub themes for each of these major pathways were also identified. The first pathway of *vulnerability* was described through four sub themes that *he didn't recognize her, he rationalized the cause, he was annoyed to the point of wanting a divorce* and *he tried to fix things.* As time progressed and the symptoms of postpartum depression did not subside in their partners, a second pathway of *helplessness* emerged with sub themes of *I couldn't do anything right* and *I didn't know*. Later, a third pathway, *coping* emerged when the fathers began to identify things that could possibly help alleviate some of the negative effects of postpartum depression that included sub

themes of *more education is needed, be patient,* and *be more attentive* to the needs of your partner.

The respondents had expected and planned for the birth of their new baby and were accustomed to seeing their partners' responses in a variety of situations which formed the basis for an expected pattern of behavior following the birth of their baby. The fathers' life pathways were detoured into a pathway of *vulnerability* when their partners' expected pattern of behavior deviated following the birth of a previous baby. The fathers noted that their partners were saying and doing things they found irrational and erratic, that did not make sense to them. Their partners demonstrated detachment from the infant and/or other children as well as a lack of interest in things in general. Their overall demeanor changed drastically with the women being described as angry or moody all the time, not wanting to leave the house and often apathetic. Some had obvious difficulty with making decisions, completing common household tasks, and taking care of the baby or the other children. The respondents' descriptions clearly indicated that as their partners began to display symptoms of depression, they didn't recognize the new patterns of behavior. They felt like they were living with someone they no longer knew intimately and personally.

When it became more obvious to the respondents that something was definitely different about their partners, they wanted to try to correct the pathway from which their lives had deviated. They began to rationalize that there had to be a logical reason for the drastic changes that were occurring in their partners' behavior. The respondents thought the behavioral changes had to be due to hormones that were 'out of whack,' some kind of

chemical imbalance, lack of sleep, or other situational crises affecting their partner. Each respondent saw that something was significantly wrong with his partner and believed there had to be a reason for the behavior changes. As the symptoms of postpartum depression continued to manifest, the behavioral changes in their partners created a disruption in the respondents' lives, relationships, and family dynamics. After the birth of their baby, they had expected their lives to be happy and joyous but instead they described the postpartum period as one of the most profoundly dangerous detours their lives could take. Things were sometimes so difficult in their lives, their relationships tittered precariously over a culvert of wanting to separate from or even divorce their significant other.

As time went on and their lives seemed to careen out of control the fathers began to realize that there were definite problems and issues with the route their lives were taking that needed to be addressed. So, despite their hurt feelings, confusion, annoyance and frustration, the respondents felt an overwhelming need to try to get their lives headed back in the right direction that would get them to a destination where things would be better for themselves, their partners, and their families. They tried to identify things that triggered their partners' negative behavior and would make efforts to avoid, minimize, or eliminate the trigger if at all possible. They sacrificed time and energy to help care for the new baby, other children, and maintain the home while trying to keep the situation with their significant other from escalating out of control. Clearly the fathers interviewed demonstrated commitment to their respective partners and to their relationships by making concessions designed to facilitate calm and rational behavior in their partners.

Despite their trying to do whatever it took to keep the family going while attempting to support their partner through the frustrating experience of having postpartum depression, their journey took another overarching detour in their lives that led them into a valley of *helplessness.* Many of the respondents' statements expressed similar thoughts that were very profound and illustrated the fact that nothing they did seemed to make things better. In some instances it actually made things worse. In many cases the fathers thought they were doing or saying exactly what they thought their partner wanted them to do or say only to discover nothing they did or said was right. They experienced a kind of double bind situation, in which there appeared to be no acceptable course of action. It seemed that anything they did was never appropriate or quite good enough. In essence they felt like they were just biding their time, like "weathering a storm" along the highway of their life until the symptoms of postpartum depression subsided.

Part of the problem, as the respondents related, was simply the fact they did not have the right road map to get them to the joyous destination on their journey. Despite postpartum depression being addressed with educational programs, on national television talk shows, and in current literature on the subject, it became obvious that respondents had very little information about postpartum depression. They were oblivious as to how postpartum depression manifested itself, with ideas ranging from 'the mom avoids the baby' to 'the mom wants to hurt the baby'. It was also obvious at the time of the interviews that the fathers currently do not possess much more knowledge about the disorder than they had when their partner was first diagnosed.

