THE LIVED EXPERIENCES OF MEN WHOSE PARTNERS HAVE POSTPARTUM DEPRESSION

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

Studies involving postpartum depression (PPD) lack in their focus on the experiences of men whose partners have been diagnosed with PPD. PPD possesses implications not only for mothers, but also for their children and the fathers. Current literature focuses on studying mothers and children, and often ignore the father.

The current study utilized a hermeneutic phenomenological qualitative inquiry to identify themes consistent with men's experiences with having a partner with PPD. This study involved participants who 1) are 18 years or older, 2) identify as cisgender male, 3) in a current relationship with the mother of their biological child, 4) have a partner with a current, official PPD diagnosis, 5) live with their partner, and 6) are the biological father of their partner's child. Participant selection included using purposive and snowball sampling from local obstetrics and gynecological, pediatrician, mental health services offices, and social media platforms.

The findings of this study provided insight into the meaning of men's experiences with having a partner that has PPD. This study yielded five major themes: 1) Getting Lost in the Shuffle, 2) My Own Worst Enemy, 3) Purgatory, 4) Light Within the Dark, and 5) Putting the "Partner" in Partnership. The current study helped pave the way for future research to analyze the mental health needs for men upon having a child and led the way to the offering of frequent mental health services to men. This dissertation discusses the findings of the study as well as provided insight into the implications for the counseling profession.

DEDICATION

I am dedicating this dissertation to the most important people in my life. First, to the light of my life: my son Jameson. You kept me going when I thought I could not go any further. Thank you for keeping a smile on my face and a fight in my heart. This is all for you. Do not let anyone tell you that you can't do something. Just smile and prove them wrong. I love you more than there are grains of sand. I am also dedicating this dissertation to my husband, Dillon. I could not have done this without your unconditional love and support. I will never be able to thank you enough for all you have done for me. You are my rock, and I will be forever grateful to have you to face life with. You finally get your wife back. I love you, Babe. Thank you for being you.

To my mom, I do not have the words to express how grateful I am for you. You showed me what it means to be a strong and independent woman. You are my biggest cheerleader, and this would not have been possible without you. This is every bit of your achievement as it is mine. I am excited to finally be your Dr. Baby Girl. I love you, Mom. Gigi and Pappy, you two mean the world to me and I am excited to share this milestone with you both. I love you both so much. Thank you for the constant encouragement and guidance. Thank you for everything you have ever done and continue to do for me.

Finally, to my guardian angel, Granny. Even though you were not physically here, I felt your presence every step of the way. You kept me focused and true to myself during this journey. I miss and love you more than words can express, and I wish you could have been here to see this.

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meant so much to me, and I am grateful I have you as a mentor. I have leaned on you for so many things, and I will never be able to tell you how much I appreciate you.

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CHAPTER I: INTRODUCTION

Postpartum depression (PPD) is a severe mental health condition that affects 1 in 8 women every year (Centers for Disease Control and Prevention [CDC], 2020; O'Hara, 2009). According to the American Psychiatric Association [APA] (2013), PPD, also known as peripartum depression, is a specifier that used for major depressive disorder. Although the Diagnostic and Statistical Manual of Mental Disorders- IV [DSM-IV] (APA, 1994) included PPD, the DSM-V reflects evidence that supports 50% of PPD episodes occur prior to birth (APA, 2013). The onset of PPD can begin as early as the first few weeks after childbirth, but no later than the child's first birthday (APA, 2013; Mayo Clinic, 2021). Women who have PPD display symptoms such as 1) depressed mood, 2) diminished interests or pleasure, 3) weight loss or change in appetite, 4) insomnia, 5) psychomotor agitation or retardation, 6) fatigue, 7) feelings of worthlessness or inappropriate guilt, 8) declination of ability to think or concentrate, and/or 9) recurrent suicidal ideation (APA, 2013). These symptoms affect not only the mother, but also the family unit.

Postpartum depression can have negative implications on the mother. For instance, women who experience PPD are more likely to develop anxiety disorders, engage in substance abuse, and have poor self-care practices (Slomian et al., 2019; Zuckerman et al., 1989). Mothers are also more likely to suffer physical health implications, such as physical limitations (Slomian et al., 2019). Furthermore, the researchers state that mothers with PPD tend to present with low mood and lower self-esteem when compared to mothers without PPD. In addition, Slomian et al. reveal that mothers with PPD frequently display higher levels of anger and a decrease in anger control. The researchers also mention that PPD negatively influences the mother's relationships. For example, Slomian et al. claim that mothers with PPD report having less social support than

mothers without PPD. The researchers continue to explain that PPD can also influence the social function of women. As for partner relationships, women suffering from PPD often report viewing their relationship as cold, difficult, and distant, according to Slomian et al. Moreover, the researchers found that mothers with PPD typically report having a decreased libido within the postpartum period. This decrease can be up to three times greater than women without PPD. In addition to implications for physical and mental health, PPD can cause risky behaviors in mothers. For instance, mothers with PPD are more likely to engage in addictive behaviors, such as smoking. In fact, most mothers who begin smoking after pregnancy have PPD (Whitaker et al., 2007). Mothers who were frequent drinkers before pregnancy and have PPD are more likely to engage in risky drinking after pregnancy as well (Jagodzinski & Fleming, 2007). Finally, PPD is associated with an increase in suicidal ideation (Do et al., 2013; Paris & Bolton, 2009; Pope et al., 2013; Postmontier, 2008; Tavares et al., 2012). The more severe the symptoms mothers have, the greater the presence of self-harm and suicidal ideation (Pope et al., 2013). With that, impacts on children of mothers who have PPD exist.

Children who are born to mothers that experience postpartum depression are at an elevated risk of being born with a low birth-rate, being born prematurely, and have poorer quality neuromotor development (Bakare et al., 2014; Gress-Smith et al., 2012; Hedegaard et al., 1993; Hoffman & Hatch, 2000; Kalita, 2010; Lundy et al., 1999; Nasreen et al., 2013; Ndokera & MacArthur, 2011; Rini et al., 1999). Furthermore, infants born to mothers who experience PPD are more likely to have their growth stunted (Avan et al., 2010; Bakare et al., 2014; Ndokera & MacArthur, 2011). When PPD is present five months postpartum, infants are more likely to have physical health concerns. PPD in pregnancy is a sufficient predictor of childhood illness (Adewuya et al., 2008; Gress-Smith et al., 2012). Higher depressive symptoms in mothers

can influence the sleeping patterns of infants; infants with mothers who have PPD are more likely to experience more frequent night-time awakenings (Gress-Smith et al., 2012; Tavares Pinheiro et al., 2011). In addition, children of mothers with PPD also experience these difficulties as toddlers. These implications present themselves as poor or delayed social, emotional, and cognitive development (Goodman & Brand, 2008; Kaplan et al., 2015). Additionally, having a mother with PPD can negatively impact children's language development. Children whose mothers have PPD are more likely to experience language delays than children whose mothers did not have PPD (Kalita, 2010; Kaplan et al., 2012; Kaplan et al., 2014; Paulson et al., 2009; Quevedo et al., 2012; Zajicek-Farber, 2009). However, it is possible that maternal PPD can benefit the language development of a child; some children are less silent and demonstrate high positive infant vocalization (Friedman, 2005). Moreover, having a mother with PPD may hinder infant social development. Previous literature found that infants whose mothers presented with PPD displayed lower social engagement at nine months than those whose mothers did not have PPD (Feldman et al., 2009). Finally, by the age of two, children whose mothers had PPD demonstrated more behavioral problems (Avan et al., 2010). These children are more likely to have more mood disorders, difficult temperaments, and internalizing disorders (Bagner et al., 2010; Gao et al., 2007; Hanington et al., 2010). Due to these implications, the centers of postpartum care are mothers and babies. However, fathers do not receive much attention during pregnancy, let alone during the postpartum period.

Understanding this phenomenon is important to the profession of counseling in several ways. First, the results of my study can help counselors develop a greater understanding of the support women are receiving from their partner. Providing this insight can help further develop the treatment of postpartum depression by identifying potential gaps in the support women are

receiving. Furthermore, this information has the potential to help identify the need for early intervention with couples to help reduce the divorce or separation rate within families where PPD exists (Reichman et al., 2015). Additionally, this study provides insight into how having a partner with PPD affects men's mental health and encouraged more appropriate offerings of postnatal treatment for men. In terms of counselor education, this study brought awareness and encouraged educators to discuss the impact of PPD on family systems. Specifically, educators can focus on teaching students how PPD influences the dynamics between partners as well as between parents and children. Thus, the further exploration of the experiences of fathers who have partners with PPD is needed.

Background of the Problem

According to the CDC (2020), postpartum depression affects roughly 13% of mothers each year. While the prevalence of PPD is significant, women are not the only ones who experience mental hardship after the birth of a child. The existing research involves males and females but does not examine males' experiences of female PPD. Research states that fathers experience their own form of PPD, called paternal postpartum depression (Mayo Clinic, 2021). During paternal postpartum depression, fathers are experiencing fatigue, being overwhelmed, anxiety, and changes in sleeping and eating habits (Kumar et al., 2018; Mayo Clinic, 2021; Wang et al., 2021). Although PPD being more common in women, paternal postpartum depression affects roughly 4% of fathers within the first year of their child's life (Dave et al., 2010). Other research shows paternal PPD has negative consequences for children as well. For example, children whose fathers face paternal PPD are more likely to develop hyperactivity behaviors, become less attached to their fathers, and have more likely to suffer from emotional problems and conduct disorders (Paulson & Bazemore, 2010; Ramchandani et al., 2008).

There is a claim that fathers are, for the most part, ignored during pregnancy, birth, and postnatal care (Warren, 2020). The researcher stated, in addition to being ignored during childbirth, new fathers are also challenged with trying to navigate fatherhood. According to Warren (2020) and Beaupre et al. (2014), previous generations of fathers did not hold the expectation that fathers would take part in active parenting, such as attending birthing classes, being in the delivery room, or changing diapers. Warren (2020) revealed most men do not have a model of how to be involved with their children. Furthermore, there is a recent shift in fatherhood expectations overlook the thought that men need support (Beaupre et al., 2014; Warren, 2020). This is true during the postpartum period as well. In addition to the lack of support for fathers, there is also lack of representation for fathers in literature surrounding postpartum depression and its implications (Warren, 2020). Though information on PPD and paternal PPD is helpful, research on having a partner with PPD is still lacking.

There is an extensive gap in the literature regarding men's experiences with a partner with postpartum depression. To date, there have only been a handful of qualitative studies that aim at further understanding what it is like for fathers to endure their partner going through PPD. Due to the lack of literature, it is not clear what it is like for fathers to currently experience their partners going through PPD (Davy et al., 2006; Ierardi et al., 2019; Maxwell et al., 2020; Mayers et al., 2020; Meighan et al., 1999). Additionally, these studies collect data anywhere from three months to eleven years after the experience (Davey et al., 2006; Ierardi et al., 2019; Maxwell et al., 2020; Mayers et al., 2020; Meighan et al., 1999). This study included participants whose partners are currently experiencing PPD, making the data collected more accurate. Furthermore, previous studies have included individuals whose partners diagnosis consists of other postpartum disorders, such as postpartum anxiety and postpartum obsessive-compulsive disorder (Davey et

al., 2006; Maxwell et al., 2020). This study only included men whose partners have PPD. With the lack of information, it is still not completely understood what it is like for men to witness their partners battle with PPD.

Statement of the Problem

Babies are the primary focus of the postpartum period. They receive constant examinations to ensure their mental, physical, and developmental needs are met. Within the first year, babies get approximately six "well baby" check-ups that intend to make sure the baby is developing properly and to potentially catch and/or prevent any health concerns (Office of Disease Prevention and Health Promotion, 2021). Mothers receive during the postpartum period, but to a lesser degree (World Health Organization, [WHO], 2015). According to the WHO (2015), the recommendation is that mothers are seen and assessed four times after birth: one day postpartum, three days postpartum, 7-14 days postpartum, and six weeks postpartum. These visits are designed to allow healthcare providers to assess mothers' physical, social, and psychological well-being (American College of Obstetricians and Gynecologists [ACOG], 2018). While these appointments are helpful, there is a push in the healthcare profession to have routine contact with their providers at three weeks postpartum, ongoing care as needed, and then a comprehensive postpartum visit no later than 12 weeks postpartum (ACOG, 2018; Stuebe et al., 2021). Although the well-being of the baby and mother are greatly important, it seems necessary to check on the father as well in order to obtain insight into how childbirth affected the family system.

Doctors do not require or encourage fathers to have check-ups following the birth of their child. Moreover, doctors do not expect fathers to discuss their experiences with them. Since the age of blogging and social media has become increasingly popular (Engqvist & Nilsson, 2011),

there are several online resources and support-type groups for dads, such as National Parent Helpline (n.d.), Postpartum Dads (n.d.), Postpartum Support International (2021), and What to Expect (2018). Although these resources maybe helpful if fathers are experiencing strains in their mental health, research recommends them to talk to a mental health professional (Chan, 2013). Being a new parent presents with its own set of challenges, including emotional, physical, and psychological strain. Furthering our understanding of men's experiences having a partner with v can increase our knowledge on how to better support them. In turn, this can help the mother, and by extension, the child, thus having the potential to positively impact the entire family system. Mental health professionals may not be well informed about the support fathers need during the postpartum period. Given the minimal information in the counseling literature surrounding men's experience with having a partner that has PPD, it seems important to acknowledge PPD and paternal PPD often lead to higher rates of divorce, less paternal involvement with child rearing, and poor attachment between fathers and their children (Bagley, 2021; Warren, 2020).

Purpose of the Study

The research completed on fathers and postpartum depression is scant and there are even fewer studies that aim at addressing what it is like for men to experience their partner going through postpartum depression. Furthermore, the existing research lacks diversity in their samples, due to most of the participants identifying as White males (Ierardi et al., 2019), does not account for the time that has lapsed between the onset of their partners' PPD and time of data collection, or the impact on the relationship between partners. The purpose of this study was to explore the experiences of men whose partners currently have PPD in order to better understand their overall experience as well as the impact on the relationship dynamic. This study's focus on men whose partners currently have PPD will address the limitations of previous research that

examined experiences after PPD, such as lacking in cultural diversity, not accounting for time that has passed between the experience and the data collection, or the impact on the relationships. Although this study does not seek a specific demographic among participants, the researcher seeks to recruit participants of diverse backgrounds through her recruitment efforts by recruiting from various sites, such as healthcare offices, mental health offices, and offices that provide other means of support to families, as well as various social media platforms. By further understanding fathers' experiences with having a partner with PPD, counselors may be able to provide better mental health services for fathers. By obtaining a more in-depth understanding of this phenomenon, counselors and other health care providers will be able to allocate more focus on the mental health and wellbeing of fathers in addition to mothers. This study has brought awareness to fathers' needs and increase advocacy for fathers across mental health and medical professions. In order to sufficiently address the purpose of this study, I utilize hermeneutic phenomenology, specifically van Manen's method (van Manen, 1990).

Research Question

The predominant research question for this study is: What are the lived experiences of men who have partners with postpartum depression?

Significance of the Study

This study contributed to the counseling profession by enhancing the research focus on men's experiences with having a partner with postpartum depression, increasing clinician understanding of this phenomenon, and informing counselor education. Future research can focus on the experiences of same-sex couples, transgender men, and blended families. Within clinical practice, the development of a deeper understanding of men's experiences with having a partner with PPD allows for the creation of interventions that, help men and their partners cope

with PPD. Furthermore, counselor educators will be able to increase their understanding of men's experiences to train future counselors.

Research has shown that fathers are in dire need of support when becoming parents (Warren, 2020). One significant impact this study could have on men whose partners currently have postpartum depression is that it may reveal what type of support the fathers need and, thus, lead to the more frequent check-in and referrals for the fathers during the postpartum period. The results of this study can also help provide more insight into how fathers experience their partners' PPD and can foster the increased understanding of the needs of those men.

Methodology

Phenomenological Approach

To adequately address the research question, I used a qualitative research design. I used hermeneutic phenomenology, specifically following the guidelines of van Manen's (1990) approach. I aimed to include seven participants in the study; however, it is important to recognize that with van Manen's approach, researchers cannot predetermine the number of participants used for risk of altering the integrity of the study (van Manen, 1990; 2014). I anticipated this number based on alternative literature that utilized this approach, which showed the number of participants ranging from three to nine (Anekstein et al., 2018; Azizpour et al., 2018; Baltrinic, 2014; Brown, 2020; Giovengo-Gurrera, 2017; Hays, 2020; Hyatt, 2018; Jahn & Smith-Adcock, 2017; Koltz & Feit, 2012; Minor & Duchac, n.d.; Nasrabadi et al., 2019; Vanmeter, 2019; Wagener-Cramer, 2018; Zust et al., 2017). Each participant is 18 years or older, identifies as a cisgender male, is in a current relationship with the mother of their child, confirmed their partner has an official PPD diagnosis, lives with their partner, and is the biological father of their partner's child. I obtained participants using purposive and snowball

sampling. I posted flyers containing information regarding the study in local obstetrics and gynecological offices (OBGYN), community mental health facilities, counseling private practices, and pediatrician offices. I also posted information on this study on social media platforms such as Facebook, Instagram, and Reddit. My goal was to obtain participants that vary in race and ethnicity to include diverse populations.

