

2003

## The Lived Experience of Men With a Postnatally Depressed Partner

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Running Head: MEN'S EXPERIENCES OF POSTNATAL DEPRESSION

The Lived Experience of Men with a Postnatally Depressed Partner

Colela M. Browning

A Thesis Submitted in Partial Fulfillment of the

Requirements for the Award of

Bachelor of Arts (Psychology) Honours


Faculty of Community Studies, Education and Social Sciences,

Edith Cowan University

23<sup>rd</sup> June 2003

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### Abstract

The aim of this study was to examine the experiences and perceptions of men living with a partner who has postnatal depression (PND). Family systems theory was used to provide a framework within which to evaluate men's relationships with immediate and extended family members. A semi-structured interview was used to understand the experiences and perceptions of seven men with partners who had PND. Schweitzer's (1997) phenomenological approach was used to explicate meaning and extract themes from the interview transcripts. Six major themes were identified from the data. These included changes in the division of labour, issues of self, altered family relationships, PND - the problem, support within the family system and interaction with health professionals. The findings suggest that PND is a real problem for men and not just women. Men's mental health and emotional well-being during their partner's PND was found to be a serious issue that can have implications for other members of the family. The men experienced both negative and positive changes in their relationship with their partner, children, parents and/or in-laws, and perceived that close family support was crucial for family functioning during their partner's PND. Several clinical implications were identified including a need for more awareness of PND and the impact it can have on men and other family members, and the need for more resources, support and services that are meaningful and appropriate for men living with a postnatally depressed partner.

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Submitted: June 2003

## Declaration

I certify that this thesis does not incorporate, without acknowledgment, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except when due reference is made in the text.

Signature: Date: 14 / 9 / 03

### Acknowledgments

I would like to acknowledge and thank a number of people for their assistance and support during my research.

I wish to sincerely thank my supervisors, Associate Professor Sherryl Pope and Associate Professor Lisbeth Pike for their enthusiasm, support and guidance during the process of my research project.

I especially would like to thank the men who participated in this study and for sharing their experiences, as without their openness and honesty the issues of men living with a postnatally depressed partner would not be heard.

I would like to thank Women's Health Care House for their assistance during my research. I especially would like to thank Tanya Watson and Joan Forward for their enthusiasm and support of my research.

Finally, I would like to thank all my family and friends for their encouragement and support. In particular, I would like to thank my husband Ian, and children Seb, Tanya, Thomas, Tabitha for their support while I have been studying. My special thanks go to my father and mother who have always encouraged me to strive to achieve in all that I have done.

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## Introduction

Mental health in the postpartum period has recently become an important health issue with increased reports of suicide and infanticide occurring in the United States (Hughes, 2001; Marshall, 2003). Government action is now endeavouring to increase public awareness of postpartum mental health and to raise more funds for research, treatment and services (Charatan & Eaton, 2002; Marshall, 2003).

Typically in the extreme cases where suicide and infanticide occur women suffer from postpartum psychosis or severe postnatal depression (Chan, Levy, Chung & Lee, 2002; Hughes, 2001). However, the most common postpartum condition is postnatal depression (PND) which affects up to 20% of mothers during the first year after giving birth (Charatan & Eaton, 2002; Hughes, 2001; O'Hara & Swain, 1996; Pope, 2000). In Australia, up to 49 740 women will be diagnosed with PND each year (Australian Bureau Statistics, 2003).

Postnatal depression is a debilitating psychological illness with serious implications for mothers impairing their health and ability to function (Pope, 2000; Pope & Watts, 1999). Most women with PND are diagnosed within the first three to six months after childbirth (Boyce & Stubbs, 1994). This is viewed as a critical time for mothers as they need to be able to function adequately to care for the baby and family (Beck, 1996b; Murray, 1992). It is essential therefore, that health care workers should be familiar with the symptoms of PND so that women can be screened for PND (Boyce & Stubbs, 1994) and receive the appropriate treatment interventions (Holopainen, 2002; Richards, 1990). However, PND often remains undetected in women (Beck & Gable, 2001) and up to 50% of women with PND do not receive treatment (Lane et al., 1997).

Postnatal depression not only debilitates the mother and impairs family functioning but can have severe consequences for other members of the family (Areias, Kumar, Barros, Figueiredo, 1996b; Ballard & Davies, 1996; Gotlib Whiffen, 1989; Morgan, Matthey, Barnett & Richardson, 1997; Pope, 2000). Infants of mothers who have PND can be negatively affected (Beck, 1995, 1996a; Fowles, 1996; Hock & Lutz, 2001) resulting in poor child development (Henderson, Sayger & Horne, 2003; Murray & Cooper, 1997). Likewise men living with a partner with PND can be affected emotionally and psychologically (Decker-Deater, Pickering, Dunn, & Golding, 1998; Richards, 1990).

Most of the research on PND has focused on maternal reports (Zekowitz & Milet, 1996) investigating rates of PND, risk factors, assessment measures for identifying women at risk of developing PND and interventions for treatment of PND (Pope, 2000). To date, scant research has been carried out to investigate how PND impacts on men and an extensive review of the literature indicates that there has been little research published. Research that has been conducted on how PND affects men has focused mainly on rates of depression in men with many studies comparing rates of depression between men and women (Matthey, Barnett, Ungerer & Waters, 2000; Raskin, Richman & Gaines, 1990). Few studies have looked at risk factors for depression in men in the postpartum period (Ballard, Davis, Cullen, Mohan & Dean, 1994; Deater-Deckard, et al., 1998) or why men get depressed in the postpartum period (Galbaud du Fort et al., 1994, Matthey et al., 2000).

Investigating how PND impacts on men is pivotal for understanding how they feel, cope and perceive the situation of living with a partner who is depressed as it can assist in determining how PND affects the family as a system (Boath, Pryce & Cox, 1998). Thus many researchers claim that further research into men's issues in

relation to PND could be beneficial not only for men but for other family members as well (Areias, et al., 1996b; Ballard & Davies, 1996; George, 1996; Gotlib & Whiffen, 1989). Additionally, George (1996) suggests that research conducted to determine how PND affects men, could also investigate the type of support men need both for themselves and to assist the family. Accordingly, research into men's issues could assist in the development of better and more efficient treatment interventions for mothers and the identification of how to best support men and families.

The following review of the literature on PND will commence with an examination of PND and how it affects women. The review will then discuss the consequences of PND for infants and their development. The changes in men's lives and the impact of PND on men will then be examined. The review will conclude with an exploration of family systems theory and how this theory may explain the impact of depression in families.

### Literature Review

#### *Postnatal Depression in Context*

Postnatal depression has been described as a non-psychotic mood disorder of moderate severity (Creedy & Shochet, 1996). Postnatal depression is more severe than the 'baby blues', which normally occurs within two weeks of giving birth and is experienced by nearly 80% of mothers. It is less severe than postpartum psychosis which affects less than 0.2% of mothers within the first month after childbirth (Bishop, 1999; Pope & Watts, 1999). Postnatal depression is the most common postnatal health disorder for women. This mood disorder has a debilitating affect on mothers, impacting on their health and level of functioning (Pope & Watts, 1999; Pope, 2000).

Researchers suggest that major and minor depression in the postpartum period is comparable to depression experienced during the normal life span (Creedy

& Shocket, 1996; Whiffen, 1992). Although depression in the postpartum period is no different than depression experienced at other times during the life cycle, Boyce and Stubbs (1994) claim that PND should be taken seriously as it affects a woman's ability to care for her child adequately and may potentially affect family functioning. If PND is not treated, women can develop severe depression increasing the risk of child abuse, infanticide and suicide (Chandra, Venkatusubramanian & Thomas, 2002; Pope, 2000).

#### *Prevalence and Course of PND*

Estimates of the prevalence rates of PND have varied between 3% and 30% (Ballard, et al., 1994; Boyce & Stubbs, 1994; Pope, 2000). Despite such considerable variability, researchers agree that the rate of PND among all childbearing women is between 10% and 20% based on diagnostic criteria (O'Hara & Swain, 1996, Pope, 2000). A meta-analysis conducted by O'Hara and Swain (1996) found that the prevalence rate for PND from the 59 studies analysed was 13%. Studies conducted in other cultures such as Portugal (Areias, Kumar, Barros & Figueriredo, 1996a), India (Patel, DeSouza & Rodrigues, 2003), Turkey (Danaci, Dine, Deveci, Sen & Icelli, 2002) and Nepal (Regmi, Sligl, Carter, Grut & Secar, 2002) indicate similar rates of depression. Boyce and Stubbs (1994) suggest that the type of assessment methods used and the duration of the study may have produced the different findings between the studies.

Forty percent to 70% of women with PND usually develop PND within the first few months after childbirth (Lane et al., 1997). Although the onset of PND usually occurs in the first three months after childbirth, women can develop PND up to three years later (McLennan, Kotelchick & Cho, 2001). As to duration, women can remain depressed for several months after childbirth with 25% to 50% of

mothers remaining depressed for more than six months (Beck, 2002). Women with a history of psychosis or severe depression have a 20% to 30% increased risk of having a relapse after childbirth (Marks, Wieck, Seymore, Checkley & Kumar, 1992). A study by Marks et al. (1992) reported that 22% of women who were severely depressed prior to having children relapsed after giving birth. In addition this study also concluded that women whose partners were highly critical were more likely to relapse.

### *Theoretical Explanations of PND*

Researchers have identified a number of risk factors that make women more vulnerable to PND (Beck, 1996b; Ferguson, Jamieson, & Lindsay, 2002; Patel, Rodrigues & DeSousa, 2002; Petrisor, Apostol, Strungaru, Schiefenhovel, 2002; Richards, 1990). These risk factors fall into four categories including psychosocial, obstetrical, physiological, and having a history of psychiatric illness (Murray & Gallahue, 1987). Psychosocial risk factors include stressful life events (Beck, 1996b; O'Hara & Swain, 1996), lack of support (Chaaya et. al, 2002; Hung & Chung, 2001; Patel, et al., 2002), abortion intention (Petrisor et al., 2002), child care stress (Beck, 1996b), poor relationship with parents (Kumar & Robson, 1984) and traditional sex role attitudes in married men (Hock, Schirtzinger, Widaman & Lutz, 1995). Obstetrical risk factors include obstetric problems (O'Hara, Neunaber, Zeloski, 1984), pregnancy problems and previous obstetric loss (Kumar & Robson, 1984). Physiological risk factors that have been identified include fatigue (Bozoky & Corwin, 2002) and problems with breastfeeding (Ferguson et al., 2002; McLennon & Offord, 2002). Risk factors associated with a history of psychiatric illness include personal history of depression (Beck, 1996b), depression in the antenatal period (Beck, 1996b; Chaaya et. al.) and family history of depression (Beck, 1996b). Of

these four types of risks factors the psychosocial risk factors are viewed by some researchers as the major vulnerability factors for PND (Boyce & Stubbs, 1994; Lane et al., 1997).