During the interviews, the fathers discussed the deviations that had occurred in their *journey* that threatened their significant others, their families and their lives. In the final leg of their *journey*, they began to put together a road map of alternative routes that would bring them out of the valley of *helplessness* that would perhaps help them and other fathers cope with the devastating effects of having a partner diagnosed with postpartum depression. Their suggestions formed the basis for the third overarching pathway of *coping*. The respondents suggested that *more education* for fathers about postpartum depression was needed as well as encouragement for fathers to demonstrate greater *patience* with and *attentiveness* to the needs of their partners.

The fathers felt that more one to one instruction or possibly class discussions about postpartum depression with both mothers and fathers during the prenatal as well as the postnatal period would be beneficial. They also felt that media campaigns at peak times would also be of benefit for the public in general. They felt mothers and fathers both needed to understand that postpartum depression is a very real complication during the postpartum period. By having more direct education on the subject, the devastating effects of postpartum depression could perhaps be minimized and the mothers would be able to receive appropriate treatment for the condition in a timelier manner.

The respondents also noted that being *patient* with their partners was a key to coping with the devastating effects of PPD. Impatience often made the situation worse. Conversely, by having patience with their partners, the respondents noted that mothers could calm down and were often able to work through their depressive feelings and gain some sense of normalcy. The fathers further emphasized the importance of being *more*

attentive to their partners by giving them more positive reinforcement that they were doing a great job and were awesome wives and mothers. Buying their partners gifts or flowers as well as encouraging the mother to get out of the house on a regular basis were also emphasized. Finally respondents recommended that fathers should attempt to talk to their partner and healthcare providers on a regular basis to keep the lines of communication open and potentially get their partners the assistance they need to recuperate from postpartum depression in a timely manner.

Discussion of the Findings

The study undertaken corroborates and extends the body of nursing knowledge through the similarities and differences that exist between aforementioned findings in this study and the articles cited in the review of the literature. While there has been much research on the subject of postpartum depression, research that directly looked at the personal impact of postpartum depression on fathers has been sporadic. George (1996) suggested in a clinical paper that male partners could influence a woman's ability to recover from postpartum depression but also contended that very few fathers understand the condition or know how to provide support for their depressed partner. The respondents' narratives supported George's (1996) assumption that fathers do not know that much about the phenomenon of postpartum depression. As a result this study not only explored the personal experiences of male partners of living with someone who has been diagnosed with postpartum depression but also added the dynamic of determining the knowledge level of men with regard to the phenomenon of postpartum depression. The study respondents felt the need to support their partners and yet, they were somewhat

oblivious as to how to truly support their partner to facilitate their recovery from the disorder (Boyce 1994; George 1996).

Another proposed assumption was that fathers may not be able to describe what they know about the phenomenon of postpartum depression. From the review of the findings in this study it became obvious that the fathers possessed rudimentary knowledge about the phenomenon at the time their partner was diagnosed and even now during the interviews their knowledge level remained minimal. They voiced clearly and distinctly that they were ill prepared for the possibility of PPD developing. They lacked awareness, understanding and knowledge about symptoms of postpartum depression and resources that were available if postpartum depression occurred (LeTourneau et al., 2011). As a result of the minimal level of knowledge that the respondents described it became quite evident that inadequate knowledge and lack of awareness of postpartum depression truly are barriers to obtaining much needed treatment for their partners (Roberts et al., 2006; LeTourneau et al., 2011).

The rich, thick descriptions of their lived experiences cited in this study supported the assumption that fathers would be able to fully and completely relate their experiences of living with a partner who has been previously diagnosed with postpartum depression. This study further corroborates and reinforces that postpartum depression not only has a negative impact on the mothers but also on the fathers and the total family structure. The fathers in this study described their lives as being a rough, tough, miserable, emotional experience that almost resulted in them separating from or divorcing their significant other (Boyce 1994; LeTourneau et al., 2011; LeTourneau et al., 2012a). The fathers in

this study related attempts to communicate with their partners; in some instances the mothers would not talk while in other instances they would become agitated and upset. It seemed like there was nothing the fathers could do or say that would make things better. They also described their partners as saying and doing things that did not make sense to them like telling the baby to stop crying or being considerably sharper in tone when they talked to their other children. The women were not actively engaged in the care of their child or other children and were angry or moody most of the time. The fathers in this study corroborated that poor communication with their partner and their partners' troubled interactions with their child or children contributed to marital difficulties (Boyce 1994; LeTourneau et al., 2011; LeTourneau et al., 2012a).