Population and Sample

In order to create the inclusion and exclusion criteria for this study, I remained consistent with van Manen's (1990) hermeneutic phenomenology which requires researchers to select participants who have experienced the phenomenon. Those who are eligible for this study must: (a) be at least 18 years of age, (b) identify as cisgender male, (c) be in a current, heterosexual relationship with the mother of their child, (d) confirm their partner has a postpartum depression diagnosis, (e) live with their partner, and (f) be the biological father of their partner's child. Furthermore, the exclusion criteria for this study include participants who: (a) are under the age of 18, (b) are not in a current, heterosexual relationship with the mother of their child, (c) do not have a partner with diagnosed PPD, and (d) are not the biological father of the child whose pregnancy resulted in PPD.

For the purpose of this study, I utilized a variety of organizations within the community. I have been granted permission to place flyers (see Appendix A) at a university's counseling and training clinic and their affiliated site (see Appendix B and Appendix C) as well as my personal place of employment (see Appendix D). Furthermore, I obtained permission from my personal OBGYN office (see Appendix E). I selected these locations due to my already established relationship with them. Additionally, I obtained permission from a local organization that interacts with new families (see Appendix F), an additional counseling office (see Appendix G),

and a pediatrician's office (see Appendix H). I informed the contact persons of these locations the purpose of my study, participant requirements, and the flyers they can hand out and at their offices. Furthermore, I was also in contact with another local OBGYN office, community mental health facilities, pediatrician offices, and the Women, Infants, and Children (WIC) office. However, these locations did not grant me permission to recruit from them. The flyers contained my contact information that allowed interested participants to inquire about this study either via telephone or email.

Data Collection

Upon potential participants contacting me about this study, I began to schedule interviews either face-to-face, by telephone, or Zoom, based on the preference and availability of the participant. I recorded each medium of interviewing using my personal Zoom account and conducted in a confidential room at a time that was convenient to the participant. van Manen (1990) stated within hermeneutic phenomenology, the researcher should focus on exploring the data collected until they possess a deeper understanding of the essence of the phenomenon. Based off information provided by van Manen (1990) and previous literature, I anticipated I would need between 7 and 15 participants (Anekstein et al., 2018; Azizpour et al., 2018; Baltrinic, 2014; Brown, 2020; Davey et al., 2006; Giovengo-Gurrera, 2017; Habel et al., 2015; Hays, 2020; Hyatt, 2018; Ierardi et al., 2019; Jahn & Smith-Adcock, 2017; Koltz & Feit, 2012; Meighan et al., 1999; Minor & Duchac, n.d.; Nasrabadi et al., 2019; Vanmeter, 2019; Wagener-Cramer, 2018; Zust et al., 2017).

Interviews

The use of semi-structured interviews allowed me to clarify and ask follow-up questions when prompted. When conducting the interviews, I had access to my interview questions (see

Appendix M). In order to create my interview questions, I remained consistent with van Manen's (1990) approach. van Manen (1990) suggested six recommendations for creating interview questions when inquiring about a lived experience: (a) describe the experience as it was lived, (b) describe the experience as if it were a state of mind, including feelings, thoughts, and moods, (c) focus on a particular incident of the experience, (d) describe sensory experiences connected with the experience such as smell or sounds, and (e) avoid beautifying your account of the experience with flowery phrases.

Data Analysis

Theoretical Approach

van Manen's (1990) hermeneutic phenomenology consists of thematic analysis, which compels the researcher to reflect on themes that are essential to the experience while identifying what contributes to the unique significance of it. This can be achieved via (a) a wholistic approach, (b) a selective approach, and/or (c) a detailed, line-by-line approach. The first approach consists of the researcher examines each interview entirely, then selects which parts of the data are consistent with the essence of the phenomenon being studied. The selective approach requires the researcher to review the interviews repetitively while drawing out text that reveals the essence of the phenomenon, by means of highlighting, circling, or underlying. The final data analysis method expects the researcher to review singular or clusters of sentences to determine what they mean in relation to the phenomenon (van Manen, 1990).

In addition, van Manen (1990) stimulates researchers to engage the participants succeeding the initial data analysis. Researchers are responsible for dispersing the transcript themes to participants, allowing them the freedom to reflect upon the initial findings. This

provides participants the opportunity to reflect upon, confirm, and/or delete themes created by the researcher as well as provide any necessary feedback.

Analysis Process

Upon the completing of the interviewing and transcription process, I provided each participant with an emailed copy of their individual transcript. I prompted the participants to analyze their transcript for accuracy as well as elicit any feedback they may have. Participants had two weeks to return their transcripts and feedback to me. Once participants returned all the transcripts, I utilized van Manen's (1990) selective approach to data analysis in which I examined the language that participants used while selecting data that was related to the experiences of men whose partners have PPD.

I moved forward with coding and theme development, which includes categorizing text and keywords and then further consolidating codes in a way that fully describes the phenomenon (Hays & Singh, 2012). Once I identified the themes, I provided participants a copy and once again elicited feedback. I incorporated any feedback provided by participants into the results of this study.

Trustworthiness

Trustworthiness under van Manen's (1990, 2014) hermeneutic phenomenology does not follow the traditionality of other qualitative methodologies. Rigor within human science, according to van Manen (1990), is determined based on its fidelity to be unique. Although he believes it is difficult to describe lived experiences, phenomenological research that is of a high caliber attempts to achieve this while accepting a true and final description is implausible. van Manen (1990, 2014) provides six guidelines that serve as measures for quality phenomenological methodology: (a) developing an appropriate research question, (b) utilizing scholarly literature

throughout the research process, (c) use of continuous and consistent reflection, (d) remaining grounded to the research question, (e) collection and analysis of rich data, and (f) involving participants in the study.

I developed my final research question via reflection of what I wanted to understand about the phenomenon. Moving forward, I have consulted existing scholarly literature to help guide my study as well as inform my interview questions. Throughout this study, I utilized reflexive journaling to examine my own beliefs and assumptions that align with this study. I remained grounded to the research question by continuously referring to it during the data analysis process as well as having open communication with my peer coder and peer debriefer. I created interview questions to obtain rich description of the participants' experience living with a partner that has postpartum depression. In addition, I requested feedback from participants regarding their individual transcripts in order to check for accuracy of the data (van Manen, 1990, 2014). Finally, I elicited feedback from the participants regarding themes that I discovered during the data analysis process (van Manen, 1990; 2014).

Role of the Researcher

It is the responsibility of the researcher within hermeneutic phenomenology to identify their assumptions and biases of a phenomenon (van Manen, 1990). van Manen stated this allows the researcher to remain oriented to their study by prohibiting these assumptions and biases from interacting with or influencing the research process. He also alluded the role of the researcher is that of an insider who is engaged in the research process. Throughout this study, I utilized reflexive journaling and open communication with my committee to further understand and identify my existing biases and assumptions as to prevent their interference with the research process.

Lens of the Researcher

Reporting the lens of the researcher is crucial to enhance the transparency within qualitative research by encouraging self-reflection and increasing awareness over existing biases and assumptions (Hunt, 2011). I have a history of experiences with postpartum depression that have shaped my perception of this study that exceed my role of a researcher. I experienced a lesser version of PPD, called baby blues, after the birth of my son and have a partner who expressed his struggles with watching me overcome it. I have close friends that either had PPD or their partner did. As a counselor, I have treated clients with PPD and other postpartum disorders. Each of these encounters led me to wonder what it is like for men whose partners have PPD. I found myself contemplating who helps these men through this physically, emotionally, and mentally debilitating event. After careful reflection, I found this to align with my assumptions relevant to this study.

The underlying assumptions of this study are: 1) participants will be willing to answer the interview questions honestly, 2) participants will be honest in regard to the status of their partner's PPD, 3) participants will experience some emotion during the interview process, 4) I will find a theme that elicits to men struggling at some point during this experience, 5) I will experience difficulty uncovering more in-depth responses from my participants, and 6) participants are completing the study voluntarily. These assumptions stem from my personal biases related to the following study. Given my personal and professional history with postpartum depression, I believe that men's mental health often goes unnoticed, and it is especially true when it comes to maternal mental health-related instances. I am viewing this study under the impression that men are silently struggling with their partners' PPD, and they are not receiving help to remedy that.

Limitations and Delimitations

This study is not without limitations. One limitation that exists within this study is I did not request proof of partners' postpartum depression diagnoses; I relied solely on the participants' honesty of the diagnosis. An additional limitation of this study is the allowance of phone interviews. Despite the numerous advantages of using phones as a medium for interviewing, such as flexibility and an increase in accessibility to participants, phones also limit the collection of the richness during the interviewing process (Drabble et al., 2016). It can be difficult to build rapport with participants over the phone, and it disables the researcher's ability to respond to nonverbal cues, which holds the potential for losing contextual data (Drabble et al., 2016).

Subsequently, this study also contains delimitations. I chose not to include race or ethnicity within my inclusion criteria because of the lack of research completed for this phenomenon. Before research can be narrowed down to be racially or ethnically specific, we need to better understand the experience of men, in general, witnessing their partners go through postpartum depression. In addition, I chose to utilize purposive and snowball sampling versus other means of sampling because I want to be able to maximize the number of potential participants I can reach. I also chose to reach potential participants across the United States to increase the likelihood of transferability to more diverse regional areas versus risking my results not being transferable to other regions. Finally, to understand men's experiencing while their partner currently has PPD, participants with partners who have overcome PPD were not eligible.

Definitions of Key Terms

This study employs terms that are typically associated within the medical field. In order to maintain universality across key terms, I have provided definitions for the more ambiguous words and phrases that exist within this study.

Postpartum depression: a major depressive disorder that occurs within one month after childbirth but lasts no longer than the first year of the child's life; also known as peripartum onset (APA, 2013; Pearlstein et al., 2009).

Paternal postpartum depression: depression in fathers that is linked to mothers' postpartum depression during the first year of the child's life (Goodman, 2004).

Postpartum psychosis: a rare condition that occurs within the first week after having a baby that is accompanied by symptoms such as confusion, paranoia, sleep deprivation, and excessive agitation. Postpartum psychosis can result in infanticide due to command hallucinations (APA, 2013; Mayo Clinic, 2021).

Perinatal depression: depression experienced during pregnancy (Eastwood et al., 2021).

Baby blues: phenomena that occurs within the first 10 days after the birth of a child that consists of symptoms such as mood swings, irritability, tearfulness, fatigue, and confusion (Pearlstein et al., 2009).

Remaining Chapters

This study aims at exploring and understanding the lived experiences of men whose partner currently has postpartum depression. Chapter two provides an extensive review of the existing literature surrounding PPD and implications that affect women, men, children, and the family system. Chapter three hosts an in-depth explanation regarding the selected methodology used for this study. Chapter four contains the results that this study found. Chapter five houses a

detailed discussion about the findings and how they relate to the field of counseling and counselor education as well as ideas for contributions to future research related to the following study.

CHAPTER II: REVIEW OF THE LITERATURE

Postpartum Depression

Postpartum depression (PPD), also referred to as peripartum depression, is a psychiatric mood disorder that affects 10-15% of mothers each year and has an onset anywhere from pregnancy to a year after the birth of a child (Anokye et al., 2018; APA, 1994, 2013). PPD is not a standalone diagnosis in the world of mental health; it has been a specifier for major depressive disorder in both the fourth and fifth editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA, 1994, 2013; Payne & Maguire, 2019). The difference exists within the inclusion; the DSM-V classifies PPD as a major depressive disorder with peripartum onset to include PPD symptoms that occur during pregnancy, which account for approximately 50% of PPD cases (APA, 1994, 2013).

Mothers with postpartum depression suffer from symptoms that mimic major depressive disorder: 1) depressed mood most of the day, 2) markedly diminished interest, 3) significant weight loss or gain, 4) insomnia or hypersomnia, 5) psychomotor retardation or agitation, 6) fatigue, 7) feelings of worthlessness or inappropriate guilt, 8) diminished ability to concentrate, 9) recurrent thoughts of death, suicidal ideation, or suicide attempt/plan (APA, 2013). These symptoms result in distress in various areas of life, such as social and occupational, and cannot be credited to the use of a substance, other medical conditions, or other psychotic disorders (APA, 2013). Mental health and healthcare professionals diagnose women with PPD if these symptoms present either during pregnancy or within four weeks after delivery (APA, 2013). Healthcare professionals should not give a PPD diagnosis to mothers who experience an onset of symptoms later than a year after delivery. Moreover, mothers with PPD report having severe anxiety and panic attacks (APA, 2013). Furthermore, mothers who display symptoms related to

anxiety or other mood-related disorders are at a greater risk of PPD. Additionally, if a mother has a history of PPD, bipolar disorder, or depression, she is more likely to develop PPD with each delivery (APA, 2013). With that, women should receive an accurate assessment should in order to provide early intervention.

There are a handful of assessments utilized to detect postpartum depression, such as the Edinburg Postnatal Depression Scale (EPDS), the Postpartum Depression Screening Scale (PDSS), the Patient Health Questionnaire-9 (PHQ-9), the Beck Depression Inventory (BDI), the BDI-II, the Center for Epidemiologic Studies Depression Scale (CES-D), and the Zung Self-Rating Depression Scale (Zung SDS) (Moraes et al., 2017). Despite the number of available assessments, the EPDS is the most commonly used assessment for the identification of PPD (Moraes et al., 2017). This 10-item has proven validity and reliability when used for assessing PPD symptoms in child-bearing women. The EPDS takes approximately 5 minutes and is simple to score, making it advantageous to both patients and healthcare professionals (Cox et al., 1987; Yawn, et al., 2009). The ease of the administration of these assessments has been extremely useful during the COVID-19 pandemic, where we are seeing consequences in maternal mental health (Chang et al., 2021; Layton et al., 2021). It is important to note that I collected the data for the study during the COVD-19 pandemic. However, this study did not include interview questions specifically related to the pandemic. As such, the results of this study cannot be specifically utilized to describe the experiences of men whose partners have PPD during a pandemic. Furthermore, the results of this study might reflect more severe mental health distress within the participants experiencing their partners' PPD due to the COVID-19 pandemic (Layton et al., 2021). Therefore, it can be inferred that men whose partners have PPD might not experiences the severity of distress as the participants in this study.

COVID-19 and Postpartum Depression

The COVID-19 pandemic has brought on countless stress for families across the world (Chang et al., 2021). According to Layton et al. (2021), the COVID-19 pandemic has heightened the negative consequences on maternal mental health. Researchers compared mothers who had their babies prior to COVID-19 and during COVID-19 in terms of their anxiety levels, postpartum depression symptoms, and mother-infant relationship (Layton et al., 2021). Research found that women who gave birth during the pandemic were experiencing higher levels of anxiety and higher levels of PPD symptoms (Layton et al., 2021). Researchers did not find a clinical significance in the differences in mother-infant bonding across the samples. However, another study did find that women who were seeking treatment for PPD during the pandemic experienced poorer relationships with their infants (Chang et al., 2021). Additionally, researchers found that, despite previous research being contradictory, that there was no clinical significance in the differences in partner relationships; mothers did not report their partner relationships were worse (Chang et al., 2021; Zhou et al., 2021). The proposed study can help break down the inconsistencies in the existing literature by providing insight into the experiences of men whose partners have PPD.

Theoretical Orientation

The driving theoretical orientation for this study is family systems. Specifically, I will consider the work of Murray Bowen (1966) and Michael Kerr (1988) in relation to the experience of fathers having partners with PPD. Bowen believed that the family serves as multiple systems that occur naturally and could only be understood in terms of the predictable and fluid processes between members (Bowen, 1966; Gladding, 2015). These systems could be social systems, cultural systems, games systems, communication system, biological systems, or

any other system that exists (Bowen, 1966). Family systems theory focuses on the idea that generations pass down patterns, and if individuals are unable to rectify those patterns, they will continue to pass them on to future generations (Kerr, 1988).

Family systems theory describes the correlation between couples' marital quality with their ability to successfully coparent (Bonds & Gondoli, 2007; Feinberg et al., 2012; Le et al., 2016; Morrill et al., 2010; Olsavsky et al., 2020; Pedro et al., 2012; Schoppe-Sullivan et al., 2004; Van Egeren, 2004). In other words, the happier the marital relationship is, the more successful the couple will be at coparenting (Bonds & Gondoli, 2007; Le et al., 2016; Morrill et al., 2010; Olsavsky et al., 2020; Van Egeren, 2004). In fact, research reveals that fathers who perceived their relationship with their spouse in a positive way tend to engage in more active parenting (Christopher et al., 2015). The transition from being a couple to being parents acts as a disturbance in the family system, especially for first-time parents due to the couple having to navigate their new roles and what that looks like for them (Morrill et al., 2010; Olsavsky et al., 2020; Schoppe-Sullivan et al., 2004; Van Egeren, 2004). During this time, the family system can either experience an increase in emotional intimacy or emotional distress (Olsavsky et al., 2020).

Family Systems and Postpartum Depression

Researchers have found that detrimental effects can occur within the family system when a woman is experiencing postpartum depression (Barnes, 2006). According to the DSM-V (2013), women who have PPD can experience an array of symptoms, including but not limited to, depressed mood and/or severe mood swings, difficulty bonding with the baby, feelings of hopelessness and worthlessness, and anxiety attacks. With these symptoms presenting themselves, it is no surprise that women who have PPD often find themselves believing they are failing to satisfy their role within their family system (Barnes, 2006; Don & Mickelson, 2012;

Parade et al., 2017). Collectively, society learned to believe that pregnancy and the beginning phases of parenthood are the happiest times of a woman's life (Aassve et al., 2012; Barnes, 2006; Berntsen et al., 2011). Unfortunately, this is not always the case. Not only does PPD affect how a woman views herself in relation to her family system, but it can also carry negative implications for the couple and their marital satisfaction (Barnes, 2006; Cooklin et al., 2015; Reichman et al., 2015).