### *Diagnosis and Assessment of PND*

#### *Diagnosis*

There are a number of affective, behavioural and cognitive symptoms that women can experience during PND (Bishop, 1999; Pope & Watts, 1999). For a successful diagnosis of PND several DSM IV criteria need to be met, including symptoms of dysphoric mood and two of the following symptoms: sleep problems, loss of appetite, psychomotor disturbance, fatigue and excessive guilt. These symptoms need to be evident for a minimum of one week (American Psychological Association, 2000).

Many women with PND feel exhausted, anxious, empty, sad, helpless, irritable and confused (Pope, 2000; Pope & Watts, 1997). Women have less energy, poorer coping mechanisms to deal with day to day living and have little or no pleasure in usual activities. Decision-making can become more difficult and women may perceive that their partner is rejecting them. Some women also think about suicide or worry that their infant or partner may get hurt (Bishop, 1999; Pope & Watts, 1999). Boyce and Stubbs (1994) suggest that the most common symptoms of PND are irritability and anxiety. A study by Beck (1992) confirms many of the thoughts and feelings women experience with PND. This study found those women with PND experience anxiety, loneliness, loss of identity, obsessive thoughts, thoughts of harming the infant, loss of emotional control and feelings of being a bad mother.



### *Assessment*

Many measurement scales have been used to assess PND including the Edinburgh Postnatal Depression Scale (EPDS; Cox Holden & Sagovsky, 1987), the Beck Depression Inventory (BDI; Beck, Ward, Medelson, Mock & Erbaugh, 1961) and the Center for Epidemiological Studies Depression Scale (CES-D Scale; Radloff, 1977). Recently, the EPDS has become more widely used by researchers and clinicians, the reason being that the EPDS was specifically designed for the detection of PND and that the EPDS is an easy and quick method to screen mothers for possible clinical depression (Regmi et al., 2002).

The EPDS has been found to be both sensitive and specificity satisfactory, sensitivity referring to correctly detecting PND in women and specificity to correctly identifying women who do not have PND. The EPDS has also been found to be able to detect changes in depression over time (Cox et al., 1987). Edinburgh Postnatal Depression Scale scores between 12 and 13 have been found to have a rating that is almost equivalent to the interview based clinical diagnosis of the Research Diagnostic Criteria (RDC) for definite major depression (Spritzer, Ednicott & Robins, 1975). Although it has been widely accepted as a tool to assess PND the EPDS can not be considered a replacement for clinical assessments (Cox et al.). However, Fisher, Feekery, Rowe and Murray (2002) suggest that the assessment procedures for PND need to be more specific, as some women diagnosed with PND may only be suffering from psychological distress.

Women who are at risk of developing PND and mothers who display symptoms of PND need to be assessed for their health and well-being (Pope & Watts, 1999). Georgiopoulos, Bryan, Wollan and Yawn, (2001) suggest that there is a need for routine screening of PND in new mothers. Early detection and treatment of PND

can reduce the impact of PND on other family members (Horowitz et al., 2002; Richards & Talbot, 1998; Wright, George, Burke, Gelfand & Teti, 2000) and prevent the recurrence of PND (Boyce & Stubbs, 1994).

*The Impact of PND on Infants and Later Childhood Outcomes*

As stated previously, PND can have a negative impact on other family members (Beck, 1996a; Richards & Talbot, 1998). In particular, infant development can be adversely affected (Nicholson & Woollett, 1998). Postnatal depression affects infant development as mothers with depression have poor maternal interpersonal functioning leading to poor mother-child interactions (Beck, 1995, 1996a). As a result, infants display less optimal behaviours including less facial expressions, more fussiness, less physical activity and vocalizations (Righetti-Velteni, Conne-Perreard, Bousquet & Manzano, 2002). Poor mother-infant interactions may also lead to attachment problems (Beck 1995, 1996a; Carlson, 1998; Fowles, 1996; Martins & Gaffan, 2000) and more temperamentally difficult infants (Whiffen, 1990). Although infants may become more temperamentally difficult, infant temperament can also influence depression in new mothers (Richards, 1990).

Research has established a causal link between infants who have a mother with PND and later negative childhood outcomes (Kahn, Zuckerman, Baucher, Homer & Wise, 2002; McLennan & Offord, 2002). Recent research found that three year old children of mothers who were depressed during their infancy had delayed language and behavioural problems (Kahn et al., 2002). These children had more problem behaviours with sleeping or eating and displayed more temper tantrums than other children. Murray (1992) suggests that children of mothers who are postnatally

depressed have poorer concentration, are less social with strangers and give more negative responses.

Early maternal depression has also been linked to children being less adaptable in the school environment (Sharp et al., 1995; Sinclair & Murray, 1998; Wright et al., 2000). These children do not perform as well academically at school, are less social, have poor peer relationships and are viewed as being less popular. Teachers rate these children as being more aggressive, angry, defiant and uncooperative (Gross, Conrad, Fogg, Willis & Garvey, 1995; Wright et al.; Zahn-Waxler, Denham, Iannotti, Cummings, 1992).

However, research on mother-infant interaction conducted over the last few decades has produced conflicting results over whether infants of depressed mothers are affected emotionally, socially and cognitively in certain situations (Campbell, Cohn & Meyers, 1995; Murray, Hipwell, Hooper, Stein & Cooper, 1996). These studies moreover, exhibited a number of limitations potentially biasing the results and generalizability to other populations including small sample sizes consisting mainly of lower socioeconomic families, and a reliance on maternal reports (Martin 1996).

#### *The Impact of PND on Men*

Research on how men are affected by PND commenced when clinicians began to explore wider psychosocial issues and PND (George, 1996; Leathers, Kelly, Richman, 1997; Nicholson, Nason, Zalabresi, & Yando, 1990). Today, this research has assumed major importance as it has been found that men's physical and psychological health can be affected during the postpartum period (Deater-Deckard et al., 1998). To establish the differences between men who are affected by PND during the transition to parenthood and men who are not affected by PND ('well

men') the next section of the review will begin by discussing the issues surrounding the transition to parenthood for 'well men'.

### *Men's Transition to Parenthood*

Many of the changes that occur during the transition to parenthood can affect men (Eost, Cox, & Payne, 2002; Delamore-Ko, Pancer, Hunsberger & Pratt, 2000). Some studies have found that first time fathers not only experience elation at the birth of their child but also the stress associated with adapting to the transition to parenthood (Delamore-Ko et al., 2000; Marshall, 1993). Marriage satisfaction tends to decline during the transition to parenthood due to the added stress associated with becoming a new parent (Levy-Shiff, Dimitrovsky, Shulman & Har-Even, 1998; Marshall, 1993). However, some men and women report that their marital relationship has remained the same or had improved since the birth of their child (Cowan & Cowan, 1992).

In today's society men take on more of a fathering role as it has been established that fathers can be just as nurturing and sensitive while caring for their children as mothers. This is particularly evident in dual earning families where both fathers and mothers work and take responsibility for the home and parenting. However, the division of labor and the parenting role can change during the transition to parenthood (Olsen & DeFrain, 2000). Many men become more traditional in their family role, focusing more on their work, while women care for the new baby and take more responsibility in the home (Cowan & Cowan, 1992; Marshall, 1993). Generally however, men still participate in some child-care and nurturing during this period (Marsiglio et al., 2000; Pleck, 1997). Some researchers propose that it is hard for men to spend time and care for their new baby, as society's structures do not allow for men taking a greater responsibility in raising their

children (Marshall, 1993; Mauthner, 1998). In addition, men are usually the main breadwinners in the family and tend to work long hours (Crouter, Bumpus, Head & McHale, 2001; Marshall, 1993; Major, Klein & Ehrhart, 2002).

This situation changes for men when their partner is depressed as they need to adopt a more 'non-traditional' role by increasing the amount of work they do in the home to support their partner and family (Boath et al., 1998; Marshall, 1993; Mauthner, 1998; Meighan, Davis, Thomas & Droppleman, 1999). As a result, adapting to parenthood can be much more difficult for men when their partner has PND during the transition to parenthood (Marshall, 1993). In addition, men can also experience problems associated with becoming a new parent. Research has indicated that some men become depressed (Matthey et al., 2000; Zelkowitz & Milet, 1996), while fathers with more than one child can carry additional burdens that first-time fathers do not experience, including higher stress levels (Condon & Esuvaranathan, 1990).

#### *Rates and Risk Factors of Depression for Men*

Most of the research conducted to date on the impact of PND on men has been investigated using a quantitative methodology and has focused on prevalence rates of men's depression in the postpartum period (Deater-Deckard et al., 1998; Rees & Lutkins, 1971; Soliday, McCluskey-Fawcett & O'Brien, 1999). Research suggests that men have lower depression rates than women (Matthey et al., 2000; Rees & Lukins, 1971) and that depression in men usually occurs later in the postpartum period. Men are more likely to be depressed if they had a partner who was depressed during pregnancy or at one to three months after childbirth (Areias et al., 1996a). Men are more likely to have a higher rate of depression when they are unemployed or have less social and emotional support (Deater-Deckard et al.). Prevalence rates

of depression in men have varied in studies from 1.5% (Lane, et al., 1997) to 42% (Harvey & McGrath, 1988). The variation in prevalence rates may be due to cultural differences and the different types of measures used to rate depression.

Cross sectional research that has investigated psychiatric morbidity in men during the postnatal period has found that a significant number of men suffer from psychiatric illness in the postpartum period (Harvey & McGrath, 1988; Lovestone & Kumar, 1993). Harvey and McGrath's (1988) study reported that 42% of men living with a partner who is depressed had psychiatric morbidity including the disorders of major depression (MDD) and general anxiety disorder (GAD). Another study by Soliday et al. (1999) found that 25.5% of men were classified as depressed. This study also reported that 69% of the men with depression were mildly depressed and 31% were moderately depressed. However, a recent longitudinal study by Matthey et al. (2000) on men's depression reported lower depression scores for men during the antenatal and postnatal period. Depression rates for men during their wives pregnancy was 5.3% and postnatally at six weeks 2.6%, at four months 3.2% and at 12 months 4.7%.

A recent study by Deater-Deckard et al. (1998) examined depression in men living in a stepfamily environment and found that men living in a stepfamily had double the rate of depression both antenatally and postnatally than men living in nuclear families. This study has particular relevance as the structure of family systems has increasingly changed in today's society and stepfamilies are becoming more common (Olsen & DeFrain, 2000). In 1997, 22.8% of Australian children lived in either a stepfamily or blended family (Australian Bureau Statistics, 1999).

The course of depression for men in the postpartum period has been hard to analyse statistically, as most of the studies to date have had small sample sizes

(Areias et al., 1996b). However, a study by Matthey et al., (2000) found that of the eight fathers who were depressed antenatally 50% were depressed in the first 12 months postnatally. Further research using larger sample sizes is needed to determine the course of depression in men.