The fathers in this study also noted that one of the preferred supportive interventions for both fathers and mothers would be individualized face to face or classroom instruction about postpartum depression (Doucet et al., 2012; LeTourneau et al., 2012b). The fathers further emphasized that they need to know practical tips on how to support their partner as well as knowing methods to help them cope with the changes that were occurring around them. In addition they noted that a list of available internet sites for more information would have been beneficial. The findings in the study emphasize and corroborate the fact that better education of both mothers and fathers can potentially facilitate earlier assessment and treatment. With earlier assessment and treatment the more negative effects of postpartum depression on the total family structure may be minimized (Doucet et al., 2012; LeTourneau et al., 2012b). The results of this study supports a third assumption that fathers in the United States want to know about

postpartum depression and feel it is their responsibility to provide care and support to their partners if they experience postpartum depression.

But the most striking similarities and differences exist between this study and the qualitative study conducted by Meighan et al., (1999). Both of these studies were designed to explore the lived experiences of male partners of women who had previously been diagnosed with postpartum depression.

The major essences identified in the existential phenomenological study of Meighan et al., (1999) included she becomes an alien, he attempts to fix the problem, he makes sacrifices, his world collapses, and he experiences losses that include loss of control, loss of intimacy, and altered relationships.

Conversely, in the current descriptive phenomenological study three major overarching themes of vulnerability, helplessness, and coping with postpartum depression were identified with each one having two to four specific, relevant subthemes. The first major theme of vulnerability produced four subthemes that included: he didn't recognize her, he rationalizes the cause, he was annoyed to wanting a divorce, and he tries to fix things. The second major theme of helplessness included two subthemes, I couldn't do anything right and I didn't know. The third major theme of coping consisted of the subthemes that more education is needed, be patient and be more attentive to the needs of your partner.

As noted above, a majority of the subthemes in this study bore striking similarities to some of the themes noted in Meighan et al., (1999). Parallels drawn between both sets of respondents included that they had been with their respective partners for a significant

number of years and were used to seeing their partners respond in specific ways in a variety of situations. Following the birth of a previous child, both sets of the fathers described sudden and drastic changes in their partners' behavior that turned their lives upside down. It was like living with someone he did not recognize or as noted in Meighan et al. (1999) *"she becomes an alien."* The person their partner became when they were experiencing postpartum depression was someone the respondents no longer knew intimately and personally in both studies.

The subtheme of he tries to fix things in the current study is somewhat similar to the theme *"he attempts to fix the problem"* (Meighan et al., 1999). The fathers in both studies were trying to figure out ways to make things better for their partners, their families, and themselves. However, finding a cause for the problem and taking on more responsibilities of caring for the new baby, other children, and maintaining the home while trying to keep the situation with their significant other from escalating out of control was discussed in Meighan et al. (1999) under the explanation of *"he attempts to fix the problem."* In the current study, he rationalizes the cause was identified as a separate and distinct subtheme under the overarching theme of vulnerable. The recent respondents overwhelmingly voiced the need to find some logical explanation for their partners' behavior changing so drastically. It had to be hormonal, a chemical imbalance, or other situational crises that was causing these changes.

Another difference between the two studies was the explanations for he attempts to fix things in this study, which included the father's willingness to do whatever it took to keep the family going and together through this difficult time. While Meighan et al.

(1999) noted this aspect under a theme of *"he makes sacrifices,"* this researcher's manipulation of the data, placed whatever it took to keep the family together as a primary component of fathers' efforts to try to fix things.

The fathers in both studies further emphasized that nothing they said or did seemed to be the right thing. Meighan et al. (1999) also included this concept under the theme of "*he tries to fix the problems,"* but the consistent emphasis in the comments by fathers in this study produced a separate subtheme under the overarching theme of helpless. The fact that he couldn't do anything right was most evident when one father commented, "they tell you what they want and you give them and it's not right…Damned if you do and damned if you don't."

The subthemes of this study support as well as expand the themes found in the Meighan et al. (1999) study. The current study contained an additional dynamic of looking at the level of knowledge that fathers had about the phenomenon of postpartum depression. The respondents in this study described that they did not know that much about postpartum depression when their partners were first diagnosed. Unfortunately, it further became obvious in the interviews that the fathers did not know a great deal more about postpartum depression at the time the interviews were conducted. Obvious gaps in knowledge demonstrated by these fathers are indicative of the failure of healthcare professionals to adequately and effectively educate the public about postpartum depression.

Another interesting dynamic that surfaced in this study was the fact that the respondents were resilient enough to recognize and clearly identify ways in which they

thought fathers might be able to cope with living with a partner who is diagnosed with postpartum depression. More one to one education by healthcare providers is needed for both mothers and fathers. However, if their partner does develop postpartum depression, male partners need to above all be patient and more attentive to needs of the woman which supports the assumption that fathers in the United States want to provide care and support for their partner if they develop postpartum depression.