The transition to parenthood is tough under the best of circumstances, and the relationship dynamic between partners is a good indicator on the level of difficulty the couple will experience (Barnes, 2006). Having any disruptions within the family system, specifically those caused by postpartum depression, can have negative impacts on a number of areas within the family system, such as the emotional experience of the woman's partner, the quality of the marital relationship, and the attachment process between mother and infant (Barnes, 2006). A recent study used 30 heterosexual couples that participated in in-home interviews to further the understanding of their perceptions of the causes of PPD as well as discover similarities and differences between those perceptions (Habel et al., 2015). Researchers recruited participants from tertiary care hospitals. The researchers selected female participants based on their EPDS ($\geq$12). Additionally, the researchers automatically selected the partners of the women who agreed to participate in the study (Habel et al., 2015). Both partners participated in separate, semi-structured interviews that lasted between 45 and 90 minutes in order to identify the similarities and differences between men and women's perceptions of PPD (Habel et al., 2015).

Habel et al. (2015) found that partners of women with postpartum depression tend to experience negative emotions, such as self-doubt, anger, helplessness, and fear. Additionally, Habel et al. identified nine perceived causes of PPD, according to the participants: 1) societal

pressure, 2) physical health problems, 3) transition to parenthood, 4) social connectedness and support, 5) personality and past psychological history, 6) child health and temperament, 7) unmet care needs, 8) unmet birth expectations, and 9) other life stressors. Under society pressure, researchers stated that husbands believed attempting to achieve unrealistic goals resulted in a negative effect on their wives' mental health, resulting in depression. For example, some husbands discussed society's pressure to breastfeed causing distress and obsessions for their wife. Furthermore, physical health problems, such as experiencing fluctuations in hormones or slow or painful healing, and lack of sleep produced PPD-related symptoms. Additionally, Habel et al. reported the transition to parenthood could take credit for PPD-related symptoms. For instance, women reported having a loss of identity or suffering tremendous pressure to be a good mother. Others reported their experience as a mother was not what they expected, which led to feeling unhappy. Moreover, the researchers also found social connectedness and support contribute to the onset of PPD. Being at home, alone, for extended periods of time trying to take care of an infant took a toll on most of the mothers involved in this study; they reported wanting and needing more support from their partner, family, and friends. This often brought on feelings of isolation. In addition, Habel et al. discussed participants' personality traits and psychological history as key causes of PPD. More specifically, participants mentioned their personalities prior to parenthood could be reason for their PPD symptoms, such as being perfectionists, or having a history of anxiety and/or depression.

Furthermore, Habel et al. revealed the health and temperament of the child can also play part in the onset of postpartum depression. Having a child that parents perceived as difficult to care for coupled with the already existing challenges of the postpartum period led to greater stress, anxiety, and depression in mothers. Additionally, researchers suspect that women who

experienced unmet healthcare needs, such as poor or nonexistent prenatal care, pressure from medical professionals to breastfeed, or poor communication between mother and doctors, were more susceptible to PPD symptoms. Similarly, unmet birth expectations can influence the onset of PPD. For example, having emergency cesarean sections were sources of distress for mothers. Finally, Habel et al. discussed participants' reporting other life stressors as causes for PPD. Examples of this would be financial stressors, returning to work, and the accretion of multiple stressors (Habel et al., 2015). In addition to this study, other research has focused more on the health of the male partners of women who have PPD.

Prior to this discovery, Roberts et al. (2006) compared the psychological health of men who had partners with postpartum depression to those who did not. Researchers administered participants of this study the Beck Depression Inventory- II (BDI-II), Beck Anxiety Inventory (BAI), General Health Questionnaire-28 (GHQ-28), and the Somatic and Psychological Health Report (SPHERE) in order to assess for symptoms of depression, anxiety, non-specific psychological impairment, and problem fatigue, respectively (Roberts et al., 2006). The researchers found that men who had partners with PPD experience increased stress and risk of psychological distress (Roberts et al., 2006).

As for the quality of the marital relationship, it is no surprise that postpartum depression would negatively affect this area of the family system. According to Habel et al. (2015), Letourneau et al. (2011), and Meighan et al. (1999), male partners of women with PPD revealed they felt a sense of uncertainty about their relationship during the period of PPD. Davey et al. (2006) found that men often became frustrated at the lack of communication and/or miscommunication between them and their partners when PPD was present. Partners of women with PPD also reported to have experienced fracturing of their family unit due to the unequal

divisions of labor and the perceived loss of shared parenting (Beestin et al., 2014). For instance, men whose partners had PPD reported perceiving their partner has absent from parenting, both emotionally and physically. This often led to fathers believing they had to take on the roles of two parents (Beestin et al., 2014). More specifically, some fathers mentioned not being able to share the hardships of parenting, such as poor infant sleeping and tantrums (Beestin et al., 2014). Additionally, mothers having PPD fractures the bonding that should occur between mothers and infants (Beestin et al., 2014). PPD often causes mothers to be more absent during this period and the support they receive from their partners is positively correlated to how they bond with their infant (Beestin et al., 2014; Ruffell et al., 2019). If there is little to no support, women will not be able to bond with their child when they have PPD as successfully as women who either have high support or do not have PPD (Beestin et al., 2014; Ruffell et al., 2019). This lack of support can be due to a declination of relationship satisfaction, a fracture in the family unit, or the poor mental health of the supporting partner (Beestin et al., 2014; Ruffell et al., 2019). PPD impacts the wellbeing of both mothers and fathers, which can lead to a lack of intimacy and/or sexual desire, which puts a strain on the relationship. As a result, this strain often results in separation or divorce (Johansson et al., 2020). Furthermore, it is important to understand the roles fathers have within the family system.

Family Systems and Fathers

Fatherhood does not look the same at it did 50 years ago. The modern father in the United States takes on a more engaged approached to parenting (Beutell & Behson, 2018; Hatfield, 2018). Today, it is not uncommon to see fathers attend prenatal appointments, be actively engaged in the laboring process, and even assist in the birth of their child (Hatfield, 2018; Warren, 2020). Most people expect fathers to be hands-on with their children within the first

days, weeks, and months of their child's life (Warren, 2020). This is a drastic change from the generation before us in which fathers did not typically engage in roles that society perceived to be a part of the mothers' role, including bathing the baby, changing diapers, or soothe the baby when needed (Beutell & Behson, 2018; Warren, 2020). As recent as 20 years ago, fathers' roles consisted primarily of that of the protector, provider, and (when the child was older), disciplinarian of the family (Livingston & Parker, 2019; Turchi & Bernabo, 2020; Warren, 2020). Occasionally, the fathers would also assume the roles of teacher and mentor if needed, but this was not very common among most family systems (Warren, 2020). The increase in dual-income families, single fathers, and stay-at-home father is attributed to this shift in the expectations of fatherhood (Kaufman, 2013; Livingston & Parker, 2019). Although many consider this shift in fatherhood a positive change, it has left fathers with new challenges.

The lack of generational guidance for the modern father has shown to have caused fathers who opt to be a more active parent than generations before to experience feelings of being lost, alone, uncapable, belief he is not doing enough, and uncertainty of himself in his role as a father (Livingston & Parker, 2019; Warren, 2020). Unfortunately, this lack of support leads to fathers suffering silently during the first year of their child's life (Warren, 2020). The first few weeks after a child is born is a crucial period for the family system due to this being the time the family learns how to operate with this new dynamic (Beestin et al., 2014). When one part of that family system is suffering, it can cause a fracture in the family system, ultimately leading to the possibility of familial dysfunction (Beestin et al., 2014; Warren, 2020). Based on the literature, many modern fathers still appear to be at a loss when it comes to navigating their role as a father within their family system (Livingston & Parker, 2019; Warren, 2020). After exhausting the literature, it appears there are no articles, at this time, which contradict these claims. This

uncertainty often results in the father being less active, purely because he does not know how to take on this role and his partner, family, friends, and healthcare providers do not provide support (Mayers et al., 2020; Warren, 2020). Consequently, their partners viewing the lack of involvement as being detached, oblivious, disinterested, uninvolved, or incapable disrupts the family system (Warren, 2020).

Another phenomenon that contributes to the decision of what a father's role is once a child is born is maternal gatekeeping, or "a relational phenomenon that emerges from the intersection of parental roles with societal expectations about gender" (Olsavsky et al., 2020, p. 574). They found different families conceive diverse ideas about what the father's role will look like. For example, some families take the more traditional mother as the nurturer and father as the provider role, while others believe in equality in childcare practices. This article also suggests maternal gatekeeping either encourages or discourages fathers' roles within their family. For instance, if a mother engages in maternal gate opening techniques, such as complementing the father's parenting, the father is more likely to feel supported, thus encouraging him to take on a more active approach to fatherhood. The authors describe this as the mother complimenting the father's parenting styles and/or decisions. This study also found taking a more adverse approach would be discouraging to the father and often leads to a disengaged role. Furthermore, this form of maternal gatekeeping is consistent with the mother criticizing the father's parenting choices. Maternal gatekeeping is often detrimental to the coparenting process because it frequently results in the father being more withdrawn due to the uncertainty of what his role is as a father (Olsavsky et al., 2020). In addition to the implications on the family unit, research has focused on ways postpartum depression affects the individuals within the family system.

Further Implications of PPD

Over the past few decades, there have been plenty of studies conducted using postpartum depression as the main topic. Studies exist that demonstrate the implications PPD have on mothers, such as increased risk of anxiety, substance use, and poor self-care (Slomian et al., 2019; Zuckerman et al., 1989). Additionally, mothers with PPD are more likely to engage in risky alcohol consumption and partake in smoking (Jagodzinski & Fleming, 2007; Witaker et al., 2007). Furthermore, PPD has proven to cause suicidal ideation in mothers (Do et al., 2013; Paris & Bolton, 2009; Pope et al., 2013; Postmontier, 2008; Tavares et al., 2012). PPD is an extreme mental health condition that affects 1 in 8 women each year (CDC, 2020) and typically occurs at any time before 12 months after the baby is born. Research discovered that women who experience perinatal depression, or depression during pregnancy, are often unable to carry their children to full term, which can result in low birth weights and lesser quality neuromotor skills (Dowse et al., 2020; Hedegaard et al., 1993; Hoffman & Hatch, 2000; Lundy et al., 1999; Rini et al., 1999). The implications of PPD also follow the children into toddler and childhood years. These children often experience social, cognitive, and emotional developmental delays (Goodman & Brand, 2008). Additionally, PPD can influence how a mother responds to her child.

Recent research discovered that the neurological response a mother has towards her infant can predict postpartum depression (Finnegan et al., 2021). Mothers who display little to no neurological response to their infant tend to report greater symptoms consistent with PPD than mothers who display neurological responses to their infant (Finnegan et al., 2021). Additionally, Islam et al. (2021) found a connection between PPD and non-exclusively breastfeeding mothers (i.e., mothers who exclusively use formula or a combination of formula and breastfeeding). Researcher discovered that mothers who exclusively breastfeed were seven times less likely to

experience PPD symptoms (Islam et al., 2021; Mercan & Tari Selcuk, 2021). This study also revealed that having positive support within the family system reduced the risk early termination of breastfeeding, which also reduces the risk of PPD (Islam et al., 2021; Mercan & Tari Selcuk, 2021). Thus, screening for complications with breastfeeding can be useful in predicting PPD before symptoms begin to emerge (Islam et al., 2021). Furthermore, PPD can have an impact on the child before it is even born.

It is also known that perinatal depression can cause a child to be born prematurely and with a low birth weight (Hedegaard et al., 1993; Hoffman & Hatch, 2000; Lundy et al., 1999 Rini et al., 1999). More recently, research uncovered that there is a reverse correlation between premature births and PPD; having a baby prematurely increase the risk of a mother developing postpartum depression (Uygur et al., 2021). This study also found that having a history of depression, psychiatric disorders within the family history, unplanned pregnancies, and health problems during pregnancy also influenced the development of PPD symptoms (Uygur et al., 2021). Furthermore, mothers are not the only ones who experience a form of PPD, but fathers may experience this as well.

Paternal Postpartum Depression

An advancement that occurred in the research related to postpartum depression is the discovery that fathers experience their own form of postpartum depression, called paternal postpartum depression (Berg & Ahmed, 2016; Scarff, 2019; Mayo Clinic, 2021). Paternal postpartum depression affects 8- 25% of fathers, and typically have the same onset as PPD (i.e., within the first year after the child(ren) is born) (Kennedy & Munyan, 2021; Koch et al., 2019; Scarff, 2019). Paternal postpartum depression presents itself differently across men, but typically displays with anxiety, fatigue, feelings of being overwhelmed, restricted emotions,

indecisiveness, and changes in eating and sleeping habits (Berg & Ahmed, 2016; Mayo Clinic, 2021). As of today, there are no assessments available that screen specifically for paternal PPD; men who receive screenings are often administered the EPDS, BDI-II, or the Gotland Male Depression Scale (GMDS) (Kennedy & Munyan, 2021). However, none of these assessments sufficiently screen for paternal PPD independently (Kennedy & Munyan, 2021). Unlike PPD, paternal PPD does not have an official diagnosis; men with paternal PPD typically receive a diagnosis consistent with some variation of depression (Kennedy & Munyan, 2021).

Recent discoveries have unveiled contributing factors related to the development of paternal postpartum depression in fathers. First, if a father has a history of depression, he is more likely to develop paternal PPD (Berg & Ahmed, 2016; Fisher, 2016; Fisher & Garfield, 2016). Furthermore, if their partner is experiencing PPD, the father is also more likely to develop symptoms of paternal PPD (Fisher & Garfield, 2016). Additionally, accidental pregnancies can often result in paternal PPD (Rosenthal et al., 2013). Moreover, the new demands, responsibilities (physical and financial), and expectations of new fathers can cause them to become overwhelmed and anxious, and have depressive symptoms consistent with paternal PPD (Fisher, 2016; Fisher & Garfield, 2016). Similar to maternal PPD, a plethora of factors can influence paternal PPD. First, negative changes within the romantic relationship serves as an indicator for paternal PPD. Research claims if the relationship between parents is experiencing distress, fathers are at a greater risk for developing paternal PPD (Berg & Ahmed, 2016; Fisher & Garfield, 2016; Kim & Swain, 2007; Rosenthal et al., 2013). Furthermore, certain circumstances related to the child can increase the father's chances of developing paternal PPD. For instance, if the parents did not want the pregnancy, the child was born prematurely or has a

chronic illness that negatively impacts their development, or if the father has a difficult time handling the child, there is a greater risk of paternal PPD (Simionescu et al., 2021).

A variety of support also act as large influences of paternal postpartum depression. For example, if the father is of a low socioeconomic status, he is more likely to develop paternal PPD than a father who is more financially stable (Berg & Ahmed, 2016; Fisher & Garfield, 2016; Rosenthal et al., 2013). Moreover, the literature shows that sleep deprivation and disruption in circadian rhythm can also be an indication of paternal PPD (Gallaher et al., 2018). Research also indicates, if the father did not have a positive male role-model in his life or finds himself not having sufficient financial, social, and/or psychological support from friends and family, paternal PPD is more likely to occur (Kim & Swain, 2007). Additionally, the family system can either foster or hinder the development of paternal PPD. Lack of attention from a partner frequently leads to feelings of exclusion and jealous of the connection between the mother and child. These feelings often result in fathers having low self-efficacy and can ultimately be a contributing factor to paternal PPD (Kim & Swain, 2007). The implications of PPD do not stop at the parental level but also affect the children.

Implications for Children

Children whose mothers, fathers, or both that have either postpartum depression or paternal PPD are at risk for emotional, social, psychological, and developmental consequences (Asmussen et al., 2022; Guerrero et al., 2021; Oh et al., 2020; Somers et al., 2019). PPD can have implications on the child well into toddlerhood, early childhood, and adolescents (Asmussen et al., 2022; Oh et al., 2020; Somers et al., 2019). It is not uncommon for PPD to lead to a declination in parental care, childhood noncompliance, and/or anger and dysregulation, as well as internalizing and externalizing disorders (Asmussen et al., 2022; Guerrero et al., 2021;

Oh et al., 2020). PPD has also been known to be linked to cognitive delays in school-aged children (Lin et al., 2017). Infants whose mothers experience perinatal PPD are more likely to be born prematurely (before 37 weeks gestation) and with a low birth weight alongside poor neuromotor skills (Hedegaard et al., 1993; Hoffman & Hatch, 2000; Lundy et al., 1999; Rini et al., 1999). As for early childhood and adolescents, maternal and/or paternal PPD can serve as an indicator for delays in social, emotional, and cognitive developments (Goodman & Brand, 2008).

Children whose fathers report having paternal postpartum depression are likely to develop hyperactivity tendencies, emotional challenges, as well as conduct disorders, while being less likely to form a secure attachment to their fathers (Paulson & Bazemore, 2010; Ramchandani et al., 2008). According to Ramchandani et al. (2008), the reflection of the child's antisocial behavior on their father's socializing role or the disruptive parenting (i.e., low mood, poor parent-child interactions) utilized by depressed fathers attributes to the onset of hyperactivity, emotional challenges, and conduct disorders. Thus, it is crucial to reach out to fathers and better understand their experience with instances that increase the likelihood of disruptive parenting, such as having a partner with PPD. Presumptuously, the limitation of disruptive parenting due to these experiences will also reduce the onset of hyperactivity, emotional challenges, and conduct disorders in children. Furthermore, PPD can also influence other areas of a child's life.