Research has identified several risk factors for depression in men during the postpartum period (Ballard et al., 1994; Deater-Deckard et al., 1998). These risk factors include being younger than 20 years of age, living in the lower social class of IV or V (Ballard et al., 1994), living with a partner who is depressed (Coyne et al., 1987; Galbaud et al., 1994), being high on the measure of neuroticism and poor partner relationships (Matthey et al., 2000).

#### *Implications of Men's Depression in the Postnatal Period*

There are several implications for family functioning when men and their partner are depressed during the postpartum period. Firstly, men who are depressed are less able to help their partner or care for their new baby (Zaslow, Pedersen, Cain, Suwalsky & Kramer, 1982). Secondly, men have less support and experience more stress trying to look after a wife with depression and new infant (Harvey & McGrath, 1988). Thirdly, although men are normally a buffer against depression in their partners, men who are depressed may contribute to women having a higher rate of depression (Gotlib & Hammen, 1992). Fourthly, instead of influencing their partner's recovery depressed men may actually increase the chance of poor recovery or relapse into depression (George, 1996; Hooley, Orley & Teasdale, 1986). These issues highlight that men's psychological well-being needs to be addressed, particularly in the context of parenthood and transition to parenthood. This is particularly important as men are expected to take on the major supportive role for

caring for both their partner who is depressed and children (Ballard & Davies, 1996; Mauthner, 1998).

*Men's Partner Relationships and PND*

Postnatal depression is associated with marital dissatisfaction (Dimitrovsky, Perez-Hirshberg & Itskowitz, 1987; Zerkowitz & Millet, 1996). However, researchers are still debating whether marital dissatisfaction is the cause or consequence of PND (Marks & Lovestone, 1995). Partners of mothers with depression report greater marital dissatisfaction after the birth of a child (Gotlib & Whiffen, 1989; Zerkowitz & Millet, 1996). Men's emotional and intimate sexual relationships with their partner can also decline during PND (Meighan et al., 1999), a situation which can result in men suffering emotional pain through the lack of emotional and physical intimacy in their marital relationship (Byrne, 2001a). A study by Meighan et al. (1999) found that men feel sadness and loss of relationship during their partner's PND. The men in this study also reported that they faced an uncertain future with a partner who was like a stranger to them. However, one limitation of this study was that the sample included several participants who were interviewed 11 years after the onset of the partner's PND. Therefore, this has the potential to affect the recall of the men's experiences living with a partner with PND and bias the results (Martin, 1995).

Marital dissatisfaction has also been associated with higher levels of criticism, hostility and aggression in men toward their partner (George, 1996). Research indicates that men with partners who have minor depression have poorer relationships and a higher level of expressed emotion than men living with a partner who has major depression (Brennan, Hammen, Katz & LeBroque, 2002; Gotlib &



Whiffen, 1989). Boyce and Stubbs (1994) suggest that in some cases couples separate during PND.

*Men's Depression and the Impact on Infants*

To date, there have been limited studies undertaken to investigate the effect of paternal depression on the interactions between fathers and infants in the postpartum period (Field, Hossain & Malphurs, 1999; Zaslow et al., 1982). A study by Zaslow et al. found that fathers who were depressed displayed less parenting behaviours, including touching their baby and care-giving compared to their partners. These fathers tended to withdraw from any interaction with their infant. This study also reported that at three months postpartum many fathers who were depressed became uncomfortable with parenting.

A recent study by Field et al. (1999) investigated the interactions between mothers and fathers with depression towards their infant in the postpartum period. They found that fathers who were depressed interacted more with their infant than the infant's mother who was depressed. Furthermore, depressed fathers did not display any negative behaviour towards their infant during the interaction. These results are in contrast to Zaslow et al.'s (1982) study where fathers displayed less than optimal behaviours towards their infant. One reason for this may be that the fathers in this study were not clinically depressed. These conflicting results indicate that further research is needed to clarify the results on infant interactions of fathers with depression. Additionally, longitudinal studies are needed to examine later childhood outcomes of paternal depression in the postpartum period.

Ballard and Davies (1996) suggest that there are major implications for children, when fathers as well as mothers are postnatally depressed. Children can have issues with their self-concept, poor peer relationships and are more critical of

themselves. According to Brennan et al. (2002) depression in both parents can have an additive effect as paternal depression can lead to children displaying more problem behaviours. However, the presence of a father who is not depressed can be a protective factor against the impact of maternal PND particularly when they have a warm and consistent relationship with their infant (Ballard & Davies, 1996). These fathers can therefore be a positive influence on their infant's development and could reduce the effects of PND on children with mothers with depression (Marsiglio, Amato, Day & Lamb, 2000; Pleck, 1997). It can be concluded that fathers have an important role to play and need to be available when their partners have PND.

#### *Treatment Interventions and Health Care Services for Men*

Scant research has been undertaken to investigate men's health and well-being during their partner's PND or treatment interventions that are effective for men with depression in the postpartum period (Bishop, 1999). Although research has suggested there are a number of effective treatment interventions currently being used to treat women with PND (Pope & Watts, 1999), there has been little or no research conducted to establish effective treatments for men who are depressed in the postnatal period (Bishop, 1999). Men with depression are usually treated with medication (Richards, 1990). Although medication can help, other interventions may be required to treat the underlying problems of depression (Creedy & Shocket, 1996). However, preventive measures have mainly been suggested for men that have partners with PND. These preventive measures include taking time to relax and unwind on a regular basis (Bishop, 1999).

Bishop (1999) suggests that most men are dissatisfied with the lack of information that is available for men on PND. The information that is available for men relates mainly to women's issues in PND, and not to issues that are relevant for

men living with a partner who is depressed (E. Webster, personal communication, May 1, 2003). It has been further suggested that treatment interventions revolve around a woman's needs and her relationship with the baby, and that there are limited support services for men to help them survive their partner's PND (Bishop, 1999; E. Webster, personal communication, May 1, 2003). Support groups that let men talk about their concerns and fears of how their partner's PND is affecting them and their family are important for men (Bishop, 1999).

### *Family Systems Theory*

Researchers have proposed that the needs of men during their partners' PND should be understood as part of a family system (Beital & Parke, 1998; Cowan & Cowan, 1992; Parke, 1996). This information is vital when dealing with persons who have health problems, as the family's interactions are often reflective of the least functioning person (Goldenberg & Goldenberg, 1996). Martel (1990) suggests that in order to help women with PND we need to understand how PND impacts on all family members. A family systems framework moreover, allows for more effective interventions to be developed (Gotlib & Colby, 1987). Clearly, research on how men perceive PND and the impact it has on them within the family system could benefit the family as a whole.

Family systems theory evolved from general systems theory (von Bertalanffy, 1968) to help understand families and stimulate new research on human interaction (Cox & Paley, 1997). Klir (1991) argues that "systems science is a legitimate science since it has its own domain of inquiry and knowledge pertaining to this domain, and its own methodology and metamethodology" (p.351). Family systems theory shares many concepts from general systems theory including multiple levels, wholeness, interdependence of parts, balance of openness and resistance to change

(flexibility), balance of separateness and connectedness (cohesion) and feedback within the system (communication) (Olsen & DeFrain, 2000). These concepts will now be discussed at length.

1. In general system theory terms the multiple levels are referred to the subsystems within a suprasystem. In the family system the subsystem is any dyad within that system and the suprasystem is the extended family (Olsen & DeFrain, 2000). These systems are connected by boundaries, which separates individuals from a subsystem and individuals, and subsystems from outside systems that include neighbourhood systems and community systems. Boundaries provide members of a family system with autonomy (Goldenberg & Goldenberg, 1996).
2. Wholeness pertains to the understanding of how a system operates with the whole system being greater than the individual sum of its parts. In family systems terms one can not know a member of the family unless you know how the all the others members and how they all interact with each other. The system operates by a set of rules that govern how all the members behave. This rule governed system is based on members having set roles so that there is structure within the family which helps to keep the family system in a homeostatic state.(Goldenberg & Goldenberg, 1996).
3. The concept of interdependence of parts within general systems theory is associated with the interconnectedness of the system. When one part of the system changes all other parts respond to this change. In family system terms when a member in the family system suffers, all other members are adversely affected. In this situation homeostasis of the family system becomes unbalanced (Goldenberg & Goldenberg, 1996).

4. Systems need to have a balance of openness and resistance to change (flexibility) to keep the family functioning. This flexibility of not being fully opened or closed gives a family system the stability it needs and the scope to change to live in homeostatic state. This is needed for growth in a family system. An open system or morphogenic system, interacts with the outside environment and changes its structure to new environmental conditions. A closed system or morphostatic system endeavours to remain stable and avoids change by not interacting with the environment (Goldenberg & Goldenberg, 1996).
5. The balance of separateness and connectedness is the core of family cohesion which involves keeping a balance of autonomy and intimacy within the family. There are two opposing forces that keep the system balanced; centrifugal interactions which keep family members apart and centripetal interactions that bring family members closer together (Montgomery & Fewer, 1988).
6. Feedback within the system (communication) is essential within the family system as it controls the family function through the information shared by the family members. Communication is necessary between systems both within the family and between a family and the outside world. Feedback loops which include positive feedback that create change and negative feedback that prevents changes or gets the system back to its normal state helps to keep the family system in a homeostatic state (Goldenberg and Goldenberg, 1996).

The development of family systems theory led to family therapy (Gottlib & Colby, 1987). Today many clinicians, counselors and therapists use a family systems

approach to treat individuals with mental health problems as it gives a greater and contextual understanding of the patient or client and their condition (Cottrell & Boston, 2002; Kazak, Simms & Rourke, 2002; Kraus, 1998). Coyne, Downey and Boergers (1992) have explored the impact of depression on the family system, developing a model that describes the relationship between depression and the family system. Their model incorporates three major concepts that show how depression and the family system are related, including the concepts of coherence, agency and general emotional dysregulation. These dimensions are evident in a family system when a member of the family has depression (Coyne et al, 1992). Coherence, the notion that family members believe that life is predictable and safe (Antonovsky, 1979) is affected when a member of the family is depressed, as routines can be disrupted, goals may not be achieved and personal commitments can be jeopardized (Brown & Harris, 1978). Families usually experience agency when members of the family system can rely on one another and have routines (Totman, 1979). When there is a parent with depression in the family, routines can change to the point where they become non-existent, family matters can be neglected and long term personal and family goals are abolished (Coyne et al.).

Families with a parent who is depressed experience general emotional dysregulation, particularly when coherence and agency are present. These families often have poor communication, misunderstanding and overt conflict. Some members may withdraw and avoid other members of the family. Couples who do not resolve problems or maintain their distance from each other have increased episodes of negative affect when further interaction takes place (Kahn, Coyne & Margolin, 1985). Thus, depression can add to the reciprocal process, which in turn leads to further family dysregulation (Coyne et al., 1992).