Conclusions

Postpartum depression is a very real complication that can occur after the birth of a baby. The men who participated in this study related rich descriptions of their experiences of living with a partner who experienced postpartum depression following the birth of a previous infant. As a result a number of conclusions can be drawn.

1. Fathers dealing with a partner diagnosed with postpartum depression find the experience emotionally volatile and tumultuous one that almost results in separation or divorce from their significant other.
2. Fathers want to make things better for their partners, their families and themselves but find it difficult to do the right thing.
3. Fathers need greater knowledge regarding postpartum depression in order to effectively cope with the situation.
4. Fathers have a limited knowledge base about the disorder at the time their partner was first diagnosed and at the time of subsequent births, they did not possess much more knowledge on the subject.

Implications

The implications that can be drawn from this study, based on the analysis of the data as well as the conclusions that have been drawn are:

1. Healthcare professionals continue to fall short not only in educating the public about postpartum depression but also in the provision of adequate support of the mother and father if she develops postpartum depression.
2. Healthcare providers need to do better assessment and more thorough screening of each childbearing woman's potential to develop postpartum depression.
3. Key to early treatment and recovery of women from postpartum depression is the need to maintain the open lines of communication between the parents and healthcare providers during the postpartum period.
4. It is important for healthcare providers to do more than just medicate a mother with antidepressant drugs during the antepartum and postpartum period.
5. Hospitals have been mandated that they have to provide patients and families information about postpartum depression. Unfortunately many community hospitals rely on pamphlets and volunteers to disseminate key information about postpartum depression.
6. Postpartum nurses need to be much more proactive in providing one to one discussion about the implications of postpartum depression with both mothers and fathers.
7. Education at a minimum prenatally and postpartum needs to include information regarding the potential contributing factors to the development of PPD, specific

information about the three varying degrees of impairment that can occur, common as well as less signs and symptoms, rates of reoccurrence with subsequent pregnancies, and methods that the fathers may employ to support their partner if they suspect that their partner is experiencing PPD as well as additional resources for more information through the internet.

8. Healthcare providers also need to provide on-going support for both the mother and the father during the postpartum period when the woman begins to develop symptoms of the disorder.

Recommendations for Further Studies

Research regarding women and postpartum depression has been prolific in the literature; however, studies regarding fathers and the effects of living with someone who has postpartum depression have been much more limited. Therefore recommendations for further research include:

1. Fathers have a wealth of untapped information about the phenomenon of postpartum depression. More research needs to be conducted utilizing qualitative research methods that provide the opportunity to explore and elaborate on their individual thoughts, feelings, and actual experiences of living with a woman diagnosed with postpartum depression.
2. Focused research on the phenomenon of fathers living with a partner who has previously been diagnosed with postpartum depression needs to be conducted in metropolitan as well as other community settings to facilitate generalizability of the data to all settings across the United States.

3. Attempts were made to recruit fathers of various ethnic backgrounds to determine if the data obtained was generalizable across cultures; however, only Caucasian respondents willingly volunteered in this study. Additional studies should be conducted in areas where a wide range of cultures live in order to develop a more comprehensive understanding of how postpartum depression affects the woman, the father, and the family.
4. Similar studies also need to be conducted in other countries, to further determine if the data that has been gathered is generalizable to other areas of the world.
5. Research to determine in greater depth and detail, the actual knowledge level that fathers in general have with regard to the phenomenon of postpartum depression needs to be conducted.
6. Healthcare professionals need to develop more specific, realistic methods of instructing both mothers and fathers about postpartum depression that will fill the gaps in public knowledge that are currently evident from this study.

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APPENDIX A

IRB APPROVALS

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Office of Research
6700 Fannin Street
Houston, TX 77030-2343
713-794-2480 Fax 713-794-2488

February 6, 2013

Ms. Judy Kaye Smith
College of Nursing
[redacted]

Dear Ms. Smith:

Re: The lived experiences of male partners of women who have previously been diagnosed with postpartum depression (Protocol #: 17254)

Your application to the IRB has been reviewed and approved.

This approval lasts for one (1) year. The study may not continue after the approval period without additional IRB review and approval for continuation. It is your responsibility to assure that this study is not conducted beyond the expiration date.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

The signed consent forms, as applicable, must be filed with the request to close a study file at the completion of the study.

TWU IRB acknowledges that the research project will be conducted at CHRISTUS St. Elizabeth.