Studies have shown a link between postpartum depression and poor child health outcomes (Woolhouse et al., 2016). For instance, researchers discovered a relationship between maternal PPD and childhood internalizing disorders, externalizing disorders, and negative affect (Woolhouse et al., 2016). Similar to paternal PPD, maternal PPD can predict hyperactivity and conduct disorders in children within the first four years of their lives (Woolhouse et al., 2016). In

fact, Prenoveau et al. (2017) found that children whose mothers received a PPD diagnosis began displaying negative behavioral problems as early as two years of age. These children also suffered emotion dysregulation and/or emotional negativity (Prenoveau et al., 2017). Furthermore, it is important to further examine the experience of men who have partners with PPD. Having a deeper understanding will provide an opportunity for future research to examine how these experience influence children behavior.

Moreover, postpartum depression has been known to negatively impact the ways in which a mother can care for her child. As previously mentioned, research supports the claim that PPD has a negative effect on the amount of milk a mother is able to supply. This increases the risk of infants being unintentionally malnourished during the beginning weeks of the postpartum period, especially in impoverished families that do not have the resources to use supplemental means of feeding (i.e., formula) (Madlala & Kassier, 2018). Additionally, Corman et al. (2016) found that PPD also influenced the mother's ability to provide adequate housing and utilities for infants. Mothers with PPD face hardships in relation to having proper housing and utilities (i.e., water and electricity) along with sufficient food (Corman et al., 2016). Insufficient resources increase the likelihood of child abuse and neglect (Corman et al., 2016). Existing research does not address how fathers' experiences with partners who have PPD would impact these circumstances, thus strengthening the need for the further exploration of this phenomenon. In addition to facing challenges providing for their family, mothers with PPD also face further difficulties in terms of caring for their child.

Postpartum depression can have an impact on how a mother views and responds to her child (Sampson et al., 2017). Sampson and colleagues state untreated depression impairs the ability of parents to provide a safe, nurturing, and stimulating environment for the child.

Untreated symptoms of both maternal and paternal PPD increases parents' risk of abusing and/or neglecting their children (Sampson et al., 2017), and it is noteworthy that the risk for childhood abuse and neglect are highest during the first year of life (Obikane et al., 2021). As mentioned above, untreated symptoms of PPD increase parental risk of inflicting physical abuse, neglecting medical needs, and psychological aggression (Sampson et al., 2017). Researchers believe this increased risk of child neglect and abuse for women with PPD is due not only to the symptoms related to PPD, but also because of the decreased feelings of competence experienced by the mothers with PPD (Martinez-Torteya et al., 2018). The mothers feel incompetent, which leads to them insufficiently carrying out the needs of the child (Martinez-Torteya et al., 2018). This understanding of mothers' experiences may leave us wondering if paternal PPD or fathers' experience with the mother having PPD increases the fathers' likelihood of engaging in abusive and/or neglectful behavior towards their children. Expanding the research on fathers' experiences with PPD or a having a partner with PPD may help increase awareness of fathers' postpartum needs, and lead to necessary developments in postpartum care for fathers.

Postpartum Care for Fathers

The transition to fatherhood can be a period of happiness. However, it is often, accompanied by stress, anxiety, and feelings of being overwhelmed (Baldwin et al., 2018). Fathers often report experiencing stress when having to find a new balance between everyday life, work, and becoming a parent (Johansson et al., 2020). Currently, the existing literature fails to recognize the important public health issue involving the mental health and wellbeing of fathers during this transition (Baldwin et al., 2018). When a new child enters a family, fathers face the challenge of forming their own fatherhood identity while navigating their new role as a father; this challenge typically coincides with feelings of fear (Baldwin et al., 2018). Fathers

frequently experience a lack of inquiry about their own mental health, especially from healthcare workers (Johansson et al., 2020). Due to the lack of support from partners, family members, healthcare professionals, and friends that focuses on their mental health during the postpartum period, it is not uncommon for fathers to strive for finding an escape, such as smoking, increased alcohol consumption, or taking on more hours at work (Baldwin et al., 2018). The lack of information resources coupled with the scarce acknowledgement from various health care professionals has largely contributed to the existing barriers fathers face regarding accessing support (Baldwin et al., 2018). Furthermore, it has research states that increasing the awareness and access of mental health support for fathers has the potential to foster enhanced experiences for fathers, which consists of help adjusting to their new roles while being able to focus on their mental health wellbeing (Baldwin et al., 2018). Prior to being able to understand fathers' experiences with mental health accessibility, literature should provide a better understanding of what the fathers' experiences with supporting their partners through postpartum depression are like.

Fathers' Experiences

Little is known about the experience of fathers supporting their partners through postpartum depression. One of the first studies that used qualitative analysis to devise a deeper understanding of PPD and how it affects the family system as told by the perspective of the father was in 1999 (Meighan et al., 1999). Researchers recruited a total of eight fathers who lived with partners that had PPD and conducted interviews and then used thematic analysis to describe the fathers' emotions and experiences. The researchers found the fathers were experiencing major disruptions not only in their relationship, but also in their marriages According to Meighan et al. (1999), participants reported making sacrifices in order to maintain stability within the

family system as well. They also found these fathers revealed they were experiencing feelings of concern, fear, and confusion towards their significant others and believed they were unable to help their partners overcome PPD. The article concluded this feeling of helplessness often led to frustration and anger. Finally, participants mentioned having this lingering feeling of uncertainty in regard to the future of their relationship because, even though PPD improved over time, the fathers did not view their partners as the same person they were before PPD (Meighan et al., 1999). Although the information provided by this study was useful, there was a wide range of time that elapsed since the onset of the partners' PPD and the time of the interview. Researchers collected the data used in this study anywhere from three months to eleven years after participants' partners were diagnosed with PPD (Ierardi et al., 2019; Meighan et al., 1999). Additionally, this study is over 20 years old. The proposed study aims at closing this 20-year gap in the literature as well as limiting for the amount of time between data collection and the phenomenon.

Another study that addressed fathers and postpartum depression was conducted in 2006. According to Roberts et al. (2006), researchers wanted to compare the psychological health of men whose partners have PPD to those whose partners did not. The researchers recruited a total of 174 couples for this study; all of which were heterosexual and had a child less than 13 months of age. Of the 174 couples, 58 included a female spouse with diagnosed PPD (Roberts et al., 2006). Researchers gave participants six different measures of psychological health: 1) Beck Depression Inventory-II, 2) Beck Anxiety Inventory, 3) General Health Questionnaire-28, 4) Somatic and Psychological Health Report, 5) Alcohol Use Disorders Identification Test, and 6) Aggression Questionnaire. The researchers used parametric tests and correlations between sociodemographic data. Researchers analyzed the information provided by psychological health

data to determine if there was a correlation between the control (socioeconomic status, age, length of relationship, etc.) and dependent (scores on psychological health measures) variables. The article concluded that fathers whose partners had PPD displayed more symptoms of depression, non-specific psychological impairment, and general aggression than the control group (i.e., fathers whose partners did not have PPD). They also state the results did not show a difference between groups in regard to hazardous alcohol use, general affective problems, or anxiety. Roberts et al. found fathers whose partners had PPD were more likely to develop psychological disturbances in two or more areas. In conclusion, fathers whose partners have PPD are more likely to experience psychological distress than those whose partners do not have PPD. While this study provides useful information regarding the implications PPD has on male partners, limitations exist. First, this study questioned the validity of the diagnosis of PPD, since it was given during a semi-structured interview process. Additionally, this study collected information from couples versus focusing just on the fathers (Roberts et al., 2006). Furthermore, seeing this study is quantitative in nature, the claim that more qualitative research regarding men's experiences with having a partner that has PPD is needed.

Within the same year, researchers conducted another study that consisted of 13 fathers whose partners had been diagnosed with postpartum depression (Davey et al., 2006). The purpose of the study was to provide information that might lead to relevant mental health services provided to men whose partners have PPD. According to Davey et al. (2006), the average age of the fathers was 29.8 (SD = 5.4), and the average number of children in the house was 2 (SD = 1.0) The researchers stated the fathers participated in a focus group that met for two hours once a week for six consecutive weeks. The focus group was held after the men participated in treatment groups. Davey et al. suggested the treatment groups were designed to

use cognitive behavior therapy techniques to allow the participants to 1) learn factual information about PPD, 2) have their experiences heard and acknowledged, and 3) gain skills and strategies to combat symptoms of depression and stress. They also mentioned upon the completion of the treatment group, the fathers were interviewed to discuss their experiences with the group. Davey et al. described four themes that emerged from the data analysis. They revealed the first theme focused on the participants' experiences of PPD. Davey et al. also stated the data revealed consistency in the discussion of frustration, feeling isolated, having other areas of life affected, such as the interactions with the children, and struggling with "traditional" views and beliefs of what it means to be a father that were pushed on to the participants by their own father.

They discussed the next theme, which focused on the societal views of men and how they "should" operate. According to Davey et al., the data to support this theme talked about the fathers' perceptions of the lack of organized support that is offered to them. They also included participants discussed feeling reluctant to reach out to others for support due to stigmas that men should be able to manage their mental health on their own. The researchers mentioned the third theme to emerge focused on the fathers' experiences of the group itself; there was a common thread that the group was normalizing due to the similar situations the participants were in. The article concluded the last theme discovered involved the lack of disclosure of group participation. The general consensus was that the participants were embarrassed by their needing help and were not willing to share with friends or family members that they were involved in the group (Davey et al., 2006). Despite the usefulness of the information obtained from this study, it was not without limitations. This study fails to address the experiences of the men regarding their partners' PPD, but rather addresses their perception of the treatment intervention group they

engaged in, making its contribution to the understanding of men's experiences with having a partner with postpartum depression limited.

Research shifted to focus more on the experiences of fathers around 2011. Engqvist and Nilsson (2011) utilized narratives from the internet provided by anonymous individuals who contributed to the online posts to explore men's experience of women with postpartum psychiatric disorders, such as baby blues, postpartum depression, postpartum psychosis, and postpartum anxiety. Eleven posts were analyzed using content analysis and five themes were found. The researchers discovered the theme of having days filled with stressful reactions such as feelings of disappointment, frustration, apprehension, and being shut out by their partners. Engqvist and Nilsson also found the posts contained themes of continued interference with everyday life. Specifically, they mentioned the participants writing about disturbances in their relationships and experiencing feelings of desperation. Additionally, Engqvist and Nilsson identified the theme of acceptance of reality and finding solutions, which encompassed taking a problem-solving approach to the alleviation of the stress. Another theme identified was that of life starting to return where participants reported feeling confident, more trusting, and prideful within this theme. The study concluded with the theme of coping with the past, which included expressing maturity (Engqvist & Nilsson, 2011). These results provide a useful introduction into the experiences of men whose partners were experiencing postpartum psychiatric disorders. However, the study was inclusive of those who had partners that were experiencing disorders outside of PPD, such as "baby blues" and postpartum psychosis, making a study that focuses solely on PPD needed.

Furthermore, Ruffell et al. (2019) conducted a systematic review of 20 papers to analyze existing qualitative research that explored men's experiences with having a partner that suffered

from a variety of mental health concerns during the postpartum period. The researchers discovered five main themes. First, Ruffell et al. revealed the studies that were analyzed consistently talked about what it means to be a father, such as difficulties in the transition to fatherhood, developing a father-baby bond, and learning how to coparent with your partner They also reported another emergent theme discussed the challenges that were consistent with being a partner. The researchers discovered that men often faced a type of uncertainty around their relationship, which often led to the breakdown or even loss of the relationship entirely. On the other hand, some couples experienced their relationship growing stronger because they were able to overcome the challenges they faced (Ruffell et al., 2019).

According to Ruffell et al. (2019), the theme of experiencing negative emotions was discussed. They reported, the studies used revealed the participants frequently experiences negative emotions such as anxiety, depression, hopelessness, stress, shock, and confusion when their partner was going through postnatal mental health issues. The penultimate theme described by Ruffell et al. focused on how these men coped with their partners' postnatal mental health issues; some of the men took to practical coping mechanisms, which consisted of learning more about their partners' mental health issues and searching for resources, whereas others took an avoidant approach in which they used various substances or withdrew from their families. The researchers found that men took to seeking support within their social circle. Finally, the researchers discovered a theme that focused on where the support lacks during this time. The article concluded that men avoided seeking help at all due to their own beliefs (e.g., they were being a burden, could not reach anyone, or others would see them as "weak"). Additionally, Ruffell et al. suggested these men also faced social networking barriers, such as their family and friends not being understanding of what they were going through or their own partners not

wanting to seek help for themselves, causing the men to not reach out as well. The researchers discovered that the men held the perception that health professionals were not informed about postpartum depression or other postnatal mental health concerns, so they decided not to seek help from professionals. They also disclosed participants across this study discussed improving the access of information about diagnoses, treatment, and recovery would be beneficial to both mothers and fathers (Ruffell et al., 2019). Similar to previous research (Engqvist & Nilsson, 2011), this study did not limit the experiences to be solely PPD; they used research that provided insight into the experiences of men whose partners experienced other disorders, such as anxiety and postpartum psychiatric disorders (Ruffell et al., 2019). This supports the claim that further research on men's experiences with having a partner with PPD is still needed.

Another study by Ierardi et al. (2019) analyzed the experiences of men whose partners have/had postpartum depression in order to create a foundation for intervention and program development. This study used a descriptive phenomenological approach to analyze data collected from semi-structured interviews of 10 men in regard to their experiences with their partner having PPD. Ierardi et al. stated each participant must have a partner that was diagnosed with PPD within the last three years. The article mentioned five themes were found upon the completion of data analysis. First, the researchers mentioned men talked about providing support to their partners through PPD and the discussion focused mainly on how they took over household chores, such as cooking and cleaning, as well as their struggles with managing these responsibilities. Next, Ierardi et al. addressed the ability to maintain stability through the men revealing they would try to not make things worse for their partners and how they often viewed their partners as irritable and short-tempered. Additionally, the participants admitted to

frequently taking up negative coping strategies, such as alcohol consumption (Ierardi et al., 2019).

According to Ierardi et al. (2019), the third theme to emerge was that of mutuality. They stated participants often found themselves having symptoms that mimicked their partners' postpartum depression, such as weight loss/gain or feelings of depression. Additionally, the article expressed the theme of isolation appeared. They found the participants noticed themselves feeling as if they were on their own and often did not turn to others for support. Ierardi et al. discovered that participants wanted to provide insights to others, which is why they were attracted to the study in the first place. The article concluded the participants offered advice for other fathers such as taking more time off work to help with the baby, educating themselves on the signs and symptoms of PPD so they can identify it and get their partner the appropriate help, and making sure their partner is getting plenty of sleep. Though this information does provide deeper insight into the experiences of men whose partners have PPD, the study does not consider how time influences how we recollect our experiences (Griffiths, 2019). Further, the study lacks diversity across participants; nine of the participants identified as White and one identified as Hispanic (Ierardi et al., 2019). As a result, further exploration of men's experiences with having a partner with PPD needs to be completed that incorporates participants who have partners with current PPD as well as provides the opportunity to involve more diverse demographics. Moreover, later studies were conducted that provide deeper insight into the experiences of men whose partners have faced challenges with maternal mental health concerns.

Mayers et al. (2020) conducted a study that utilized an online questionnaire to analyze the experience of 25 fathers whose partners reported poor postpartum mental health. Mayers et al. suggested this included depression, anxiety, obsessive-compulsive disorder, and psychosis.

They stated through the use of thematic analysis, researchers found three themes: 1) support received, 2) support fathers want that was not received, and 3) father's mental health. According to Mayers et al., the theme regarding support received to help support partners included information about the maternal support and mental health services the mothers received. The researchers explained participants provided information on the mothers' experiences with those services as well as the fathers' perceptions of those services. Mayers et al. also mentioned two sub-themes found: 1) not enough support/information, and 2) low quality support. The article found that fathers are not given enough information on how to support their partners through postpartum mental health problems. Fathers receive the information in readable formats, such as brochures, or via pre-recorded videos (Mayers et al., 2020).

In addition, Mayers et al. (2020) discovered there were forms of desired support that fathers wanted but were not provided to them. For example, the article mentioned men wanted specific information they believed would have helped their partners cope, such as understanding and recognizing poor postpartum mental health signs. Furthermore, Mayers et al. discussed the participants wanting to have someone to talk to help them understand what was happening with their partner as well as serve as emotional support for their own mental health needs. Consistent with this, the article outlines information stating the participants believed they would have benefitted from communication from maternal healthcare providers. Mayers et al. also reported the participants believed both themselves and their partners could have benefitted from mental health referrals. Within this study, participants focused on the effect of their partners' poor postpartum mental health on their own wellbeing. The researchers found participants disclosed having low moods, anxiety, and stress that negatively impacted physical areas of their life (i.e., sleep, concentration, childcare abilities). The article concluded the fathers reported receiving, at

most, minimal mental health support, despite experiencing feelings of isolation and confusion. Fathers would have liked to have been given support on father-child bonding activities or to have been treated with sympathy from healthcare professionals (Mayers et al., 2020). Although this study provided good insight into the experiences of fathers, it was not without limitations. First, the study collected data via online questionnaires that included participants whose partners experienced "poor postnatal mental health" (Mayers et al., 2020, p. 360). In other words, this study did not focus solely on men whose partners had postpartum depression; their partners could have additional postpartum disorders. Furthermore, with the study being conducted via an online questionnaire, there was no opportunity for the researchers to elicit deeper responses from the participants (Mayers et al., 2020). This potentially inhibited the richer investigation of participants' experiences.