Coyne et al. (1992) suggests that dyadic relationships are often affected when a parent has depression. Emery, Fincham and Cummings (1992) highlight the importance of linking multiple levels of the family system and the impact it can have on child development. A couple's relationship can become more strained and the partner of the person with depression can also suffer while they often put their lives on hold during their partner's experience of depression. In extended families parent's relationships with grandparents can be affected by the stress they can put on the family. This in turn can impact on the parents family functioning.

Triangulation in family systems can occur when a dyad is under stress and when one of the individuals in the dyad looks to a third person, which is often a child in the marriage to reduce the tension in the relationship. However, when the triad can no longer take the tension other persons can become part of the tension and stress (Goldenberg & Goldenberg, 1996). Kerr and Bowen (1988) therefore suggest that tension in families such as when the birth of a child brings marital conflict, is not always reduced by triangulation. Although triadic family system patterns are evident in some family situations, more studies on depression are needed to explore this concept more fully as little research has been done in this area to date.

By studying men's experiences of PND in the context of a family systems framework we may not only confirm previous research findings on depression and family systems, but gain insight into the triadic nature of relationships within families who have a member who is depressed. Family systems theory offers a way for men's experiences to be viewed at different levels within the system so as to understand their position within the whole system and not just as individuals within the system viewed as separate entities (Goldenberg & Goldenberg, 1996).

### *Rationale for Current Study*

The review of the literature indicates that men's issues in relation to PND have not been widely studied (George, 1996; Nicholson et al., 1999) and that there is a need for more qualitative research in this area to understand men's experiences of PND. Qualitative research has been widely used in mental health research (Nicholas & Pope, 2000) and has the capacity to benefit mental health services, health practitioners (Nicholson, 1995) and PND research (Hickman, 1992). In addition, research on men's issues in relation to PND could benefit men and other family members (Areias et al., 1996b; Ballard & Davies, 1996; Boath et al., 1998; George, 1996).

To date, only a few studies have been conducted to investigate the impact of PND on the family (Boath et al., 1998; Morgan et al., 1997). Only one phenomenological study has been found that has specifically examined men's experiences of living with a partner with PND (Meighan et al., 1999). This study was conducted in the United States and may not be relevant to Australian men. In addition, the retrospective accounts given by the men up to 11 years after the onset of their partner's PND may have affected the recall of their experiences. This highlights the importance of this current study, which will endeavour to investigate men's experiences of living with a partner who has PND using a qualitative design. A phenomenological methodology will be used to explore and understand the experiences of the men as it has the potential to extract rich and meaningful information (Moustakas, (1994).

### *Research Questions*

As men's experiences of PND and how it impacts on them within the family system will be investigated the research questions of this study are:



1. What are the experiences of men living with a partner who has PND?
2. How have these experiences impacted on the men's lives?
3. Do men's relationships with the other members of the family and extended family change?
4. Is family systems theory useful in understanding the impact of PND on men?

## Method

### *Design*

To research the men's experiences of living with a partner with PND, a qualitative study was conducted using one to one semi-structured interviews. The use of semi-structured interviews gives more depth and quality to research (Palmerino, 1999) as the researcher can enter into the psychological and social world of the participant (Smith, 1999). This research design also gives men an opportunity to express their experiences and perception of PND in their own words and has the potential to identify unrecognized problems and needs of the subject under investigation (Lincoln & Guba, 1985).

An interpretative phenomenological approach was used to access the experiences and perceptions of men as it provides an excellent avenue to seek meaning from individual's experiences through an interview process (Moustakas, 1994; Nicholson, 1995). According to Moustakas (1994), this type of approach provides comprehensive descriptions and is an efficient way to attain information on personal issues. The personal description of the participant's experience gives meaning and direction that allows themes to be identified. Information gathered in this research was partly interpreted within a family systems framework as this approach has the capacity to explain the systemic issues relevant in parenthood and the impact of depression within a family unit (Coyne et al., 1992).

### *Sample Selection and Setting*

A purposive sample was used in this current study, as certain criteria had to satisfy the informational needs of the study. Men living with women who scored high on the EPDS postnatally (i.e.,  $\geq 12$ ) were recruited as participants. This EPDS score gives a clear indication of clinical depression (Cox et al., 1987). These women

had attended the postnatal depression treatment program at Women's Health Care House (WHCH) in Perth, Western Australia. The partners of prospective participants were approached through the group treatment program facilitators at WHCH and offered the information sheet (Appendix A) and consent forms (Appendix B and C) for them and their partner to sign. The men in this current study had become fathers, though they did not need to be first time fathers (see Table 1). The interviews were conducted with the men between eight and 24 months after their partners being diagnosed with PND. The men's partners were diagnosed with PND after the birth of their youngest child (see Table 1).

*Table 1*

*Demographic Details of the Male Participants*

	Age of Participant	Number of Children	When Partner was diagnosed with PND
Participant One	33	2	Second Birth
Participant Two	34	2 (Twins)	First Birth
Participant Three	34	1	First Birth
Participant Four	34	2	Second Birth
Participant Five	33	2	Second Birth
Participant Six	37	1	First Birth
Participant Seven	47	2	Second Birth

### *Participants*

Eight men living in Perth, Western Australia were interviewed for the study. However, the transcribed data from one participant was withdrawn, as it did not meet

the criteria of the study. The sample size of seven participants was deemed satisfactory as saturation of the data was reached and this sample size has been found to be adequate by other researchers (e.g., Beck, 1992; Meighan et al., 1999) who have conducted phenomenological studies (Byrne, 2001b). The participants were between 33 years and 47 years of age. All seven participants were married and working full time at the time of the interview.

#### *Instrument*

A semi-structured interview was used to obtain the data. The interviews were tape-recorded for accuracy of the data (Breakwell, 2000). An interview guide that was developed to take account of the family systems perspective contained a number of questions that were used to gain the experiences of the men in the study (Appendix D).

#### *Procedure*

When the completed consent forms were returned to the researcher, the participants were contacted by telephone to arrange a time for the interview that was suitable for both the participant and researcher. The interviews were conducted over a five-month period either at the participants' workplace, at the WHCH or at a private residence. Before the start of each interview the researcher gave a description of the research and answered any questions asked by the participant. The participants were informed that they could withdraw from the interview at any stage if they felt uncomfortable or stressed discussing their experiences of PND.

The interview started with several demographic questions to help facilitate a conversation between the participant and researcher (Holroyd, 2001). The conversation on the men's experiences of living with a partner with PND always

started with the general open-ended question "Can you tell me what your experience has been living with a partner with PND?". Occasionally additional probes were used to clarify and expand on specific areas of the participant's lived experience of PND. A list of questions was referred to when needed to help guide the conversation so that men's experience of living with a partner with PND could be expanded on during the interview. Each interview took between 45 minutes and 80 minutes, and after the interview the participants were thanked for taking part in the study. The taped interviews were then transcribed and each interview transcript was later read and validated by the relevant participant.

### *Ethical Considerations*

The participants were over the age of 18 years and were informed of the voluntary nature of the study. As a requirement of the Ethics Committee the participants signed a consent form. The participant's partner was also required to sign a separate consent form giving permission for their partner to be interviewed on the experience of living with a partner who has PND. Consent was given for the researcher to access their demographic details from WHCH. During the research process the anonymity of the participant was maintained as it is essential that they are not identifiable in the data.

### *Data Analysis*

Phenomenology can seek meaning from a participant's experiences and gives the essence of that experience through pre-reflection, reflection and reduction. Phenomenology reduction incorporates a thematic framework which aids in analyzing the data as phenomenology is rooted in themes (Moustakas, 1994). Schweitzer's (1997) phenomenological approach was used to reduce the data and explicate meaning from the interview transcripts (Holroyd, 2001). This method

"combines the procedures of Dusquesne School of Phenomenological Psychology and a system of thematic analysis" (Schweitzer, 1998, p. 2). Schweitzer's (1998) approach incorporates a number of steps to reduce and analyse the transcribed data.

First, the transcripts were read to gain an intuitive and holistic understanding of the raw data. Second, the transcripts were read again to search for natural meaning units and central themes to form a constituent profile. During this stage natural meaning units, which are segments of the participant's experience were highlighted and underlined. These included words, phrases or sentences that capture the participant's experiences that help answer the research questions. Concepts, thoughts and ideas formed from reading the men's lived experience of PND were written in the margins. Third, central themes were identified for each participant and then grouped together until there was a non-repetitive list of statements that gave descriptive meaning to each man's experience. This formed the thematic index. All repeated statements were reduced by removing them from the list. The referents and the words highlighting the essence of each of the participant's experience under investigation were listed separately. Fourth, referents of all participants were compared and central themes interpreted. These were compiled into a list to establish a set of interpretive themes. Fifth, the interpretive themes were referred back to the transcript. Finally, a master list of the interpretive themes and sub-themes was compiled and a summary for each interpretive theme was put together to create a picture of the participants' experiences (Holroyd, 2001).

Two independent co-analysts reviewed the themes and sub-themes with the assigned interview statements to provide rigour through analyst triangulation (Patton, 1999). In addition, the researcher discussed the themes with a health

professional experienced in men's issues, health and well-being, and how they compare with his knowledge and understanding of men's experience of the postpartum period with a partner who is depressed.

## Findings and Interpretation

Six major themes relating to men's experiences of living with a postnatally depressed partner emerged from the data. These themes were (1) Division of Labour, (2) Issues of Self, (3) Altered Family Relationships, (4) PND - The Problem, (5) Support within Family System and (6) Interaction with Health Professionals. Table 2 contains the six major themes and the related sub-themes that were identified in the analysis of the participants' responses. The issues discussed in each theme answer the research questions as they give detail of the men's experiences and how they have impacted on their lives and relationships within the family system.

Table 2

*Relational Themes of Men's Experiences Living with a Partner who has PND*

Main Themes	Sub-themes
1. Changes in Division of Labour	Breadwinner Domestic Changes in Parenting
2. Issues of Self	Psychological Expressed Emotions He Makes Sacrifices
3. Altered Family Relationships	Impact on Spousal Relationship Impact on Children Extended Family Members
4. PND - The Problem	Changes in Men's Partner during PND Understanding of PND
5. Support within Family System	Partner Support Family Support
6. Interaction with Health Professionals	Medical Professionals Service Providers



What follows is a discussion of each of these themes with illustrative quotes, and although the themes are discussed separately many of the themes are connected to each other.

### *1. Changes in Division of Labour*

During the transition to parenthood the division of labour for most men changes. Typically, men take on a more traditional role where they become the main breadwinner (Cowan & Cowan, 1995; Marshall, 1993). The division of labour for majority of the men during the peak of PND had become unbalanced, with men not only being the main breadwinner, but also doing more domestic chores. This resulted in the men "*burning the candle at both ends*". This situation can have serious consequences as men's health and well being can be affected (Knauth, 2001).