[redacted]
Carolyn Kelley, PT, DSc, NCS
Institutional Review Board - Houston

cc. Dr. Karen Lyon, College of Nursing- Houston
Peggy Landrum., PhD, College of Nursing - Houston
Graduate School

CHRISTUS Health

CHRISTUS Health Institutional Review Board

Date: April 19, 2013

To: Judy Kaye Smith

Re: **IRB Protocol #2013-008: The lived experiences of male partners of women who have previously been diagnosed with postpartum depression**

This letter is to inform you that CHRISTUS Health IRB has approved the above research study. The approval period is from **19 / APR / 2013 to 18 / APR / 2014**. The following items were approved for implementation:

- Investigator qualifications and Clinical Research Training
- Full Interview Protocol Version 1.0 IRB-approved on 19-APR-2013
- Demographic and Screening Data Form Version 1.0 IRB-approved on 19-APR-2013
- Consent to Participate in Research Version/Record 1.0 IRB-approved on 19-APR-2013
- Recruitment Materials Version 1.0 IRB-approved on 19-APR-2013

Continued approval is conditional upon your compliance with the following requirements:

- A copy of the approved Informed Consent Document is enclosed. No other consent form should be used. It must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.
- All protocol amendments and changes to approved research must be submitted to the IRB and may not be implemented until approved by the IRB except where necessary to eliminate apparent immediate hazards to the study subjects.
- The enclosed recruitment advertisement has been approved. Advertisements, letters, internet postings, and any other media for subject recruitment must be submitted to IRB and approved prior to use.
- Significant changes to the study site and significant deviations from the research protocol and all unanticipated problems that may involve risks or affect the safety or welfare of subjects or others, or that may affect the integrity of the research must be promptly reported to the IRB.
- In the event there are untoward effects or injury to any person undergoing, or participating in these investigational studies, it is incumbent upon you to make a written report to this IRB immediately following such events. Failure to comply with the above requirements may result in termination of the study covered by the CHRISTUS Health IRB.

The next Annual/Interim Report is due: **18 / MAR / 2014**

If you have any questions, please feel free to contact the IRB at [redacted].

CHRISTUS Health Institutional Review Board

Sincerely,

Darrell Dixon, M.D.
CHRISTUS Health IRB Chair

Cc: **Rick Tyler, M.D., Regional CMO**
Peggy Landrum, Faculty Advisor @ Texas Woman's University
Nancy Luca, Ph.D., Director Houston Office of Research, Texas Woman's University

APPENDIX B

DEMOGRAPHIC DATA SHEET

DEMOGRAPHIC DATA SHEET

THE LIVED EXPERIENCES OF MALE PARTNERS OF WOMEN WHO HAVE PREVIOUSLY BEEN DIAGNOSED WITH POSTPARTUM DEPRESSION
Judy Kaye Smith, MSN, RN-BC

Please fill in the blank, place a checkmark, or circle the correct response

Age _____

Race _____

Income: (please circle correct response)

$15,000-30,000 $30,001-45,000 $45,001-60,000 greater than $60,000

How many years of school have you completed? (please circle correct response):

High School or Equivalent	Some College	College Graduate	Graduate Degree	Doctoral Degree

Which child is this for you and your partner? ____2nd ____3rd ____4th ____ 5th or more

What was the date of the delivery? _____

Did your partner have a _____Vaginal Delivery or a _____ Cesarean Section?

Did your partner experience any of the following complications of pregnancy?

high blood pressure bleeding have an infection preterm labor

Is the baby in ____ Newborn Nursery ____Intensive Care

Is there a history of anyone in your family having depression? _____ Yes ____No

Is your partner currently taking medications for general depression? _____ Yes _____No

APPENDIX C

INTERVIEW PROTOCOL

INTERVIEW PROTOCOL

THE LIVED EXPERIENCES OF MALE PARTNERS OF WOMEN WHO HAVE PREVIOUSLY BEEN DIAGNOSED WITH POSTPARTUM DEPRESSION

Judy Kaye Smith, MSN

1. Describe what led you to believe that your partner was developing postpartum depression (PPD) with a previous pregnancy.

2. Tell me what it was like when your partner first began to experience PPD.

3. Describe how you felt when you first realized that your partner was having a problem.

4. Describe what a typical day in your home was like living with a partner who was diagnosed with PPD after a previous child was delivered.

5. In general describe how you felt after the birth of your previous child.

6. Tell me what you know about postpartum depression.

7. What kinds of things did you think would have helped your partner recover from PPD with a previous child?

8. What kinds of things did you do to help your partner recover from PPD with a previous child?

9. What kind of information about PPD do you feel would have been most beneficial for you to know?

10. What advice would you give to other fathers about dealing with a partner experiencing postpartum depression?

THANK YOU FOR YOUR ASSISTANCE WITH THIS RESEARCH STUDY