Moreover, a recent study by Maxwell et al. (2020) focused on the perception of individuals who experienced their partner having postpartum depression. Maxwell and colleagues utilized an online forum via Reddit and conducted thematic analysis on 294 posts. The researchers reported four themes were found: 1) just be there for her, 2) seek outside support, 3) understand what she goes through, and 4) not all partners make it through. According to Maxwell et al., the first theme consisted of discussion of providing emotional and instrumental support to their partners via helping with chores and talking to their partners. Within the second theme, researchers identified data consistent with asking for help outside the home. Participants of this study mentioned seeking support primarily from close family and friends in addition to seeking clinical support for themselves and/or their partners. According to Maxwell et al., the third theme provided insight into the need for individuals whose partners have PPD to be empathic. Finally, the study concluded with data that supported the struggles partners go through

during parenthood and PPD. More specifically, participants of the study reported filing for divorce due to the "burdens" (Maxwell et al., 2020, p. 9) they faced. The themes identified within the study provided deeper insight into the perceptions of those who have partners with PPD. However, the study included data collected from mothers who posted in the online forum as well (Maxwell et al., 2020), making the themes not unique to the experiences of men. In addition, due to the online nature of this study, the rigor of this study can be called into question since there is no way to verify the information provided; the internet is less secure and there is no way to verify the identity of those who posted the responses (Higginbottom, 2014). Thus, further research in this area needs to be completed.

Summary

Postpartum depression is not a new focus of research. The negative implications PPD has on mothers and children are recognized within the literature. Where the literature is lacking is with the experiences of fathers when their partner has PPD. The few studies regarding how fathers experience their partner with PPD have been extremely useful in adding to the literature; however, there are limitations to these studies which support the need for further research. For example, the study by Meighan et al (1999) is over 20 years old; it is important to have access to current research surrounding fathers' experiences with partners who have PPD. Additionally, Roberts et al. (2006), while highlighting the mental health impact PPD has on men, did not focus on the actual experience men were having when their partner had PPD. As such, it seems necessary to expand the research in this area. Furthermore, research by Davey et al (2006) seemed to address the treatment group experience versus the experience of fathers whose partners have PPD. Moreover, Ruffell et al (2019) analyzed studies focused on the experiences of men and women, not just men. Additionally, Ierardi et al. (2019), while being remarkably

similar to the proposed study, had participant criteria that included the partners of the participants having PPD within the last three years versus having participants with partners that have current PPD. Having the criteria of three years has the potential to negatively influence the participants' recollection of their experience due to time elapsed impacting our memories (Griffiths, 2019). Additionally, studies that utilize online forums as a means for data collection not only limit the accuracy of the information provided, but the inclusion of information from mothers render these studies non-specific to the experiences of men (Engqvist & Nilsson, 2011; Higginbottom, 2014; Maxwell et al., 2020; Mayers et al., 2020). Furthermore, the current literature frequently includes men whose partners have other mental health concerns, such as baby blues and postpartum psychosis (Engqvist & Nilsson, 2011; Mayers et al., 2020; Ruffell et al., 2019). In other words, despite the beneficial studies that have contributed to the literature, the proposed study is much needed to better understand lived experiences of men whose partners have PPD. Developing a better understanding of this phenomenon will allow counselors and other health care providers to focus more on the mental health and wellbeing of fathers and provide support to men that will increase the administration and use of effective coping skills that can be utilized to combat negative experiences associated with having a partner with PPD.

CHAPTER III: METHODOLOGY

Introduction

The purpose of this study was to examine the lived experiences of men whose partners have postpartum depression (PPD). My primary focus was to examine the essence of the lived experience while simultaneously understanding the meaning surrounding this experience and explaining the nature of what it is like for men having partners with PPD (Guillen, 2019). I designed a hermeneutic phenomenology study that utilized semi-structured interviews with men whose partners have current PPD. The following sections provide further detail into the methodology used for the implementation and analysis of the study.

Research Question

The research question used to drive this study is: What are the lived experiences of men whose partners have postpartum depression?

Qualitative Research Design and Rationale

To sufficiently conduct this study, I utilized a qualitative approach. Qualitative research allows researchers not only to learn and understand the lived experiences of individuals in natural environments, but also allows the findings to emerge from the data (Berrios & Lucca, 2006). The use of qualitative research provides the opportunity to explore existing areas of interest in more depth and with more detail (Hunt, 2011). According to Hays and Singh (2012), qualitative research provides the opportunity for researchers to examine their chosen phenomenon from an innovative angle. Instead of focusing on finding the root cause of a phenomenon, the goal of qualitative research is to discover the process of that phenomenon through inductive analysis (Hays & Singh, 2012).

For this study, I employed a qualitative approach so that I could provide a thick description that provides depth within the data (Hays & Singh, 2012). The topic of postpartum depression is not unfamiliar in research. There has been extensive research on how PPD influences the family systems (Barnes, 2006; Beestin et al., 2014; Habel et al., 2015; Johansson et al., 2020; Mayo Clinic, 2021; Roberts et al., 2006; Ruffell et al., 2019) as well as the psychological effects PPD can have on male partners of women with PPD (Davey et al., 2006; Roberts et al., 2006). The existing literature also contains studies that display how PPD influences the mother (Finnegan et al., 2021; Zuckerman et al., 1989) as well as the child (Goodman & Brand, 2008; Hedegaard et al., 1993; Rini et al., 1999). Though some research focused on male partners (Davey et al., 2006; Roberts et al., 2006), they were quantitative studies that were insufficient in gathering information regarding the in-depth experiences of men whose partners have current PPD. Further, extant qualitative literature either does not focus solely on the men's experiences (Habel et al., 2015). Moreover, research is limited in that years have elapsed between the experience and the study, making it difficult for participants to accurately recollect the events as they occurred (Griffiths, 2019; Ierardi et al., 2019).

Phenomenology

Typically, we do not assign a name to our everyday experiences (van Manen, 2017). van Manen also states it is human nature to live in the "now" and too often this causes us to be unsuccessful in being able to recapture that moment when trying to reflect upon it. van Manen discussed that the aim of phenomenology is to bring awareness to those experiences to be able to reflect meaningfully on that experience. Additionally, he shared one aspect of phenomenology that makes it an ideal approach is that it can take any lived experience and turn it into an extraordinary experience by transforming the lived experience into "a textual expression of its

essence" (van Manen, 1990, p. 36). According to van Manen (2017), since most experiences conceal, hide, or fade meaningfulness, phenomenology is needed to provide clarity to those experiences. van Manen concluded with discussing how phenomenological description teaches researchers how to examine the meaningfulness of the experiences and draw out deeper meanings of human existence

The following study used phenomenology to further explore the phenomenon of men's experiences with having a partner that has postpartum depression to gain a deeper understanding of this lived experience from men that are currently coping with it. More specifically, van Manen's (1990, 2014) hermeneutic phenomenological design will study the phenomenon men who have a partner with current PPD.

Hermeneutic Phenomenological Inquiry

Hermeneutic phenomenology is defined by van Manen (1990) in an assortment of ways: a) the study of lived experience using a scientific process, b) the explicitness of the phenomenon as it presents to the consciousness, c) the examination of essence, d) experiential meanings as they are lived, e) the human scientific study of phenomena, f) the attentive practice of thoughtfulness, g) the exploration for what it means to be human, and h) a poetizing activity that consists of pondering an original experience. This approach provides meaning to the analysis of phenomena by gathering and analyzing data, and reporting the findings (van Manen, 1990).

Hermeneutic phenomenology is an appropriate approach to answer the research question because it allows for the description and interpretation of the participants' lived experience (Guillen, 2019). This approach allows for the examination of the essence of the lived experience, not just the surface of what happened. Taking a hermeneutic phenomenological approach

provides the opportunity to find meaning surrounding the phenomenon while attempting to explain the nature of the phenomenon (Guillen, 2019).

I used van Manen's (1990) hermeneutic phenomenology to guide this study. van Manen described a six-step approach to hermeneutic phenomenology that should take place throughout the research process. The first step in hermeneutic phenomenology is "turning to the nature of a lived experience" (p. 36). For this step, the researcher formulates their research question by being open to the nature of a phenomenon and serves as an area of interest to the researcher. The phenomenon I examined in this study is men's lived experiences with a partner who has postpartum depression. The second step in van Manen's approach is to investigate the experience as it was lived by the individuals. This activity involves the use of investigation methods (e.g., interviews or focus groups) to capture the phenomenon. Next, van Manen discusses that researchers must characterize essential themes that have the potential to describe the phenomenon; that is, determine the overall meaning of the experience.

In the fourth step, van Manen identifies writing and rewriting to describe the phenomenon in question. The purpose of this step is to make the thoughts, feelings, and attitudes that each participant has regarding the phenomenon visible (van Manen, 1990). I communicated the phenomenon through writing my results section of this dissertation. In this section, I included not only the emerged themes, but also provided examples taken from the transcripts that allow the participants' voices to tell their individual experiences. The fifth step in this approach is for the researcher to ensure they maintain a strong and oriented relationship to the phenomenon. It is crucial that I remained focused on the research question that was conceived at the beginning of the process and not stray when completing the data analysis. I completed this via utilizing a peer coder, discussions with my peer debriefer, and reflexive journaling. These steps allowed me to

ensure my data analysis did not deviate from my research question and that the data presented was consistent with the phenomenon I examined. The sixth and final step in van Manen's hermeneutic phenomenological approach is to consider the part as a whole to balance the research context. According to van Manen (1990, 2014), the researcher should be creating specific plans throughout the research process to ensure equal effort in each step. For example, I reviewed my reflexive journals to help keep track of how long I spend in each phase of the research process. I will also complete bi-monthly check-ins with my dissertation committee to ensure I am not focusing too much in one area of the research process.

The hermeneutic phenomenological perspective of van Manen (1990) calls for the researcher to live within the experience. The idea driving this study is to understand the experience of men whose partners are diagnosed with postpartum depression. By using this approach, I immersed myself in the experience of the participants, allowing for the discovery of a deeper, more meaningful understanding behind those experiences (van Manen, 1990, 2014).

Role of the Researcher

van Manen (1990, 2014) suggested that the research process happens only once a topic comes alive to a researcher. Within qualitative research, the researcher can immerse themselves into the study once they uncover the phenomenon. One of the most predominant aspects within qualitative research is that of the role of the researcher. Those conducting research using a qualitative lens function as moving gears within the study; for the research process to move smoothly, the researcher must become and remain deeply rooted within their selected phenomenon or experience (Hunt, 2011). Within hermeneutic phenomenology, Hunt (2011) also emphasized that the researcher works directly within the phenomenon. The researcher should remain grounded in their research question to foster and perpetuate a strong interconnection with

the phenomenon (van Manen, 1990, 2014). Remaining grounded in research allows for the development and maintenance of a deeper sense of curiosity and wonder about the phenomenon, further driving the research surrounding it.

Lastly, researchers should be transparent throughout the research process, including data collection, analysis, and the reporting of findings. This includes researchers recognizing any assumptions, biases, and/or expectations that may exist (van Manen, 2014). The rationale for this is to limit any potential influences that can affect how the researcher develops themes or meanings. van Manen (2014) pushed researchers to make these acknowledgements to prevent variations within the data collection, analysis, and findings distribution processes because it is unreasonable to ask researchers to effectively disregard any biases they may have.

In congruence with van Manen's expectations, I acknowledged my experiences, assumptions, and biases regarding men who have a partner with postpartum depression. While I was fortunate enough to not have to endure PPD after the birth of my son, I did experience "baby blues." Baby blues ultimately presents with symptoms similar to PPD, but just at a very mild degree and they do not last longer than the first few weeks postpartum (Moore, 2018). During this time, I could tell that my husband was doing more around the house and even took more time off work than we had initially planned. After the baby blues subsided for me, I sat my husband down and discussed what it was like for him to see me "not myself." He mentioned that it was difficult for him to watch me not have the energy to do much and that he felt like he had to take over most of the day-to-day operations of our household. He also brought up feeling helpless because no matter what, he was not able to pull me out of the baby blues. I also have had close friends who have a history of PPD. Additionally, my work as a counselor has exposed me to several clients who suffered from PPD. My identity as a counselor also influenced the

theory in which I use for this study. In my role as a counselor, I use family systems within my practice. Even though this study focuses on men, the family unit is a crucial factor. Both instances have granted me access to a more holistic understanding of PPD and its implications.

This experience with my own husband, friends, and clients made me question what it is like for men whose partners have postpartum depression. PPD is notoriously more severe than the baby blues, and if my husband had difficulties coping with me having the baby blues, I could only imagine what it is like for men whose partners have PPD. Thus, my personal and professional experiences informed my research question. I currently hold the assumption that this study will reveal themes consistent with my experiences; I assumed the participants will report struggling in one form or another. Another assumption I held is that the men in the study will display some emotions, such as frustration, sadness, or feelings of being overwhelmed, while completing the interview process. Additionally, I assumed that I would encounter difficulty uncovering deeper thoughts from my participants because of the social idea that being emotionally restraining is equal to masculinity (Oliffe et al., 2019). Although this assumption goes beyond the scope of this study, it does hold value for future research. In order to assure my biases and assumptions did not interfere with data analysis, I utilized a peer coder and peer debriefer for the duration of this study.

Peer Coder

I used a peer coder to check any existing biases as well as ensure the capturing of the totality of participant experience during the data analysis phase of this study (van Manen, 1990). The peer coder I selected is a fellow doctoral cohort member. She has experience with qualitative coding and theme development through our program. My peer coder has experience with postpartum depression via a close family member recently receiving a PPD diagnosis. She has

experience with PPD as a clinician as well. She also holds the assumptions that the participants in this study will know very little about PPD outside of their own experience. A bias my peer coder holds is that the men will want to fix their situation and the lack of knowledge of how to do so will create frustration. I selected this peer coder because we have an established relationship with coding and theme development via a course in our program and I can trust her to serve as a peer coder. The peer coder will also engage in reflective journaling to organize any existing biases and assumptions she may have during the data analysis process (van Manen, 1999, 2014).

Peer Debriefer

In addition to a peer coder, I also utilized a peer debriefer throughout the research process. My peer debriefer has extensive experience with qualitative research that allowed her to effectively provide an external perspective for the data analysis process, which is recommended for qualitative research (Scharp & Sanders, 2019; van Manen, 1990, 2014). Having an objective view on the data increased the credibility and accountability of my study by allowing my peer debriefer to ensure my existing biases and assumptions were not influencing the identified themes (Hays & Singh, 2012; Scharp & Sanders, 2019; van Manen, 1990, 2014). I utilized my peer debriefer by periodically meeting throughout the data analysis process and discussing concerns that came up. For instance, two of the interviews were emotionally difficult for me. I discussed this with my peer debriefer to ensure my emotions were not interfering with the results (Hays & Singh, 2012; Scharp & Sanders, 2019; van Manen, 1990, 2014).

Trustworthiness

Within qualitative research, the quality and rigor of the study is determined through trustworthiness (Hunt, 2011). An important aspect of trustworthiness is transparency, where

researchers are charged with the task of showing readers what steps were taken to establish the quality of the study (Hunt, 2011). Depending on the approach utilized, establishing trustworthiness can be achieved in a variety of ways, such as engaging in self-reflection, including participants in the data analysis, and using peer reviewers (Hunt, 2011). For the following study, the approach to trustworthiness was consistent with van Manen's (1990, 2014) work, which describes six actions that researchers can take to establish the quality of the study.

First, van Manen (1990, 2014) states the creation of an appropriate and relevant phenomenological research question is the first step at ensuring trustworthiness. For the experience to be investigated as it was lived, identify the experience, and inquire the world as it is experienced in some way, hermeneutic phenomenology requires the primary research question to ask what or how (van Manen, 1990, 2014). I developed the current research question throughout this study to ensure the process being concrete. To maintain trustworthiness, it is also important to consult the literature.

The second action related to trustworthiness through the perspective of van Manen (1990, 2014) suggests that researchers continuously utilize scholarly, phenomenological literature throughout the research process. I utilized a variety of scholarly resources that implemented qualitative inquiry, including phenomenology and hermeneutic phenomenology, to examine research related to men's' experiences with postpartum depression. This process allowed me to ensure rigor within this study. The third action consists of hermeneutic phenomenologists to remain open to their study while being intentional throughout the data collection and analysis portions of research (van Manen, 1990, 2014). I engaged in continuous, consistent reflection throughout the research process to achieve this. I acted upon this in the form of consistent journaling as well as tackling concerns that came up, such as further biases or assumptions, with

my peer coder and peer debriefer (van Manen, 1990; 2014). For instance, one of the interviews was emotionally taxing for myself and my peer coder. I met with my peer debriefer and discussed this in order to ensure my own experiences were not influencing the themes that had emerged from this dataset.

The fourth action of van Manen's (1990, 2014) hermeneutic phenomenological approach expresses the importance of the researcher staying grounded to the experience that will be investigated as well as the research question that will be used to guide the current study. I ensured success in this area of trustworthiness through consistent self-reflection and open communication with my methodologist and peer coder. I also remained grounded by continuously consulting the research question during the data analysis process to ensure the findings were consistent with what I wanted to know. The fifth action described by van Manen (1990, 2014) emphasizes rich data as being an important aspect of trustworthiness in hermeneutic phenomenology. Unlike other qualitative research, van Manen's (1990, 2014) perspective of hermeneutic phenomenology does not list data saturation as the goal. As an alternative, researchers utilizing this approach should aim at reaching a deeper understanding of their selected experience as it is lived through data that is both descriptive and illustrative. The following study met this criterion for trustworthiness by using semi-structured interview questions, which allowed for the use of follow-up questions as needed. Follow-up questions are an effective technique researchers can use to elicit deeper responses regarding specific experiences or to collect clarification from participants (Hays & Singh, 2012).