#### *1. (a) Breadwinner*

The literature suggests that many men believe their main role within the family is that of breadwinner (Marshall, 1993; Western, Qu & Soriano, 2002). The men of this study believed they were the breadwinner of the family, even though they had taken on additional work in the home to support their partner. In the words of one man: "*... I still needed to work and bring the money in*". Although the men saw that supporting their partner was important during the PND, going to work to bring the money in was also a high priority (Hand & Lewis, 2002).

The men needed to have work flexibility as they needed to occasionally take time off work to help their partner during the critical times of PND. One man illustrated this by stating "*I had to take some time off at times when my wife was really upset, just emotional*". This was further demonstrated by the words of another man: "*Through her PND, if she was upset or couldn't cope, she would usually then*

*ring me in tears and I would go home. If she wanted me, I would go home".*

According to the men, their partner needed extra attention and support during PND.

In addition, the majority of the men mentioned that they had worked long hours prior to their partners PND. During their partner's PND some men decided to work less hours at their place of employment so they could support their partner: *"As the year has gone on I realise that she [partner] needs me more than my work needs me. Work is on the back burner and it has helped our relationship".* This statement indicates that although work was important for financial security, the partner's emotional needs became a priority for some men. This shows that men provide extra respite and support for partners during PND (Ballard & Davies, 1996) as women with PND need more assistance and attention (Boath et al., 1998). It also supports the research findings that the extra time men spend at home supporting their partner can have a positive effect on their relationships (Russell & Bowman, 2000).

Conflict between work and family is often referred to in the literature and is related to poor family functioning and is associated with psychological distress (Major et al., 2002; Russell & Bowman, 2000). This study found that for some men the responsibilities of the workplace created feelings of guilt about the respective amount of time they spend at work and at home supporting their partner and family: *"... the biggest thing is the guilt factor, and the guilt and stress that it leaves me. Guilt about not getting my work done in the office with things piling up and then I bring it home and then getting guilty about not spending enough time with my family..."*. Another man felt that he was not there to support his wife as he had heavy work commitments: *"Frustration of just the hours being away from home. Not helping out and giving the support to my wife that I would have liked."* These statements support other research as many men often work long hours (Russell &

Bowman, 2000) which results in less time for the family. Consequently, this can lead to poor marital relationships (MacEwen, Barling & Kelloway, 1992) and negative parent-child interactions (Broman, 2001; Repetti & Wood, 1997).

#### *1. (b) Domestic*

The majority of the men often stated that they had increased their domestic duties in the home during their partners' PND: *"When my wife is down there is a lot more for me to do with dishes and getting kids ready for bed, doing the washing, occasionally the ironing ..."*; and *"I cook a couple of nights a week, clean, mop, I do the dishes which my wife used to do"*. Some men felt that with the added responsibilities of the domestic duties around the home it became another place of work: *"I feel like I am burning the candle at both ends with work and home life. I have not necessarily found my home to be my refuge as it used to be. It used to be my refuge, away from the office..."*. These comments demonstrate how the men's lives had been impacted on living with a partner who has PND as they had to increase the amount of work they did around the family home (Morgan et al., 1997). Set roles within the family system changed as the men took on more of the domestic duties while maintaining paid work. According to family systems theory, when set roles become unbalanced the homeostatic state in the family system changes and becomes unbalanced as routines are disrupted (Goldenberg & Goldenberg, 1996), especially when a member of the family is depressed (Brown & Harris, 1987). Also agency, the reliance on other members to follow routines was affected when their partner was postnatally depressed (Goldenberg & Goldenberg, 1996).

#### *1. (c) Changes in Parenting*

Many men report that they value being a father and find the parenting role satisfying (Marsiglio, 1991) even though parenthood can be stressful and demanding

(Parke, 1996). The literature suggests that men develop complex parenting expectations, which helps them to become cognitively ready for the ups and downs of parenting. Men who are cognitively ready for parenting are more positive in their parenting (Pancer, Pratt, Hunsberger & Gallant, 2000). This study found that the men expected that parenting would be hard and that their experiences of parenting had confirmed their expectations. Examples include *"I new it would be tough..."*, *I didn't expect it to be easy, so my expectations were pretty right on* and *"I was expecting the endless screaming, the constant grind of changing nappies ..."*.

Although most men stated that they expected parenting would be tough, they found that it was even tougher with their partners having PND: *It "[Parenting] was certainly more difficult with my wife having PND, it threw a few spanners in the works"*. Another man stated *"...I just realize how difficult children can be and how hard it is to rear children and how much time is put into them. And even though you feel tired and worn out or depressed ... certainly one has to continue ..."*. For one man the impact of PND on the family had made him feel that parenting wasn't a happy event to the point where he had doubted the value of being a parent: *"...during the postnatal [depression] I guess there were times when you felt bitter that these children have created this thing. It's just how you look at it. The postnatal [depression], the effect it has at certain points, you know, if life's like this you think that it's not worth it. So why bother to do it. It's not worth it because if we're like this you can't protect children from it"*.

These statements support that parenting for men living with a partner who has PND is more difficult and stressful than for men going through the transition to parenthood without a partner who is postnatally depressed (Ballard & Davies, 1996, Marshall, 1993). These statements indicate that coherence in the families was

affected as life was no longer predictable and safe when the men's partners were postnatally depressed (Antonovsky, 1979). Therefore, PND is a real problem that impacts on men and other members of the family (Boath et al., 1998).

## *2. Issues of Self*

Many men experience more psychological and emotional problems when they are living with a partner who is postnatally depressed (George, 1996, Meighan et al., 1999). Working long hours and coming home to more work and a partner who is depressed can lead men to become depressed and resentful, particularly if they are not getting any time for themselves (Marshall, 1993). In addition, men find PND distressing and tend to express their emotions more during their partner's PND (Mac Ewan et al., 1992). This study found that the men's mental health and well-being can be impacted on living with a partner who is postnatally depressed, as many of the men were negatively affected psychologically, emotionally and socially.

### *2. (a) Psychological*

The existence of depression in men in the postnatal period has been well substantiated in the literature. Men's depression is associated with women's PND and the onset of depression in men usually occurs later in the postpartum period (Ballard et al., 1994; Matthey et al., 2000). Men living with a partner who is postnatally depressed have a 70% chance of getting depression themselves (Hippisley-Cox, Coupland, Pringle, Crown & Hammersley, 2002). This study revealed that four of the seven men had feelings of depression during their partners PND. This finding is consistent with the literature, and provides further support for quantitative studies that have found a significant number of men develop depression in the postpartum period (Harvey & McGrath, 1988; Lovestone & Kumar, 1993).

Some men believed that their partner's depression had impacted on them to the point where they themselves had become depressed. This was confirmed by the statements *"... I went downhill and I am on medication myself for depression, a doctor diagnosed me". With my wife being depressed it triggered my depression*, and *"I started becoming really depressed and I had to work really hard not to go down and I guess I didn't want to go down the medication route so I started taking St. John's Wort and stuff like that"*. These statements highlight that men are affected by their partner's PND as they were experiencing symptoms of PND (Hippisley-Cox, et al., 2002). This is an important issue as men are viewed as the main support for their partner and family during PND (Ballard & Davies, 1996; Mauthner, 1998). If men's health and well-being is not taken into consideration during their partner's PND then their partners may develop severe depression (Gotlib & Hammen, 1992) or their partners may take longer to recover from PND (George, 1996; Hooley et al., 1986). Therefore, men's mental health issues need to be taken into account when their partner has PND (Areias, et al., 1996b).

In addition, some of the men suffered a loss of self-esteem during the PND due to them not being valued as a person or for the support they provided: *"I discovered it impacted on my self-esteem"*. Another man stated *"... I didn't feel worthy, during that period I didn't feel worthy or wanted", It just didn't seem enough for my wife ... "*. These statements confirm that men living with a partner who is postnatally depressed are psychologically affected. These statements also support the literature as women who are postnatally depressed often do not appreciate their partners or what their partners do for them and that this can lead to lower self-esteem (Meighan et al., 1999).

## 2. (b) Expressed Emotions

Higher levels of expressed emotion are found in partners of people who are depressed (Brennan et al., 2002). Men feel more anger and frustration (Marshall, 1993) and conflict occurs more often in relationships (Coyne et al., 1992; MacEwen et al., 1992). This indicates that the family system is experiencing general emotional dysregulation (Coyne et al.). This was confirmed by the majority of the men as they experienced frustration and anger when trying to deal with their partner's PND and the impact it was having on their life. This was demonstrated by statements that included *"It is very frustrating and very difficult for me sometimes [during partner's PND]"; "A few anger outbursts from myself. Just through frustration" and "[I was] Quite angry about it, but I didn't display that anger. At one stage it got to the point where I burst out into tears ..."*. These statements show that PND impacts on men's emotional well-being. As a result, men may need help and support during their partner's PND to ease the burden of living with a partner who is depressed so that they do not become so frustrated where they become angry or violent.

## 2. (c) He Makes Sacrifices

Most of the men stated that they sacrificed their social time for the family during their partners PND. Socially, these men experienced isolation as they found it difficult to make time to go out and do something for themselves: *"You don't even sometimes get an hour for yourself. You just need a bit of time for yourself. All social things were limited and at the peak of the PND all social things stopped. I stopped a lot of things I was doing and that kind of impacted and made it worse because then you're only solely dealing with this problem that you've got"*. Another man acknowledged *"I don't get as much of the required social interaction that I ought to, so I resent that to some degree"*. These statements reveal that the men are

constantly busy working or looking after their partner and family, leaving them no time to relax or socialize.

Furthermore, one man reported that the lack of time he had for himself was affecting him emotionally: *"[Time for self] Sometimes it is non existent. I need to find some way of unwinding from work apart from yelling and screaming at people which I do not want to do. I try to find something relaxing like music or playing computer games or playing sports. So PND has not helped these issues"*. This statement reflects that men need to have time out and if men don't, then serious consequences can occur including severe emotional problems that lead to aggressive behaviour. The literature suggests men need time for themselves to relax for their health and well-being so they can function adequately to help the family (Zelowitz & Millet, 1996), otherwise family life can become more stressful and the impact on family functioning can compound (Marshall, 1993).

### 3. *Altered Family Relationships*

According to the literature family relationships invariably changed during the course of PND (Larson & O'Hara, 2002). An issue raised in the literature is that PND has a negative affect on relationships as the depression makes a woman more reactive in certain situations. (Zaslow et al., 1982). The men reported that they had experienced changes in their relationship with their partner, children and parents in both a negative and positive way.

#### 3. (a) *Impact on Spousal Relationship*

Relationships often decline when a person in the relationship is depressed (Larson & O'Hara, 2002; Zelowitz & Millet, 1996) as depression affects couple communication, emotional intimacy and relationship commitments (Byrne, 2001a). This can lead to men threatening to leave the family (Coyne et al., 1992). Although



marital relationships can deteriorate after the onset of depression, poor marital relationships can cause PND (Gotlib & Whiffen, 1989).