The sixth and final step of reaching trustworthiness consists of participant involvement in the research process (van Manen, 1990, 2014). I used follow-up hermeneutic conversations (van Manen, 1990, p. 99), which allowed me to collaborate with the participants in clarifying and

editing the transcripts as well as interpreting the significance of the initial themes. Not only did this allow participants to play active and engaged roles in the research process, but it also allowed them to do so in a way that is meaningful and impactful to the data. Though van Manen calls it hermeneutic conversations, this is similar to what other researchers call member checking transcripts and member checking results (Hays & Singh, 2012).

Another way to establish trustworthiness in hermeneutic phenomenology, according to van Manen (2014) is to identify assumptions, biases, and/or expectations researchers may have throughout the research process to communicate openness, which is essential when conducting qualitative research. I focused my journaling throughout study on the thoughts, emotions, questions, and any other relevant experiences that will come up during the research. When engaging in discussions with my methodologist and the identified peer coder I sought feedback on any existing concerns they have regarding any potential biases that may have influenced the findings. For instance, one interview elicited a strong reaction from me. It brought up thoughts surrounding my own birthing experience and I found it to be emotionally difficult for me. I also struggled with not stepping into a counselor role when interviewing a participant that disclosed emotional, verbal, and physical abuse he endured from his partner. When I met with my peer coder and peer debriefer, both instances were a topic of discussion. This process allowed me to determine if the themes found accurately capture the participants' experiences, or if existing biases influenced the themes.

An additional step I took to establish trustworthiness in this study was engaging in self-reflection in the form of reflexive journaling. During each step in the research process, I maintained a digital journal that allowed me to reflect on my thoughts, attitudes, and biases that came up during the research process. Reflexive journaling also helped in allowing myself to

record any insights I gained and reflected on previous biases and assumptions (van Manen, 1990).

Participant Feedback

Transcript Feedback

Hermeneutic phenomenology places a heavy emphasis on rich data and participant involvement to support trustworthiness (van Manen, 1990, 2014). To check the accuracy of the transcripts as well as to encourage participant involvement, I used transcript feedback via follow-up hermeneutic conversations (van Manen, 1990). For this study, once I completed all transcripts, I provided participants an email that contained a copy of their respective transcripts. Within the email, I prompted participants to review, edit, or add comments that they felt are necessary within the Word document. I gave participants the option to communicate their changes and/or comments either via the comments function of Word, by using a different font or color, or verbally communicating with myself over the phone. Those who wished to make comments or changes in the Word document emailed the document back to me within the provided timeframe. I included all the clarifications and edits in the data analysis process. I allowed two weeks from the day I sent the emails for participants to make any changes to their transcripts. This step in the data collection process was not a requirement to participate in this study, and participants could decline engagement in transcript feedback without penalty if they do not wish to complete it. I had six out of seven participants engage in transcript feedback.

Initial Findings Feedback

To conclude data collection for this study, I used initial findings feedback. Within this process, I provided the initial findings to all participants engaged in this study. Related to transcript feedback, initial findings feedback allowed for the assurance of trustworthiness and

data richness via participant involvement. Initial findings feedback also helped guarantee the accuracy of the identified themes as they identify what occurred during the selected phenomenon (van Manen, 1990, 2014).

To elicit initial findings feedback from the participants, I sent an additional email that invited participants to review and comment on an attached Word document that displayed the themes that I found. Participation in initial findings feedback was also optional for participants. Participants documented feedback via the comments function in Word, noting feedback using a different font or color, or verbal (via phone call) communication with myself. I allowed the participants who wish to engage in initial findings feedback two weeks to complete it. Once again, six out of seven participants engaged in initial findings feedback.

Triangulation

In order to establish trustworthiness within this study, I utilized a less formal version of van Manen's (1990) research seminar/group. Instead of collaborating with an entire research team, I invited one fellow cohort member, along with one member of my dissertation committee, to review the text and the initial themes I found in order to check existing biases within the findings and fully capturing the participants' experiences (van Manen, 1990). This process is called triangulation of investigators and it is often utilized in qualitative research to maximize trustworthiness of a study (Hays & Singh, 2012). Within triangulation of investigators, researchers utilize more than one individual to assist in the collection or analysis of data, writing reports, and presenting findings (Hays & Singh, 2012). By utilizing triangulation of investigators, I built upon the confidence in my findings as well as significantly strengthened my study (Hays & Singh, 2012).

Although triangulation of investigators can take many forms, the form I used consisted of a single team member and was only during the data analysis process (Hays & Singh, 2012). I used the peer coder mentioned in previous sections as well as a peer debriefer. Peer debriefing required me to present my findings to another researcher trained within qualitative research and that individual produced an external check to ensure the accuracy of my observations and interpretations of the data (Scharp & Sanders, 2019). My peer debriefer is an assistant professor in a counselor education program with extensive experience in qualitative research. She has been responsible for challenging my findings as well as providing me with support throughout my research efforts (Hays & Singh, 2012). Peer debriefers not only provide emotional support, but they also enhance the credibility of the qualitative study (Hays & Singh, 2012). Utilizing a peer debriefer add to the accountability within my study as well as enhanced the recognition and understanding of my own influence on the interpretation of data (Hays & Singh, 2012).

Settings and Participants

In order to obtain participants, I used purposive and snowball sampling. Purposive sampling allows for the selection of potential participants based on criteria that is specific to this study (Etikan et al., 2016). Snowball sampling allows for one case to naturally lead to another (Babbie, 2013; Patton, 2015). I posted flyers (see Appendix A) with the purpose of the study, participation criteria, and my contact information in selected obstetrician and gynecological (OBGYN) offices, community mental health facilities, and pediatrician offices as well as on Instagram, Facebook, and Reddit. By utilizing snowball sampling, I was able to recruit participants by requesting existing participants to pass on information regarding this study to those whom they might know that would meet the criteria (Babbie, 2013; Patton, 2015). The reason I chose these potential sites is because these organizations are more likely to serve

someone experiencing PPD. Furthermore, the women experiencing postpartum depression will be able to provide their partners the information to my study, making them ideal locations for recruitment. The flyers also had instructions on how to contact me either via a Google Voice phone number or through my university email address. The first site I contacted was my personal OBGYN. Since I already had an established patient-doctor relationship, this site was more accessible to me. My doctor agreed to let me put up flyers in her office. I have also received permission from a university's counseling and training clinic to post both physical and virtual flyers. I made this connection by using my existing role as a counselor at this site. For the remainder of potential sites, I contacted them either via phone call or face-to-face interactions and requested permission to post flyers. This allowed me to recruit the number of participants needed for this study.

According to van Manen (1990, 2014), data saturation is not the goal of data collection, but rather to develop a deep and meaningful understanding of the phenomenon. Therefore, there is not a specific number of participants I needed for this study. Sim et al. (2018) suggested guidelines for selecting the number of participants for qualitative research. Researchers can create an assumption of generality in which they examine the number of participants used in previous studies related to their topic and create their anticipated number of needed participants. Since researchers can assume the number of participants they will need based on previous literature, I anticipated that I would need between 7 and 15 participants for this study (Anekstein et al., 2018; Azizpour et al., 2018; Baltrinic, 2014; Brown, 2020; Davey et al., 2006; Giovengo-Gurrera, 2017; Habel et al., 2015; Hays, 2020; Hyatt, 2018; Ierardi et al., 2019; Jahn & Smith-Adcock, 2017; Koltz & Feit, 2012; Meighan et al., 1999; Minor & Duchac, n.d.; Nasrabadi et al., 2019; Vanmeter, 2019; Wagener-Cramer, 2018; Zust et al., 2017). Eligible participants for this

study must have met the following inclusion criteria. All participants must have been 18 years of age or older and must have identified as a cisgender male. Participants must have been in a current, heterosexual relationship with the mother of their child. Participants' partners must have a current, official diagnosis of postpartum depression. Furthermore, participants must live with their partner that has PPD. Additionally, the participants must be the biological father of their partner's child.

I set exclusion criteria for participants as well. I did not consider individuals who are not in a current, heterosexual relationship with the mother of their child for this study because these couples are more common, creating fewer access barriers. This also consisted of the exclusion of men who do not live with their partner that has postpartum depression. Additionally, I deemed participants ineligible to participate if the potential participants' partners did not have an official PPD diagnosis. This included men whose partners have a history of PPD from former births or self-diagnosed PPD. I excluded these men because I was interested in seeing the immediate experiences of having a partner with PPD. Furthermore, I excluded men who are not the biological father of the child whose pregnancy resulted in PPD because of the added number of stressors experienced by blended families, including shifts in parent-child relationships and conflicting family culture expectations (Jensen et al., 2018). Lastly, I excluded men whose partners are experiencing postpartum psychosis because of the rareness of this disorder; research estimates that anywhere from 0.89-2.6 per 1000 women will experience postpartum psychosis (Vanderkruik et al., 2017). In addition, postpartum psychosis presents with symptoms far greater than PPD, including infanticide (Barr & Beck, 2008), causing risk of skewed data.

Data Collection Process and Procedures

Informed Consent and Demographic Survey

The first step for this study was to obtain informed consent and demographic information for all participants. Once potential participants contacted me about the study, I sent an email containing a URL link to the informed consent and demographics survey (see Appendix K and Appendix L) that I provided through Qualtrics. If participants did not have access to email, I provided them a paper copy of the informed consent and demographics survey that they completed prior to the interview. Participants had the option of receiving a mailed copy of the documents or completing the required documents the day they interview. At the end of the demographics survey, I prompted participants to select a day, time, and format (i.e., face-to-face, phone, or virtual) for their interview. I sent an email or phone confirmation to each participant one week prior to their selected interview date. Once I collected the informed consents and demographics surveys from all participants, I downloaded the information from Qualtrics and transferred it to an Excel document. I put all information onto an encrypted, password protected folder on my laptop. I also saved the files on an encrypted, password protected flash drive for back up. I stored the flash drive in a locked cabinet in my home that will only be accessible to me.

Interviews

Once I selected participants, I scheduled individual interviews with each participant. The interviews were virtual, over the phone, depending on the availability of each participant. None of the participants elected for a face-to-face interview. Each form of interviewing allowed for complete privacy of the participant. For instance, if participants were completing their interviews virtually, I held the interviews via my Zoom personal room. This platform allowed me to lock

the interview, ensuring no one was able to join the meeting without my permission. Zoom also allowed me to record the interviews. I conducted all interviews in a closed room that had a noise machine outside the door, preventing any individuals from hearing the interview and ensuring participant confidentiality. For participants who elect to conduct their interviews over the phone, I used the mobile phone application NoNotes, which transcribes the phone calls in real time and send the transcripts directly to my email. I listened to the tapes and cleaned up the transcripts to ensure the accuracy of the data collected. These phone call interviews were also audio recorded using my personal Zoom account.

I audio recorded all interviews, including the ones completed via phone, on my personal Zoom account. I also transcribed all interviews that I did not complete using NoNotes. I saved the recordings and transcripts of the interviews in an encrypted, password protected folder on my laptop as well as on an encrypted, password protected flash drive. I completed the transcripts using Word and removed any identifying information from the transcripts. I assigned participants a pseudonym to protect their identity that I used during the interviews. I removed any other information or descriptors the participant shared that could reveal their identity (e.g., location, partner's name, etc.). Once participants verify the accuracy of the transcript, I permanently deleted the recordings of the interviews from my personal Zoom account as well as the encrypted, password protected folder and flash drive.

The interview process was semi-structured and last approximately 45-60 minutes. I took an audio recording of each interview. Once I completed all interviews, I transcribed each interview. I listened to each interview multiple times to ensure the accuracy of the transcript (Hays & Singh, 2012). I removed all identifying information from the transcripts to protect the

privacy of the participants. I used pseudonyms in the interviews and transcripts. I saved each transcript in an encrypted folder on my laptop.

Interview Questions

The interview process within van Manen's (1990) approach to hermeneutic phenomenology, depending on the nature of the project, provides researchers with the opportunity to gather lived-experience materials. Interview questions should be geared toward the phenomenon that is being studied as the person experienced it (van Manen, 1990). Interview questions are rendered useless if they "lack sufficient concreteness in the form of stories, anecdotes, examples of experiences, etc." (van Manen, 1990, p. 67). To ensure usefulness, van Manen (1990) provided suggestions to consider when creating interview questions. First, the researcher needs to ask the participant to describe the experience as it was lived. It is important to remind participants to avoid generalizing, using causal explanations, or abstract interpretations. The next suggestion is to have participants describe the experience as if it were a state of mind; this would include the feelings, moods, emotions, etc. associated with the experience. Researchers should also create questions that assist participants to focus on a particular incident of the experience. Researchers achieve this by asking participants questions about parts of their experience that stand out. Next, interview questions should include themes that compel participants to think about specifics of the experience, such as how their body felt, what sounds did they hear, or what smells were present. Finally, it is important to avoid beautifying the account with embellished terminology (van Manen, 1990). Furthermore, I was also mindful of the theoretical lens I planned to use for this study when creating my interview questions. Since I am operating from a family systems lens, I made sure I included interview

questions that focused on the family and the interactions that exist within the family unit. I created my initial interview questions with this in mind.

Piloting Interview Questions

I created my initial interview questions by considering what I wanted to know about the phenomenon. I also consulted previous literature to discover what researchers had already asked in respect to this phenomenon. I then transferred that information into questions and requested feedback from my methodologist. The next step I took was piloting my interview questions. According to Majid et al. (2017), the most crucial aspect of using interview questions for research is piloting interview questions. Piloting interview questions will enable me to test the questions as well as practicing interviewing prior to my data collection process (Majid et al., 2017). Researchers discuss the importance of piloting interview questions in qualitative research because it allows for the identification of flaws or limitations in data collection. Despite Majid and colleagues reporting that piloting interview questions does not directly guarantee the quality of the interview to improve, they did find that piloting interview questions allows researchers to modify their interview questions in a way that more accurately collects the data they are seeking. In order to pilot my interview questions, I contacted two men whom I personally know that either 1) had a partner that had PPD in the past, or 2) had other experiences with PPD. Upon the completing of the pilot interviews, I refined my interview questions based on feedback from these men. The interview questions that I used in this study are in Appendix M.

Data Analysis Process and Procedure

Data Analysis Process

van Manen's (1990) approach to hermeneutic phenomenology allows for three different means of data analysis. First, van Manen (1990) offers a wholistic approach in which the

researcher examines each interview as a whole and then determines what information contributes to and represents the essence of the phenomenon. Furthermore, researchers can take a selective approach. In this approach, researchers review the data several times and discover the existing themes via methods such as highlighting, underlining, and circling. Finally, researchers have the option to use a detailed, line-by-line approach to data analysis. In this approach, researchers review singulars or clusters of data. Then, they determine what each grouping means in relation to the phenomenon (van Manen, 1990). He also describes the use of free imaginative variation, which allows me to verify if the found themes belong to the phenomenon that I am studying. In this process, I defined essential themes by imaginatively changing or deleting them and asking the question "is this phenomenon still the same?" (van Manen, 1990, p. 107). This allowed me to identify themes while keeping the fundamental meaning of the phenomenon (van Manen, 1990).

Coding Procedure

To maintain organization and clarity during the coding process, I had attempted to utilize the ATLAS.ti data analysis software (ATLAS.ti.9, 2020). This software should have allowed me to manage my data, in both Word and audio formats. ATLAS.ti, 2020 should have provided me the tools to systematically organize and code my data, which will assist with developing the final themes (Qualitative Data Analysis, n.d.). However, the ATLAS.ti, 2020 software was not consistent with my personal data management routine. After trial and error, I decided to analyze my data using Microsoft Excel. By using Microsoft Excel, I was able to organize, code, and develop themes within my data.

For this study, I used a selective approach to analyzing the data. Using a selective approach for data analysis allowed me to examine the language participants used, which serves as the means within the data (Sloane & Bowe, 2014; van Manen, 1990). A selective approach to

data analysis allowed me to select information within the data that related to the experiences of the individuals and conduct a follow-up with the information to reveal how it relates to the data as a whole (Sloane & Bowe, 2014; van Manen, 1990). I utilized this data analysis approach to help with coding, which involves categorizing text and keywords that influence one another (Hays & Singh, 2012). A code, according to Hays and Singh (2012), is a label that groups a variety of data. Codes can either be descriptive or interpretive. Researchers should describe codes in detail and paired with an example from the data (Hays & Singh, 2012). I coded my findings by reviewing the transcripts and creating memos throughout and organizing my data. I then considered the text in relation to the context of my study (Hays & Singh, 2012). I also utilized in vivo coding, in which I took the words participants shared and developed codes (Hays & Singh, 2012). Once I organized the data, I began to manually code inside the Word document and later transferred those codes into a codebook using Excel. After the coding process was complete, I began to identify themes that existed within the data.

The final data utilized consisted of themes, and if appropriate, subthemes. Themes should be created by grouping together codes in a way that is able to describe the phenomenon more fully (Hays & Singh, 2012). I collaborated with my peer coder and the participants until we agreed upon the themes and subthemes. The data selected was consistent with hermeneutic phenomenology and the initial research question. Additionally, I selected quotes from the interviews in order to report the analyzed data. The quotes selected appropriately demonstrated the themes and subthemes that are reported (Anderson, 2010).

Summary

This chapter discusses information that is crucial to the current study and the research design I utilized. Additionally, this chapter describes the methods used for this study, including a

detailed description of qualitative research, phenomenology, and hermeneutic phenomenology guided my approach as well as a rationale for the utilization of the selected methodology. Furthermore, I included the participant criteria, data collection and analysis procedures, and data management.

CHAPTER IV: FINDINGS

The purpose of this research study was to examine the lived experiences of men whose partners have postpartum depression (PPD). This chapter begins with discussing participant demographics as well as a review of the data analysis process. The majority of the chapter presents the results of seven individual interviews, which yielded five themes: 1) Getting Lost in the Shuffle, 2) My Own Worst Enemy, 3) Purgatory, 4) Light Within the Dark, and 5) Putting the "Partner" in Partnership. Each theme includes a description and supporting evidence from the participant interviews. It is important to note that the themes emerge as a parallel process to participants' partners' PPD diagnoses. The first theme typically presented when the participants' partners began displaying symptoms of PPD. The second theme occurred when their partners received a PPD diagnosis. The third theme emerged during the most severe part of the PPD. The fourth theme usually presented when the participants' partners started experiencing relief of their PPD. Finally, the fifth theme acted as a supplement that aided in the progression to the fourth theme.

Participant Demographics

To recruit participants, I created a flyer (see Appendix A) and posted it in several obstetrics and gynecological (OBGYN), pediatrician, and mental health offices. This flyer contained a link to a Qualtrics informed consent and demographic survey for potential participants to complete. Additionally, I posted the flyer and study information to multiple social media sites like Facebook, Instagram, and Reddit. Nine individuals originally consented to participate in this study, but two decided to withdraw their participation prior to data collection. The remaining participants (n =7) engaged in individual, semi-structured interviews that lasted from 35 to 50 minutes (M = 40.14 minutes). All participants identified as cisgender male. A

racial breakdown of participants included one African American participant and six White participants. The age of participants ranged from 24 to 45-years-old (M = 30.57 years). The participants varied in level of education as well. One participant did not finish high school, one earned his GED, two have some college experience, two have bachelor's degrees, and one participant earned their master's degree. Two participants of the seven men have partners that have received two postpartum depression diagnoses. One participant has endured PPD with his partner three times. In terms of recruitment, three of the participants learned of this study via their partner's OBGYN office, one from his partner's counselor, and three saw postings on social media. See Table 1 for an overview of participants' demographics.

Research Findings Analysis

The results discussed below depict the essence of the lived experiences of men whose partners have postpartum depression via five major themes. I conducted six semi-structured interviews independently over Zoom, and one interview over the phone. I transcribed each interview, provided each participant with their individual transcript, and requested they provide feedback for accuracy or additional clarification. Five out of the seven participants provided feedback. Three out of those five participants provided clarification on wording, one requested I remove a sentence from the transcript, and the final stated he had nothing to add. The remaining two participants did not respond to the request for feedback. Upon the receipt of the transcript feedback, my peer coder and I independently coded each transcript. We then met and reviewed our initial codes together. We utilized the line number function for efficiency in the coding process. My peer coder and I were mostly able to meet in-person but had to conduct our final two meetings virtually, due to geographic differences.

Staying true to van Manen's (1990, 2014) approach, we originally coded using a line-by-line approach to capture the essence of the lived experiences of men whose partners have postpartum depression. However, the more we coded, the line-by-line approach quickly became difficult to keep organized. This caused my peer coder and I to shift to a selective approach. In addition to this selective approach, we also utilized in vivo coding in which we developed codes directly from the participants' voices, which is recommended for qualitative research (Saldana, 2016). My peer coder and I met a total of eight times: once per transcript and a final time to identify the final codes and themes. While we met to code each individual transcript, we utilized consensus coding (Creswell, 2013), in which we agreed on each code name and description. I created the initial codebook and updated it with any new codes or changes after each meeting. During the final meeting, we consolidated the final codes into themes until we believed the major themes captured the essence of the participants' experiences. During this time, I also conducted check-ins with my methodologist/peer debriefer for feedback since she was able to provide a more objective look at the data, as recommended by Hays and Singh (2012). I initially attempted to use the ATLAS.ti (2020) data analysis software, but due to unforeseen complications, I reverted back to utilizing Microsoft Excel to help keep my data and results organized. The final analysis produced five major themes that describe the essence of the lived experiences of men whose partners have PPD. The five themes are: 1) Getting Lost in the Shuffle, 2) My Own Worst Enemy, 3) Purgatory, 4) Light Within the Dark, and 5) Putting the "Partner" in Partnership. I identify and define each theme below. I utilize direct quotes extracted from participant interviews to support each theme.

Getting Lost in the Shuffle

The first theme identified in this study is Getting Lost in the Shuffle. This theme described participants' experiences with friends, family, and their partner forgetting about them during this time. For the men who are first-time fathers, they experienced this shift from their partner putting them first, to being the last thing on their partners' mind. Others who already had children were seemingly demoted in terms of where the focus lies within their immediate family. Though that shift is somewhat expected after bringing a new member into the family, having a new baby coupled with their partners' postpartum depression, caused an automatic forced decision for participants to be forgotten within their families. When a baby is born, the main focus is on the child and the mother, leaving very little, or in some cases no, attention for these fathers. One of the biggest challenges participants voiced in this theme to Getting Lost in the Shuffle was having their needs forced aside and unmet. Furthermore, most of the participants spoke about various disruptions within their relationships such as feeling connected and having communication issues with their partner. They also discussed navigating their new roles as parents while having to take over most of the responsibilities both inside and outside the home due to their partners' PPD; all of which caused their own needs to be forcibly pushed aside, or even lost.

For instance, Sean, a father of four, declared needs of his were unfulfilled. He stated, "Certainly there were emotional needs that went unmet." Dean, who has three children, shared what needs went unmet since his partner's PPD diagnosis. He reported:

> I'm at work and I'm dealing with meetings and I'm dealing with problems up on a construction site and then I have someone calling me at home and crying because she can't take it anymore, she can't find something or whatever it is it's I, I think, I consider

> that a need. My needs weren't met. My need was for her to take care of the kids. That need wasn't satisfied as blunt as that sounds.

Cory described some of his supportive needs that were not met by stating, “I have needed someone to be there to support me” and “Meanwhile, I had no one helping me deal with my problems.”

Also, within this theme, some of the participants explained how postpartum depression negatively impacted their relationships with their partners, specifically regarding connection and communication. Participants revealed they became disconnected from their partners during this time. For example, Dean described the current state of intimacy with his partner and how that has influenced his connection with her. He mentioned:

> I mean we did have sex sometimes, but I do feel like she was just trying to satisfy my need and she didn't really have a libido overall like it was it felt like it felt like pity. That's a big one because I do, I do need that to feel connected to my wife and if it's if it's not there it's hard to connect.

Similarly, Sam revealed ways in which his communication with his partner suffered by stating, “ . . . and I can’t talk to her about anything really because she won’t listen to what I am saying. It leads to confusion and misunderstanding all the time.” Sam also discussed him feeling lost in terms of where his relationship with his partner stands by saying, “. . . our marriage has become uncertain. She doesn’t know whether she wants to even still be married or not.” Similarly, Cory explained ways he believed his relationship is suffering by exclaiming, “It feels like there is a hole in our relationship.”

Furthermore, the participants shared instances where they were the ones having to become primarily responsible for their children and household since their partners’ postpartum

depression diagnosis. Cory disclosed this shift in responsibility caused him distress by stating, "That would leave me to take care of the baby and do all the housework alone. I really enjoy her company, so that made it hard to be doing everything alone." Similarly, Steve shared his experience with being the primary parent when he comes home from work:

> I'm the one cooking, cleaning, and doing all the things my wife used to do before this. I take over the baby duty with the exception of feeding since my wife is still breastfeeding. I will stay up and put the baby to sleep and give him a bath and everything.

In addition to friends, family, and their partners forgetting about them, adjusting to their new roles, and experiencing disconnection with their partners, participants also discussed ways in which they contributed to their suffering.

My Own Worst Enemy

The second theme, My Own Worst Enemy, brings forth the essence of internal barriers participants shared that prevented them from reaching out to others for support. Within this theme, participants acknowledged things they believed served as roadblocks to their own relief. Unlike Getting Lost in the Shuffle where circumstances of a new baby and their partners' postpartum depression automatically pushed aside their needs, this theme demonstrates how participants made the conscious decision to push their needs aside, to their own detriment. Furthermore, one of the underlying messages the participants conveyed was related to stigma and how it is not masculine to talk about your feelings or struggles. This theme encapsulates how the participants bought into this existing stigma and how it impacted their ways of dealing with their partners' PPD, such as experiencing poor functioning and unhealthy coping. Finally, how participants' traditional views of their roles within their household also served as barriers to relief.

In terms of personal needs, many of the participants actively chose to ignore them. For example, some of the participants spoke of intentionally to ignoring their own needs. Cory, who is a first-time father and married his high school sweetheart, shared his conscious decision to put himself last and mentioned, “I’ve been so focused on her that I never thought about myself. I put all my needs aside to help her.” Steve explained what contributed to his conscious decision to stop engaging in things he enjoys by sharing:

> I think about the things I like to do, and I no longer want to do them because I feel like if I attempt to go do something I want to do, I’ll feel guilty about leaving her behind because she can’t do things she wants to do. So now I can’t do the things I enjoy.

Jacob, who is a father of two and works as a miner, shared, “I haven’t had any other needs. I am setting it [my needs] aside until she gets better.” He also encouraged other men experiencing this to push aside their own needs by stating, “Put your needs aside because they aren’t as important as the one who is going through postpartum depression.”

Moreover, stigma surrounding men and mental health also proved to be barriers for these men. Steve spoke to personal stigma regarding his view of mental health that contributed to him not reaching for support by reporting, “I don’t want to talk to my friends about it because I don’t want them to know what’s going on at my house and I don’t want to be made fun of.” He continued to share, “I can’t talk to other guys about it because they just make fun of me and tell me to suck it up. There is no one you can talk to as a guy, especially about stuff like this.” Buying into the shame and stigma of talking about mental health, Dean similarly shared:

> . . . so, when my wife became postpartum, I didn’t reach out to anyone. I tried to hide it from everyone and to myself because I didn’t want her to be judged for it. I didn’t want to be judged myself. I felt like her being postpartum was a reflection on me and it was

> also going to affect our kids. If I know that a woman is depressed and she has three kids, I will automatically think less of her and I realized that might be a bias.

Furthermore, the participants mentioned personal views of postpartum depression that inhibited them from seeking solace from others or prevented them from supporting their partners. Dean also went on to state how society has influenced the way he has been perceiving his partner's PPD by sharing, "They [society] see them [the partners] as weak and then it comes back to my subconscious and maybe I saw her as weak, and I know that affected her as well. It was like fuel on the fire." He also shared his personal upbringing and how that influenced his view on reaching out for support. Dean claimed, "I was always told in my family you don't talk about your problems. You hid your big problems." Moreover, Sam explained how his perception of himself going through abuse prevented him from seeking help by stating, "I also felt embarrassed about being abused by my wife, so I hadn't sought help." Further, Sean, a father of four who is experiencing having a partner with PPD for the first time, mentioned:

> For better or for worse, I've probably got an old school way of handling emotions, which is you just cram them down for a little bit until you can get through whatever it is. There is nothing wrong with being emotional, but an effective way of dealing with an emotional thing is to suck it up.

Additionally, the lack of support caused some of the participants to seek relief elsewhere. Some participants displayed unhealthy ways of coping with their partners' PPD, such as withdrawing from their family and engaging in substance use, which prolonged their own suffering. Jacob admitted to turning to marijuana to help cope with his partner's diagnosis. He commented, "I medicate for stress and stuff like that. I have a medical marijuana card but sometimes it leads to paranoia, so I stopped doing that." Dean acknowledged his coping involved

emotionally pulling away from his wife. He shared, “I think reality sets in and then I felt like it was already too far gone, and I couldn’t help her. So, I think I turned away from her. Yeah, I shielded myself emotionally.”

Participants also discussed their role within their family and how there is a belief that these men were to be the foundations of their relationships. Most of the participants hold family views that are consistent with traditional gender roles, where the man has to be the primary supporter. Participants’ perceived roles within their family also prevented them from reaching out to others for support. For instance, Cory described him being the main source of support for his family. He shared, “My role in the household is to be there for everyone to lean on.” Similarly, Jacob contributed by mentioning how his role as a husband caused him to push his needs aside. He expressed, “The way I see it, if someone has postpartum depression, the guy should be supporting her.”

Participants’ experiences with Getting Lost Within the Shuffle and serving as My Own Worst Enemy contributed to feeling suspended in their suffering. Moving forward, these men discuss the deep emotional and psychological pain they experienced since their partners’ diagnosis.

Purgatory

In religious terms, Purgatory is an intermediary other world that exists between Earth and Heaven or Hell (Le Goff, 1981). In this space, those who died are seemingly stuck in this state between death and expiatory purification until they reach the relief of moving upward to Heaven. Le Goff states these individuals reach this relief by either helping themselves or through the help of others via prayer. Purgatory is known as a state of punishment and those who find themselves trapped there are often faced with a sense of uncertainty. This transitional world was not meant

to be a permanent resting place; instead, Purgatory was designed to be temporary, according to Le Goff. While the men who participated in this study were not in a literal purgatory, what they described goes beyond emotional turmoil. For them, Purgatory looked like facing significant emotional and psychological suffering with an unclear end, all while believing they have to keep things together for the sake of their family. It has been a flood of intense emotions for which these men have had little to no relief since their partners' postpartum depression diagnosis. The participants described how they longed for a break but were unable to take one. Furthermore, participants spoke of ways in which their relationships suffered after their partners' PPD diagnoses. Participants revealed feeling detached from their partners. Unlike Getting Lost in the Shuffle, the detachment that occurs in Purgatory is a deeper severance of the relationships that go beyond a disconnection. In regard to psychological implications, participants explain how they do not recognize their partners, or in some cases, their partners have turned into completely different people.

In an emotional sense, this theme describes participants feeling trapped in their own heads and watching life continue on as they silently struggle. Participants explained how they became suspended in a state of battling constant, overwhelming emotions with their experience as a whole. They described instances in which they were facing severe levels of hopelessness and guilt and were not certain when things would get better for them or for their partners. Jacob expressed his own emotional turmoil by sharing:

> For me personally, it was the worst. I have never been so worried in my entire life. I was on edge. I'm constantly checking up on her. I'm worried and I'm stressed out. I'm mentally tired and mentally drained. On top of working and dealing with this at the same

> time, and helping with the kids and all that, I'm just exhausted… I'm very worried right now. It's just worrisome. My anxiety has gone up, my stress has been pretty high.

Consistent with other participants' experience with feeling overburdened by their emotions, Dean revealed his struggles with balancing all his responsibilities:

> I mean I didn't know what to do, so I would leave [work] and then the bills will pile up. Then there's also frustration on my side. I got frustrated at some points. And I mean at some points, I think I screamed at her to toughen up and I realized that was completely unfair but, I don't know it just came out. Of course, I have guilt for many reasons.

At times, it appeared that the participants were so overwhelmed, that all they wanted was a break, but were unable to take one. For example, Sean described how he felt trapped and could not take a break:

> That and feeling like I could never turn off. Now that I think about it, I don't think I've ever said it out loud but that's the thing that's the most remarkable. I never had time where I could just… I work hard and then I come home and I'd either be watching my kids from my previous marriage or I'd be watching the baby, or I'd be enmeshed in some kind of argument. So, there was never a time where I could just sit on the couch, open a beer, and watch TV. So, I think those were the two biggest things; just the lack of ability to chill out. Because I was always on. I felt like I had to always be on in one capacity or another.

Similarly, Jacob has been experiencing being "on" all the time. He added, "I have to be positive for her and for my kids. I can't turn it off." Steve admitted to his fight with wanting to be there for his partner, but also having to financially support his family. He contributed, "I wanna leave

work early everyday so I can make sure everything is okay at home, but I know if I do, my check will be short, and we won't be able to pay our bills on time. It's a lot for me to think about."

In addition to overpowering emotions, the men have also been harboring guilt during their experiences. For example, Dean expressed guilt regarding ways he handled his partner's postpartum depression. He stated:

> . . . I don't know if I could have changed the way I felt, but I definitely could have changed the way I acted. I could have been more supportive. I could have agreed to bring her to the hospital and see the psychiatrist way sooner.

Sean also expressed feelings of remorse by stating, "I felt a whole lot of guilt." Jacob mentioned his own guilt has been an impactful aspect of his partner's PPD. He affirmed, "Just like guilt and feeling sorry for her. . . The most impactful thing has been the constant worry and the constant stress. . . And the physical and mental load." Dean shared his own feelings of guilt for removing his wife from support they had. He described how he believed moving away from his partner's family contributed to her symptoms of PPD:

> . . . but I should have known better. In hindsight, to take a woman who's still breastfeeding and a one-month-old and move away from her family, I should have known that she was struggling, and she was just looking for a change.

Steve, who is a first-time father and has a stressful job as an ironworker, affirmed his own fears:

> It's scary. You never know what's going to happen. You are constantly in a state of worry. It feels like it's never going to end. I feel guilty for not knowing how to help her. I should have talked to her doctor sooner than I did. Maybe she'd be out of it and get to enjoy being a mom. I never knew the danger of postpartum depression until I saw it.