The findings of this study are consistent with the literature as the men in this study all reported that the relationship with their partner had deteriorated during their partner's depression. Examples include *"That [PND] affected in a sense the total relationship, physically, mentally, and how we felt. It wasn't what we felt that having a family was all about"; "The relationship with my wife is the one that has suffered the most. That's the one that has changed the most" and "There have been a lot of arguments. There have been times where you just want to forget about it all and go way. Just go our separate ways"*. These statements indicate that men's relationships with their partner can deteriorate to the point where they have thoughts of leaving their partner. Although men may have thoughts of leaving their partner, the literature suggests that couples with children who are not happy in their relationship tend to stay together for the sake of the children (White & Booth, 1985). The findings are consistent with family systems theory literature as dyadic relationships are negatively affected when one of the individuals in the relationship suffers from depression (Coyne et al, 1992).

As the relationship deteriorated during the PND so did the intimacy in the men's relationship with their partner: *The only one [intimacy] was none at that stage. It was pretty hard and everyone being tired. But especially if you're bitter and twisted and angry and all those sort of things. It's a bit hard to have a good relationship when that's all going on*. In particular, the sexual relationship of a couple can deteriorate during PND (Marshall, 1993). The men stated that their sex life was impacted on to the point where all sexual intimacy ceased: *"As far as our sex life was concerned it was non-existent, and it is still not at the moment, which is a*

*bummer" and "... on the sexual side of things that took a beating as well. Everything just suffers from that point of view ... from the PND".*

Furthermore, the men also reported a lack of affection in the relationship: *"...there was certainly no tenderness between my wife and I at the time. It was kind of get out, get the kids to bed, go to work and come home. There was no point in there for just hugs and things like that. It was just survival. There was no intimacy".* Another man reported *"At times my wife did not want me to touch her or give her a kiss, which I found very hard".* These comments are consistent with the literature as poor marital relationships during a woman's PND impacts on the emotional intimacy of a couple (Byrne, 2001a). This reported lack of intimacy in the relationship would be particularly hard on men, as their partner is their major source of emotional support (Edgar, 1997; Martel, 1990).

Emotional pain can be experienced from the lack of emotional and physical intimacy in a relationship (Marshall, 1993). One man stated that the poor relationship with his partner and the lack of intimacy was a painful experience: *"It would have been nice to experience something sexual, rather than hostility or her tiredness and crankiness. Quite often I was hurt by it. But it was best if I did not dwell on it, as when on those times when I did indulge my thoughts of being hurt and I was hurt and I felt hurt, I knew it would lead me to misery".* This comment reflects that men experience emotional pain during their partner's PND and that this can be lonely time for men, especially as their partner is usually their main companion and confidant (Edgar, 1997; Richards, 1990).

Although the men's relationships had deteriorated during the PND, they believed that going through the PND with their partner had made the relationship stronger. For some men the relationship was the best it had ever been. This was

acknowledged by comments that included: *"It made us stronger. I think, once we'd gone through it, because we had both gone through it together. Although she had the symptoms, I was a part of it. I think it has made us appreciate one another a bit more, because you've gone through such a hard time and come through it with success, so it made us stronger"; "Between my wife and I, I think it has brought us closer together. We can now talk to each other a lot better than we ever have been able to" and "As part of my experience is that you learn to communicate better in your relationship ... and I have had a growth experience from it where you feel like you need to grow up and work harder to become more adult "*.

The above comments reflect that going through the PND process can be a source of growth for the individual. Additionally, couples who have gone through the PND process together can experience a stronger and better relationship. This is supported by the literature as couples who go through the process of depression and jointly deal with the depression can experience a more positive relationship (Byrne, 2001a). The findings indicate that communication in the men's relationship was important during PND. The building of better communication in the men's relationship indicates that within the family system, feedback was used to create positive change in the relationship. Thus, this helped the relationship to improve and brought back homeostasis to the relationship (Goldenberg & Goldenberg, 1996).

### 3. (b) Impact on Children

Some men in the study who had two children reported that they had problems initially bonding with their new baby. The partner's of these men were diagnosed with PND with the birth of this youngest child. Men's relationship with their second born child has been found not to be as close as that of their first born (Condon & Esuvaranthan, 1990). Consistent with the literature bonding with the second born

child was an issue for some men: *"I don't know if it's got anything to do with the PND but the bonding that I have with my second, I don't feel is quite as strong as with my first..."*. Another man had similar feelings about his baby: *"... when our son [second child] came out we loved him, but it wasn't the same quality [as the first child]*. Although bonding with the baby was initially viewed negatively by some men, other men reported that their new baby was a delight, particularly if it was a girl. In the words of one man *"I love having a beautiful baby daughter"*.

For these men, living with a partner who is postnatally depressed was a source of frustration that reduced their level of patience when parenting the older child in the family. As a consequence the men became firmer in the way they responded to their older child as they used physical punishment to discipline them. Examples include *"I took my frustrations out on him. Yelling at him, I have given him a smack and I was not as tolerant as what I should have been ..."*; *"...I have spanked him as well, even though we both have said we do not want to spank our kids and we feel super guilty about that kind of stuff"*; and *" There were times when disciplining him I knew I was probably harsher than that I would have been normally"*. These statements indicate that PND can undermine the effectiveness of men's parenting (Fendrich, Warner & Weissman, 1990). Men with more than one child can have more stress so that combined with the negative environment in the home during PND, men's parenting behaviours can be negatively influenced (Condon & Esuvaranathan, 1990).

Postnatal depression can impact on infants and on children's behaviour and emotional state (Whiffen & Gotlib, 1989). Children can become angry over the disruption in their family life during PND and when exposed to the aggression in their parent's relationship, may engage in reciprocal hostility (Coyne et al., 1992).

Some men in this current study reported that there were concerns over how PND may impact on their children. One man stated that his wife had concerns over her emotional outbursts in the presence of their children: *"She was worried about her crying in front of the kids. She was concerned that at some point they may become scarred by it"*. Another man stated that he was concerned over how the aggression in their spousal relationship was affecting their older child during the peak of the PND: *"And what became difficult was the acting out in front our three year old and then see her reacting to it as well. Our daughter became at times, insecure, but at times she would go kind of quiet or her behaviour would become quite aggressive. She was just playing it out regularly"*. These statements support that PND impacts on children (Murray & Cooper, 1997). This finding also highlights that triangulation in the family system had occurred, as the older child became part of the parent's tension and stress (Coyne et al., 1992). Additionally, this confirms that tension in the family does not necessarily get reduced by the third person in the triad, but increases the tension and problems in the family (Kerr & Bowen, 1988). The findings also support that the family member's interactions are reflective of the problems associated with the mother's PND and that all members in the family system are interlocked with each other (Goldenberg & Goldenberg, 1996).

### 3. (c) Extended Family Members

Relationships with close family members are often improved by the support and care that is given to the mother and family during PND (Cox & Paley, 1997). Many men stated that certain relationships within the family have been strengthened through the support given during their partner's PND: *"I have gotten on with them [in-laws] pretty good and as time has gone on we have become close"*. Another man stated *"My wife has become closer to my parents. They both suffer from*

*depression.... They have understanding of what your wife is going through which helps. It brought my parents closer to her.* These comments suggest that good relationships in the extended family are important and that these relationships can be enhanced during PND when there is understanding of the family problem and support is given. This also indicates that close family members are an essential source of support for the family during PND (Brown, 1987; Cox & Paley, 1997).

#### 4. PND - The Problem

Women with PND can experience affective, behavioural and cognitive symptoms that impacts how they function (Bishop, 1999). Postnatally depressed women do not function well and have less coping mechanisms to cope with day to day living (Bishop, 1999, Pope & Watts, 1999). This impacts on other family members as it can affect infants and their later childhood development (Henderson et al., 2003; Murray & Cooper, 1997) and men's mental health (Ballard & Davies, 1996; Matthey et al., 2000).

##### 4. (a) Changes in Men's Partner during PND

The men related that their partners had become highly emotional during the PND: *"...all these things resulted from the depression, which resulted in mood swings. We were happy one moment, emotional and crying, living out there the next, anger and her softness at times".* Another man stated *"... but my wife's mood swings and she was emotional, they just kind of got worse and worse to the point where you thought, there has to be something wrong".* For one man PND became a real crisis when his young son became the carer: *"I got home and my wife was in a fetal position on the couch and my son said 'mum needs you'. He was quite concerned and upset. My son who is only three and a half was looking after his mum".* The changes in the men's partners were part of the PND, a situation which for many

families PND becomes a real crisis (Bishop, 1999; Boath et al., 1998). This finding highlights the need for social support and treatment interventions for women with PND (Pope, 2000; Pope & Watts, 1997).

The literature indicates that men find it difficult to cope having a partner with PND (George, 1996; Marshall, 1993). This study found that some men find it hard to deal with the PND situation and that it can be a time of crisis for them as well. One man acknowledged that PND is a real crisis for men: *"PND has a life of its own and even though I know my wife was not coping very well, I guess there was this expectation that things would get better and I told that to myself for some time, but there came a time when I couldn't keep all the balls in the air at the same time with what was happening"*. This statement indicates that men need to have support as they find it difficult to cope with the demands made on them trying to meet the needs of their postnatally depressed partner and other members in the family.

#### 4. (b) Understanding of PND

Although PND is a real problem that impacts on all the family (Boath et al., 1998) it is a disorder that is difficult to understand (Ugarriza, 2002). The literature indicates that men have problems understanding PND and what women experience (George, 1996). One of the major problems for men in this study was accepting that their partner had PND as they lacked understanding of PND and what their partner was experiencing. Examples include *"Originally, I tried to ignore it as every good or bad husband does. So yea it got worse to start with .... Then shit hit the fan to be blunt and then I realized this is not going to go away"*; *"My experience was that for me it was very difficult to come to terms with [PND]. I eventually did come to terms with it, but I did not still understand it. I did not understand and why it happened in the first place"* and *"My experience is, at first it was a lack of understanding of what*

*was going on. Things didn't seem to be running smoothly, there were more arguments, everyone was tired".* These statements confirm men do not understand PND or what their partner was experiencing. This indicates that men need to have prior knowledge of what can happen to women after the birth of a child so that they can recognise the symptoms of PND and recognise it as a real problem. This in turn, may also help men to understand PND and what women are experiencing.

Some of the men reported that their extended families also experienced a lack of understanding and acceptance of PND: *"... her parents or her mother does not think she is postnatally depressed and she has no real understanding of why my wife is depressed. She sees it to be depressed or clinically depressed is something that you have to be in a psych ward or something to be a depressed person ...".* Another man stated *"It's been frustrating in some respect, especially as her mother denies it. I don't think she has any understanding of it at all and the one time that my wife raised the issue with her, her mother just said to her 'you just have to get on with it and get on with life' ".* These statements support the literature as depression is hard to understand for older people as it can have a different meaning for different age groups and sociocultural groups (Ugarriza, 2002). Thus, awareness of PND and how it impacts on women and the other family members is essential so that people can gain some understanding of PND and the implications it can have on the family.

### 5. Support

Support in the literature refers to "the commitment, caring advice and aid provided in personal relationships" (Ross, Mirowsky & Goldsteen, 1990, p.1062) and is related to the promotion of better health for those suffering from PND. Partners and family members are viewed as the primary source of support for postnatally depressed women (Bost, Cox & Payne, 2002). If support is not given during PND



women can become severely depressed, recovery will take longer (George, 1996; Hooley, Orley & Teasdale, 1986), and family functioning can deteriorate (Brown, 1987).

#### 5. (a) Partner Support

The literature suggests that partner support can ease the tension within the family as well as having a positive impact on a partner's depressive mood state (Matthey et al., 2000). Partner support also is associated with the recovery of postnatal depression in women (Misri, Kostaras, Fox & Kostaras, 2000). Women value both emotional and practical support from their partner. However, men believe that giving practical support is of major importance (George, 1996). The men in the study were a major source of support to their partner as they provided the much needed practical support of helping out with domestic duties: *"...if you could do a few things and do practical things to take the pressure off and make things at least easier around the house... get the food on the table, take care of the kids ..."*. Another man reported *"I was trying to make things smooth as in just the general duties of the house, housework and looking after the kids"*. These statements reflect that the men were trying to maintain the homeostatic state in the home by helping out more with the domestic duties to support their partner (Goldenberg & Goldenberg, 1996). This highlights the fact that men need to be available to provide extra support to their partner during a woman's PND.

Furthermore, one man stated that PND is a family issue that needs to be solved within the family: *"When the doctor said she needed to go to hospital for a week to get away from all the pressures. That was the turning point for me and that's where I done the strategy thing with my wife at that point. We discussed with the doctors and counselors what I wanted to do instead. I didn't think going to hospital*

*was the right thing. I think family is the much better solution than the medical solution any day and that's what I did. So I took some time off of work and got her mum involved".* This statement clearly identifies that these men want to be involved to help fix their partners' problem and that PND is a family problem (Martel, 1990).

#### 5. (b) Family Support

The literature indicates that close family members are the main source of support in crisis situations such as PND. In extended families, women have been identified as the main support persons (Brown, 1987). This was confirmed by the men as they reported that parents and in particular mothers were a major source of support during their partner's PND: *"My wife's mum has been super supportive. She's the one who has come over a lot and really helped out" and "Her mum is really great. She has our daughter every Monday and has done for quite a long time".* The men's parents and in-laws provided the much needed support to the family. This family support helps family functioning to improve during a woman's PND (Coyne et al., 1992).

Some of the men believed that only parents are available to be of support as most family members are busy leading their own lives. This was acknowledged by one man who stated *"It has shown to me that only certain family members can provide you with long term assistance and generally that is your parents or your husband. Your brothers and sisters have their own lives and that is probably in keeping with them doing their own thing and while they can help out a bit, they can jump back and do their own thing".* This statement shows parents are viewed as the only reliable source of support outside the immediate family, this has implications for mothers with PND and families who do not have parents to help out.

Furthermore, many men reported that their partners needed to have more practical support from the family, rather than emotional support: *"So not the emotional support of the phone calls doesn't mean much, rather than the practical support that's what I think she wants. Someone to sit there and to talk to or do the dishes for you, that's what my wife wanted, so she could sit there and veg out while someone looked after the kids or make the bed for her or even watch the midday movie with her, that's what she wanted"*. This comment reflects that these men believe women with PND need to have someone physically there for them offering companionship as well as giving practical support.

However, some of the parents or in-laws were not that supportive and the men reported that these family members were either too old, lived too far away or did not understand PND and what their partner's were going through. In the words of one man *"Up until she was diagnosed with PND her mother did not understand or didn't really want to understand .... My wife felt like that she didn't want to help her and wasn't very supportive, whereas my mum would help her out"*. Another man stated *"We have very little support in our family structure anyway [greater family]. My family is in Sydney and they are the youngest of the grandparents and my wife's parents are much elderly ..."*. Although family support is integral to the well-being of women with PND and family functioning (Morgan et al., 1997) the men's comments reflect that some parents are not available to support the family. Therefore, health professionals treating women with PND need to be aware of this family situation so that they can refer services that can support the family to function better (Holopainen, 2002; O'Hara, Stuart, Gorman & Wenzel, 2000).

## 6. *Interaction with Health Professionals*

Interaction with health professionals is essential for women with PND (McLennon et al., 2001; Pope, 2000; Pope & Watts, 1999). During the course of PND health-care services are used more often (Webster, et al., 2001) to obtain appropriate treatment interventions and support to overcome the PND (Holopainen, 2002). Men's involvement in the treatment process is vital for better long-term outcomes (Johnson & Lebow, 2000). Programs for PND are now being implemented to include men's sessions or couple sessions (Morgan et al., 1997). The men's beliefs concerning interactions with health professional were contained in the categories of medical professionals and service providers.

### 6. (a) *Medical Professionals*

The literature on medical professionals suggests that General Practitioners (GPs) have limited time to counsel patients with PND. Instead GPs prefer to prescribe medication to treat the depression (Righetti-Veltema, et al., 2002). This has resulted in dissatisfaction with the service given by health professionals (Righetti-Veltema et al., Webster et al., 2001). Most of the men confirmed the dissatisfaction with the treatment given by GPs and health professions: *"Her doctor she had seen for years obviously seemed to me had no compassion, for my wife. All her doctor did was just write out a script and send her off and no follow up or anything ... to the point where she changed doctors"*. Another man stated *"...and then I was angry with the medical professionals because they said it would be all better, and it wasn't"*. These statements indicate that health professionals need to be more sensitive and caring towards women with PND (Richards, 1990) and that they may need to refer some women to other services for additional care and treatment (Creedy & Shocket, 1996).

Some of these men were dissatisfied with the medical profession, because the initial treatment their partner received was ineffective: *The medication didn't work. I really thought that she was sorted out by the doctors and the medical professionals. And they increased it [the dosage] and they said 'you have got to try it for two weeks and if it doesn't work come back and we will increase the dose a bit more and try that for two weeks'... and we did that for three or four times".* The statements suggest that women and their partners need to have an understanding and knowledge of the problems associated with getting the correct dosage for an individual including the length of time it takes for the medication to take effect (E. Webster, personal communication, May 1, 2003).

The literature indicates that postnatal depression is often unrecognized and left untreated by health professionals (Georgiopoulos et al., 2001; Kumar & Robson, 1984). This is of major concern as if PND is not treated early women can become severely depressed (Pope, 2000). This can have serious consequences due to the increased risk of child abuse, infanticide and suicide (Chandra et al., 2002; Pope, 2000). A few men stated that they felt dissatisfied with the health professions as their partners were not diagnosed at the onset of PND: *"My wife could have been diagnosed earlier based on what the hospital may have found. Another man stated "I suppose the doctors to pick it up earlier would have been nicer. My wife had changed GP's and when she changed GP's this female doctor picked it up. The previous doctor she had was her regular doctor and she did not pick it up".* These statements clearly suggest that GPs and medical professionals need to become more aware of PND symptoms so that women can be screened for PND earlier (Boyce & Stubbs, 1994; Pope & Watts, 1999). Early detection, assessment and treatment by health professionals will lead to quicker recovery for women with PND (Pope,

2000). This has positive benefits as it can reduce the affects of PND on men and other family members (Ballard & Davies, 1996; Boath et al., 1998).

#### 6. (b) Service Providers

The literature suggests that there is a lack of services for men dealing with issues of PND (Nicholson et al., 1999). In particular, there is a lack of support networks where men can confide how they are coping and feeling (Harrison, Maguire & Pitcreathly, 1995). This was confirmed by many of the men in this study as they claimed that there was little help or support for men with a partner who has PND: *"There is not a huge amount of help or it appears that there is not a huge amount of help or anything where you can talk to other guys who have trouble dealing with what the women are going through"*. In addition, some men believed that men's needs are ignored and that men need support during their partner's PND. This is confirmed by the statements *"My wife needs this, my wife needs that and it was like, yes, well I need a bit of that ...there's more consideration for the mother not for the male. ...everyone else seemed to consider the female in this, not really the fact that the male has, because of this depression by my wife, how it affects the father..."* and *"I think they could look at men's issues a bit more. How they should be coping with it all and how they could be coping with it all"*. These statements reflect that men want support and additional services during their partners PND. Therefore, health care professionals need to consider partners of women with PND. Thus a family systems approach should be used so that men and other family members are considered when planning treatment interventions (Gotlib & Colby, 1987). A family systems approach offers positive benefits as it can provide better long term outcomes for persons who are depressed (Johnson & Lebow, 2000).

Many men believed there needs to be more information on PND given out by services for men as it is also a crisis time for them: *"A course that is informative. Like a place for partners, a forum for the men to express their views, to see if it is normal what they're feeling. Maybe even part of antenatal, maybe they should have a section on issues for men or more information about postnatal [depression]"*.

Another man stated that information through brochures would be beneficial: *"I think they could have a brochure for men which many may not be that different from the women's one but be a bit more direct in terms of how men do these things. And in the PND situation men are more likely to feel like this, and that these things are normal. Most of the brochures talk about the women's depression. ... they don't talk about what is normal for men"*. These comments suggest that services and resources need to be made meaningful for men and to address their needs if they are to be of any real benefit for men (Brooks & Good, 2001). These statements also indicate that men are open to seek help from larger systems outside the family system to obtain information and services which will help them to survive during their partner's PND (Goldenberg & Goldenberg, 1996).

Two men confirmed that giving information to others is important. In the words of one man *"I feel happy to offer this information to what you're doing now, as feedback to others. I think that's important because in life you can go through a lot of things and get learning from it, but unless it's shared, it's not really valuable"*.

### Conclusions

This study aimed to investigate men's experiences and perceptions of living with a partner who has PND, examining the changes in their lives and relationships within the family systems perspective. The PND of their partners was found to constitute a real crisis for men as they experienced a substantial impact on their work, home life, relationships, mental health and emotional well-being. This study showed that support from the men and close family members was crucial for family functioning. However, the lack of support services for men with a postnatally depressed partner was found to contribute to men's experience of stress and perception of their situation as an extremely critical one.

The findings of this study supports the literature as it clearly demonstrates that men's mental health and well-being can be affected from living with a partner who has PND (Arieas et al., 1996b; Boath et al., 1998; Harvey & McGrath, 1988). Over 50% of the men in this study reported depressed feelings during their partner's PND, indicating that men also need to be assessed for depression so that they can receive the necessary treatment interventions (Arieas et al., 1996b). This is important as there are a number of implications for family functioning when both men and women are depressed during the postpartum period (Zaslow et al., 1982; Harvey & McGrath, 1988). Despite feeling depressed, these men still continued to support their partner and family throughout the PND crisis. How these men with depression managed to cope with work demands and extra domestic duties during their partner's PND is an issue that could be further investigated (E. Webster, personal communication, 1<sup>st</sup> May 2003).

The men experienced more negative emotions living with a partner who has PND. For some men the lack of time for themselves and the social isolation led to



more negative emotions of anger and frustration as they had no time to unwind during their partner's PND. This clearly shows that men's lives can be impacted on living with a postnatally depressed partner. Therefore, it is suggested that men and their families need practical support so that men have time to relax and unwind from the pressures of work and home. Although this study found that many of the men expressed more negative emotions during their partner's PND, further studies are required to confirm the findings of this study as much of the research conducted to date has been on depression and expressed emotions during the antenatal period.

It can be clearly demonstrated from the findings that medical and health professionals need to become more aware of PND and the impact it has on men supporting other researchers conclusions (Bishop, 1999; Marshall, 1993). Additionally, men need to have support groups and services available to help them to better cope with living with a postnatally depressed partner (Bishop, 1999). These services should be advertised so that people are aware that they are available. Information and brochures on PND that are relevant for men need to become available. Furthermore, men should be told about PND and the implications for them and the impact it can have on their family. This study's finding has identified new areas that need to be focused on in relation to the type of information men with partners who are postnatally depressed need to become available. It is recommended that this information be given at antenatal classes and after the birth of the baby, so that men are aware of PND and the potential impact it can have on them and the family.

The men lives were impacted on as they experienced changes in their working lives and domestic conditions, which resulted in the division of labour becoming unbalanced for many men during the peak of their partner's PND. The

men used a number of coping mechanisms to survive during their partner's PND including reducing the amount of hours at their paid work and taking time off of work to support their partner. Although strategies for coping were used during PND, many of the men were still '*burning the candle at both ends*' as they went from their job to more work at home. This indicates that extra support is required in the home from outside sources, which would allow men to take time out for themselves and reduce the effects of PND that can impact on them (Bishop, 1999). These findings not only support the literature (Ballard & Davis, 1996; Meighan et al., 1999; Morgan et al., 1997) but adds to the understanding of how men cope during their partners PND. The findings of this study would, of course have implications for policy development in the work place, given that men often need to take time off from work when their partner is suffering from PND.

Men's relationships with their partner, older child, parents and/or in-laws were found to have changed during the PND. The men's relationship with their partners and older child deteriorated during the PND, while some men's relationship with their parents and/or in-laws had improved during their partners PND. Although the men's relationship with their partner initially deteriorated during the PND, after going through the PND process with their partner the relationship improved and became stronger to the point where some men believed their relationship to be better than before the PND. While there have been reports in the literature that couples can have better relationships as a result of going through the experience of depression together (Byrne, 2001a), this is the first study to actually identify stronger relationships in couples after going through PND together. In addition, a stronger relationship in couples after PND has not been found in clinical situations (E. Webster, personal communication, 1<sup>st</sup> May 2003). Further research is needed to

confirm this finding of this study and to explore how and in precisely what ways these relationships get stronger as a result of joint negotiation of PND.

With regard to family relationships, the men were found to act more firmly in the way they disciplined their older child and used physical punishment to keep the peace in the home during their partners' PND. This would indicate that children are not only susceptible to problems from the impact of their mother's PND (Murray & Cooper, 1997), but are at risk of increased problems from the impact of their father's lack of tolerance when living with a postnatally depressed partner. Furthermore, this study supports the literature as it found that men's relationship with their older child was not as warm and consistent during their partner's PND (Ballard & Davies, 1996). This study also found that older children showed more behavioural and emotional problems when exposed to their parent's arguments and fighting during PND. This finding supports the general literature's findings that children are affected during PND (Murray & Cooper, 1997). These findings add to the PND research, as there have only been a limited amount of studies on the impact of depressed men on infants in the postpartum period and little or no research on how the behaviour of men living with a postnatally depressed partner impacts on older children. More research could examine further how the impact of men living with a postnatally depressed partner effects older children in families and the consequences this may have for their long-term development.

The findings of this study support the use of family system theory in the examination of inter-familial relationships as the men were negatively affected from living with a postnatally depressed partner. Family systems theory can therefore be used to help understand the impact of PND on men living with a postnatally depressed partner. There was some evidence of triangulation in the men's family

system, as the older child became part of the men's tension, stress and frustration from living with a postnatally depressed partner. This supports the finding of Kerr and Bowen (1988) regarding the negative triadic nature of relationships in families with a depressed person (Kerr & Bowen, 1988). The findings also support Coyne et al.'s (1992) model of depression in family systems as coherence, agency and general emotional dysregulation was evident in the men's lives and their relationships with other members in the family system.

The findings of this study provide support for the claim that close family members are the main support persons for women suffering PND (Bost, Cox & Payne, 2002; Brown, 1987) and that men perceive practical support as more important for their partner with PND than emotional support (George, 1996). The men perceived that they were the main source of support for their partner (Ballard & Davies, 1996; Mauthner, 1998) and that their parents and in-laws were the only persons within the extended family who were able to give any on going assistance. This finding highlights two major issues concerning support from the men's parents and in-laws.

Firstly, the parents and in-laws who gave support had an understanding of PND as they had themselves been depressed in the past and knew from past experience some of the problems associated with the depression. Some parents and in-laws gave little or no support during the partner's PND as they did not understand PND or what the family was experiencing. This lack of understanding can be a potential problem in families that need support, pointing to a need for greater awareness of PND in families and the community.

Secondly, parents or in-laws were generally too old to help out or were only able to help out in a limited capacity. This is a major issue for couples today as more

couples are having children at an older age (Olsen & De Frain, 2000) with the consequences that should this trend continue more families affected by PND will have little or no on-going support from their extended family. This situation needs to be taken into consideration by health professionals with the recommendation that the amount of support required within the family needs to be assessed so that support networks become a major part of the intervention plan. This situation clearly has implications for future policy development.

To conclude, living with a partner who has PND has a detrimental effect on men's mental health, well-being, lives and relationships. This situation is exacerbated by the fact that there are few support services where men can go for help and support. It could therefore be suggested that men are the silent sufferers of PND (Meighan et al., 1999). If men are the main support for their partner and family during PND, then they need to be in good health, both mentally and physically. As PND is a family problem a family system perspective should be used to treat PND, so that men can be included in the planning of treatment interventions and receive the necessary treatment and support they need at this time.

### *Limitations*

Although understanding was gained through using a qualitative design no causal links can be made of the issues presented in this research. Therefore, future studies need to quantitatively validate whether these issues are significant for all men with a partner who is postnatally depressed. Phenomenology is a useful way to gain understanding (Moustakas, 1994) but one person's experience may differ from other people's experience of a phenomenon. Although this is a potential limitation this study found that there was a communality of the participant's experiences thus

eliminating this bias. The use of volunteer participants may have brought some bias through self-selection thus the findings may not be transferable to other populations (Martin, 1995). In particular, men from stepfamilies may have different experiences of living with a partner who is postnatally depressed. This would be an area where further investigation is warranted, especially as family structure is changing in society (Olsen & DeFrain, 2000). Sample size is another potential limitation as the sample size in this study was small. However, as stated previously the sample size used in this research is consistent with other sample sizes used by other researchers (Meighan et al., 1999) and is viewed as satisfactory.

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## Appendix A

## Participant Information Letter

Dear Participant

My name is Colela Browning and I am a student at Edith Cowan University undertaking a Psychology Honours course. As part of this course I am conducting a research project about men's experiences of living with postnatal depression and whether this has affected their life. This research conforms to guidelines produced by the Edith Cowan University Committee for the Conduct of Ethical Research.

For my research, I would like to interview men whose partner has been diagnosed with postnatal depression. This will involve a face to face interview that will last approximately one hour. A tape-recorder will be used to record the interview to ensure accuracy of the conversation. The information that I will collect from the interview will help to gain a better understanding of postnatal depression from a male's perspective, which may lead to more effective interventions and services for families being developed.

Be assured that any information you provide will be confidential and at no time will your name be reported along with any responses. At the conclusion of this study, a report of the results will be available on request. Please understand that your participation in this research is totally voluntary and you are free to withdraw at any time during this study.

If you would like to participate in this study, please fill out and sign the attached consent form and return it in the reply paid envelope. Should you require further information or have any questions please feel free to call myself, Colela Browning on 9729 3153 or my principal supervisor, Associate Professor Sherryl Pope, at the School of Psychology, Edith Cowan University, Joondalup, on 9400 5194.

Please retain this letter so you have a copy of the contact details, if you should need them at any time. I would appreciate your response within one week of receiving this letter, if that is possible.

Yours sincerely

Colela Browning  
(Researcher)

## Appendix B

## Participant Consent Form

I ..... have read the information letter about this  
 (Name)  
 research and any questions I asked have been answered to my satisfaction. I agree  
 to participate in the individual interview, realising that I may withdraw at any time,  
 removing any information I have provided. I understand that the research data  
 gathered in the interview for the study will be tape-recorded. I agree that the results  
 of this study may be published, provided I am not identified.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Could you please provide your contact details and preferred day and time to arrange  
 a time for the interview. After completing this form, please return it in the enclosed  
 reply paid envelope. Thank you for your assistance.

**Contact Details**

Preferred Time/Day for Contact \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Appendix C

Consent Form (Female Partner)

I ..... have read the information letter about this  
(Name)  
research and any questions I asked have been answered to my satisfaction. I give  
consent for my partner to be interviewed about his experiences of living with  
postnatal depression. I also give consent for the researcher to access my  
demographic  
details for this purpose of the research.

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Signature

---

Date

## Appendix D

## Interview Schedule - Part 1

I would like to talk to you about your experiences of living with a postnatally depressed partner. If you wish to stop the interview at any stage of the interview please let me know and we will do so.

I will start with getting a number of details from you and then we will begin with the research questions. The facts that will be at the time of the interview will include:

- Date of birth and gender of infant
- Type of delivery
  - Vaginal (spontaneous, assisted)
  - Caesarean (elective, emergency)
- Age and gender of older children
- Method of infant feeding
  - Initial
  - Current
- When partner was diagnosed with PND
- Expectations of birth and parenting
- Your Age

## Appendix D

## Interview Questions - Part 2

1. Can you tell me what your experience has been living with a partner who has PND?
2. How has living with a partner who has PND affected your life?
3. Have any of your views or perceptions on family life changed since your partner has been diagnosed with PND?
4. How has this affected your family life?
5. Have any of your relationships within your family changed?  
If so, how?
6. Has your relationship with your partner changed? If so, how?
7. What is your relationship like with the new baby? Is it what you thought it would be like?
8. Has this affected your relationship with the other children in the family? (If they have other children)
9. Has this impacted on your work or home roles/duties? How?
10. Has this impacted on any other areas of your life?