Moreover, Sam expressed emotional struggles he faced. He shared, “In the beginning, I felt very hopeless and trapped.” Steve described his own experience as, “For the last few months, I have put on a brave face, but on the inside, I have been screaming at the world.” Rip, who is a father of three and has a partner who has endured postpartum depression three times, revealed his own experience with his overwhelming circumstances by sharing, “. . . when I work out, I try to get all of my frustrations out. I’m dealing with a lot right now, so I’m trying to get my frustrations out.” Dean explained how he felt when his partner received her diagnosis by sharing, “I remember just getting this sinking feeling because I knew what it was. . . and I felt really, really scared.” Sean shared instances where he was struggling with how he viewed his contribution to his partner’s wellbeing. He stated, “You know that sucks. I felt guilty. I felt hopeless and I felt sad for my own sake, but beyond that, I felt really guilty and shitty.”

Some participants expressed desperation on how to help find solutions but remained suspended in the unknown. Rip, whose partner received her third PPD diagnosis in October 2021, claimed, “I don’t know what to do, and I know that adds to her postpartum depression because she doesn’t have all the answers either.” Sharing his uncertainty, Rip continued, “I feel like I need to know what questions that need to be asked so we can figure out a happy medium.” Steve claimed, “I want to take it all away from her. I’d do anything to make her feel better.” Dean mentioned, “I was trying to break her free from it. . . I realized that nothing I could do was going to help her.”

Additionally, participants spoke of implications postpartum depression has had on their relationships that caused them emotional distress. For instance, Dean mentioned, “We have been isolated in some moments. . . You’re sometimes close by but you’re still isolated in a sense.”

Sam explained ways in which his relationship began to suffer after his partner's diagnosis by revealing:

> At the moment it is very strained. Before this happened, we had a very good relationship. We would share our problems and issues and work through them and also talk about a lot of things. We were very loving toward each other and prior to the birth of our son, we would talk about how happy we were to have a son and what our future would be like. That's gone now.

Similarly, Cory shared, ". . . but some days were harder than others. Some days we just didn't make it through." Dean shared his views toward his partner contributed to concerns regarding their relationship, "I think I resented the fact that she has postpartum depression and that might have come out in certain ways. I think she senses it and I think that's one of the reasons why we are having marital problems." Sean discussed ways in which his partner hurt him with things she said to him. He claimed:

> Some of the stuff she said was really, deeply hurtful. I don't know exactly how that impacted me, but it definitely stuck with me. She would just reach down as far as she could to say stuff like "I really wish we hadn't had this baby" or "why did we bring you into this world?" Stuff like that. It was just really, really hard.

Sean also mentioned ways in which he viewed his relationship as hopeless. He reported:

> It's funny because I think we have historically had a pattern of periodic arguments that I experienced as pretty ugly. So, I experienced the postpartum as an acceleration of that, which made me feel pretty hopeless because as things accelerate, you look out into the future and you're like "oh my God, pretty soon it's going to be always arguing and in this really, deeply, unpleasant way." So, it made me feel pretty hopeless about us.

Though all of the participants experienced a suspension in emotional distress, for some participants, they described how the emotional turmoil manifested physically. Specifically, some participants became physically ill from this experience. For example, Sean shared, "So, if being with me was demolishing her ability to thrive and her ability to be a better version of herself, it made me sick to my stomach that I was making her worse." Sam, a father of one and a schoolteacher, shared:

> This has really taken a toll on me physically and mentally. I lost about 30 pounds in two months and don't get enough sleep. I began having panic attacks and stress-induced fainting episodes which resulted in me being taken to the hospital by ambulance twice and admitted once. On top of this, even with her diagnosis, she refuses to believe she has any problems and has solely placed all the blame on me. This makes her seem even more distant and makes me feel even more hopeless. . . The most impactful part is definitely the effects on my health. I got very sick physically and mentally. I never thought I could reach a point like that. I don't have a history of anxiety or depression, but this has caused huge bouts of both. It also affected my self-esteem badly. Because of the things my wife said, I stopped believing I was of any worth and that I had no skills. I started believing I was useless, a liar, and an angry person.

Sam also disclosed physical abuse he endured from his partner. Prior to his partner's postpartum depression diagnosis, Sam described his relationship as "very loving" and "happy." Once his partner began displaying symptoms of PPD, he noticed a shift in their relationship. Sam described the most impactful part of his partner's PPD diagnosis. He admitted, "She also started abusing me both physically and mentally, saying things like I was a terrible father and husband, and I didn't deserve a son."

Furthermore, Purgatory demonstrates ways in which the men have been suffering psychologically. They mention being in a constant state of fear and worried about how their partners' postpartum depression affect themselves as well as will affect their children. Participants reported struggling with not recognizing their partners due to the PPD. Jacob admitted to some of his own fears by stating:

> I still worry. Like I worry about her taking all these medications and what if she takes them, goes to sleep, and then doesn't wake up? Or what if she wakes up and does something crazy? I can't do this without her. It's scary. It's a scary thing to think she would do something like that. And I'm definitely a firm believer that it wears off on the husband. . . There is a lot weighing on me.

Dean shared fears related to the effect on his children:

> Now that I think, that's also a part that scares me. How early childhood postpartum for her will affect the kids later on in life. Because that's not something that I dealt with as a child, so I don't know. I can't relate to it, and it scares me. I just know that it's a part of childhood that my kids will never get. A mother that is happy. . . I think that's the biggest worry that I have, how did it affect them? How did it affect their brains or development?

For Sam, he found himself feeling hopeless that his partner would not get better. He expressed:

> It has been terrible. It almost feels like my wife has died. The person who she is now is nothing like the person she used to be. She refuses to support [me] when I ask for help with things like housework. Instead, she will abuse me and call me names. She also refuses to do most housework, except laundry. If I don't prepare her food every day, she won't make her own and won't eat.

Likewise, Steve contributed ways in which he viewed his partner differently since PPD:

> It is hard seeing the person you love turn into someone else. She has fallen into a slump that she can't get out of. I feel like she is a completely different person than she used to be. If I had a bad day, I feel like I can't talk to her anymore, so now I don't have anyone to talk to. . . I'm still stunned that when I look at her, I don't recognize her.

Furthermore, the psychological implications of their partners' postpartum depression included one participant questioning his existence. Sam allowed himself to be vulnerable with me and shared his experience with intrusive thoughts. He admitted:

> Around the beginning of January this year, I thought about dying quite regularly. I love my son very much, but my wife was stopping me from bonding with him. I just thought if I was not necessarily dead, but not existing, it would be better. I felt very embarrassed about things too, like I had failed.

Despite being stuck in this described Purgatory, participants were able to discuss positive circumstances that acted as a source of hope for them. This hope contributed to moments of relief for the participants.

Light Within the Dark

The fourth theme of Light Within the Dark shows glimpses of hope the participants experienced during their pain. The essence of this theme encompasses the type of support or help they found during their partners' postpartum depression. For most of the participants, participating in the interview for this study provided some and relief. Additionally, having a positive mindset regarding their partners' diagnosis was helpful in reducing the hardship the participants experienced. For those who had it, their positive mindset stemmed from participants reflecting on their experiences from the time of their partners' diagnosis to how things are for them now. It is important to note that the participants who had a positive outlook were the ones

whose partners have a recent PPD diagnosis. For all participants, finding support for themselves contributed to glimmers of hope. Sam is the only participant out of the seven who can give credit to his own counseling for instilling hope and providing him with relief.

Regarding their participation in this study, without prompting from a question, five out of the seven participants admitted that simply having the space to discuss their experiences provided them with some relief. For example, Cory stated, "Today is the first time that I have really been able to express what this has been like for me." Rip shared his own experience with his interview and how he found comfort by explaining, "I don't know if that answers the question, but talking about this has been good. It's the first time I've felt like I could talk about it." Similarly, for Steve, participating in the interview was the first time he had been able to talk about his struggles with his partner's postpartum depression. He mentioned, "This is the first time I've really talked about it, and to be honest, it's been nice. Nice to let it out. Nice to have someone listen." Jacob confirmed his participation in the study helped him by stating, "I'd also like to say that this has helped. Talking about this has been good." Finally, Sean recognized that verbalizing his experience offered him some ease. He claimed, "I think just saying that out loud makes me feel better."

Furthermore, positive thinking regarding their partners' postpartum depression has proven to be helpful for participants. For example, some participants seemed to believe that the worst part of their partner's PPD was behind them. It seemed as if once their partners sought treatment which involved a combination of mental health counseling and medication, and they were making progress, the participants were able to see some light. For instance, Cory, whose partner has only been receiving mental health counseling for a month, shared, "Now that her postpartum is getting better, we are getting better too." Dean's partner started taking medication

two months prior to participating in the study and has been going to counseling once a week. He explained how treatment for his partner has instilled some hope in him:

> But we seem to be on an up curve right now. We've just decided to put our house for sale and possibly build our own home with the funds or travel a little bit, and I think that helped both of us see a bit of light at the end of the tunnel.

Sean discussed how his partner sought treatment from a psychiatrist and began taking antidepressants. Since his partner started on medication to help manage her PPD, he claimed:

> Oh gosh, the change has been night and day. Just an enormous difference in how she is. Just an enormous difference. I don't want to say it's all behind us because everyone gets into arguments and I'm sure we will have some wing dingers, but just a huge, huge change in quality of life. Going from constant, everyone being bummed out and angry to us going back to enjoying being around each other. Very good changes.

Sean also shared, "I don't know how it impacted me other than it seems like we made it through the worst of it. It's really something to think about how horrible it was and how pretty awesome things are now." Since his partner began her road to recovery, which includes medication and time itself, things seem to be going well for Dean, too. He reported, "She's happier now. She's much happier now." He also shared, "She recently got a job, and her social life is expanding now that she feels better." Moreover, Dean reported, "I think there's a lot of stars that aligned and everything is getting better." Jacob's partner received her PPD diagnosis two weeks prior to participating in this study and hospitalized. During hospitalization, doctors referred her to a psychiatrist and prescribed antidepressants. In just those two weeks of seeking professional treatment, Jacob shared the progress he has seen in his partner. He stated, "She hasn't cried. She started to sleep normally. She hasn't cried and she says she is starting to feel good."

In addition to their partners' improvement from seeking professional treatment, other participants shared a more positive way of thinking that has helped them through this experience. This positive thinking includes one participant understanding his experiences are not perpetual. For another participant, he reflected on how his relationship recovered, which contributed to his hope. Jacob stated, "I know postpartum is not permanent." Sean concluded:

> It's got a really ambivalent impact. I know it was hard for her and I'm deeply appreciative of how she put in the effort to try to work through that. Right now, I think we are in a good spot for the time being and I definitely don't take it for granted. I wake up every day and think, "what a beautiful life." I'm sure both of use were a whisker away from going to a divorce lawyer at some point, but we figured it out.

Additionally, some of the participants were able to shed light on ways they were supported by external relationships. For some, this support is contradictory to their earlier claims in My Own Worst Enemy where they shared not having support available or choosing not to open up to others. At a certain point, whether it be due to desperation for relief, or realizing having a partner with postpartum depression is difficult to overcome, a few of the participants decided to reach out to others for support. One participant sought support from his family. Another found support within his colleagues. Rip, who shared he felt "isolated" and didn't "have anyone to talk to" was able to find support within his family. He explained how he realized he needed to find support and decided to reach out to his family. He claimed the emotional toll was weighing on him, and he just knew he needed someone. Rip shared, "I talked to my wife, will talk to my parents, and sometimes I talk to my mother-in-law." Sam, who was also feeling alone and believed he did not have any support at the beginning of his partner's diagnosis, began

opening up to his coworkers. The emotional and physical abuse became unbearable, and he wanted to get away from it. Sam described how he found support by adding:

> After I shared with my supervisor at work, the social support has been amazing. My boss has even let me stay at their house at times when my wife got too abusive. Every day, people ask how I am doing and if I need anything and I have friends that check in with me often to make sure I am ok. This has really helped me get through this time. . . The support network has become stronger, and I am very grateful for that.

However, for some of the participants, support from their job and family has always been there. For example, Jacob, who is the only participant who did not appear to buy into the stigma of mental health, stated:

> My support has been great. Our families are our biggest support and I have been able to talk to them. Just for me, the guys at work are the ones I usually talk to. At work, we are more like a family because we are there more often than not and there are more guys there that are dads or have been where I am, and they give me advice and tell me to just be there for her and stay positive. But yeah, I have a lot of good support.

For another participant, they had to find support elsewhere. Sam sought out support from a counselor of his own. He shared how being in counseling for the past few months has contributed to his own relief. Sam shared:

> I am still a bit anxious some days but overall, I am feeling a lot better. I have had some quite intensive therapy sessions since January and have learned a lot of skills to help control my feelings and to not think too much about things. This has helped with my feelings too.

Putting the "Partner" in Partnership

Finally, Putting the "Partner" in Partnership demonstrates ways these men have offered emotional support to their partners through this trying time. This support looked like holding empathy and compassion for their partners as well as serving as advocates. According to the participants, providing this support helped them and their partners cope with the postpartum depression. This theme also focuses on the strengths within their relationships, such as strong communication and a good foundation prior to their partners' PPD diagnosis, which helped the participants, and their partners move towards relief. Sean, who has been helping his partner through PPD for three months stated, "I very much did and continue to think I should be as supportive as I can." Jacob, who conveyed understanding of what his partner is going through, described ways in which he demonstrated empathy and compassion toward her. Jacob claimed:

> Her being at home with our two babies alone and me at work all the time, it was a lot for her to take on and I think with her being alone all the time and the baby blues and postpartum depression and all that, I think it really had a bad effect on her.

Consistent with this, Dean, who has been married for 11 years and has three children, expressed other factors, such as moving and being away from family, he believed contributed to his partner's PPD. He demonstrates having insight into his partner's diagnosis and how outside factors contributed to it. Dean shared, "I think a lot of the postpartum was due to stress factors other than the baby." Sam admitted he does not condemn his partner for having PPD, ". . . I don't blame her. . . It hurts me to see her hurting like this." Steve displayed empathy by sharing, "I get things have been scary and hard for her." Rip expressed he is aware of what PPD has been like for his partner. He commented:

> . . . if she's feeling frustrated, or the baby's been fussy today, so she's a little bit more shut down with the baby being fussy and I totally get it. It makes you feel like you're not doing your part, so I understand completely. I have empathy for her.

For one participant, emotional support looked like holding admiration for his partner. This admiration is something he has held for his partner since before her postpartum depression diagnosis. Having admiration contributes to strength within this participant's relationship. For instance, Rip stated, "I have a lot of respect for my wife, and she is doing what she needs to in order to get better. She is strong and she makes me want to be better." He recognizes going through PPD is a process that has no time limit and is trying to provide his partner with as much time and space so she can recover. Rip also continued to show his compassion for his partner by saying, "I want her to get back to where we were, but I know she needs time for that."

In other instances, the participants felt the need to advocate for their partners' well-being. For example, Steve said, "I talked to her doctor, and I told her that my wife's ambition of being a mother has drastically changed from what she thought it would be to what it is now." In addition, Cory claimed:

> I went with her [to the doctor] and I'm glad I did. The doctor told her it was normal and that there was nothing to be upset about. I told the doctor that my wife had changed. That she was not the same person I knew and that this was not normal for her.

Sometimes, this even meant advocating for their partners within the relationship. One participant shared his partner was not confident she was doing well, so he decided to show her she was. Cory reported, "She never believed she was doing a good enough job, so I made it my job to tell her she was doing a wonderful job."

Furthermore, having a strong foundation within their relationships also seemed to have a positive impact on the postpartum depression. Having a strong foundation consisted of friendship, connection, admiration, and being able to communicate with each other. Cory spoke to strength within his own relationship by stating, “We don’t have individual jobs at home. We both put in the effort to get things done.” He later spoke about more specific ways he would support his partner. Cory admitted, “I check in with her to see how she is dealing with anything that she is going through.”

Sean spoke of the friendship that exists within his relationship. He claimed, “We are each other’s best friends and soulmates and partners.” Similarly, Jacob added:

> We have a pretty awesome relationship. If there is something that we need to discuss we talk about it. If something is on our minds, we talk about it. Just overall a pretty great relationship. It makes things easier with the postpartum depression for sure. . . Honestly, we are soulmates. We are the old kind of love I guess you could say. Like we are probably going to be together until death do us part in like 50-60 years. She’s my other half. I have a lot of love for her. She is amazing. . . I have no intentions on giving up. It’s been something seeing her get through this. I feel like we have gotten stronger.

Steve described the love and connection that exists in his own relationship. He stated:

> We do have small arguments, but nothing crazy. Nothing to where we want to walk out on each other. Just typical little fights. I don’t think either one of us would be able to handle being separated from the other. . . Our relationship is strong. Very strong. We try to talk about our problems, so we get them resolved so it’s not a problem later on. We try to do things together as much as possible. I love her a lot. Our relationship is strong. It needs work like every relationship does. . . She is my soulmate. I love when I am around

her and now, I love when I am around her with the baby. I love being a family. I've loved watching her grown into this amazing person. . . I can confide in her about my fears or my excitements.

In the end, despite all the emotional, physical, and psychological hardships, these men have found ways to cope with their partners' PPD. Even though the men have been going through an intense tribulation, with the help of family, friends, and having a strong relationship, they manage to see the positive and continue to have hope that one day this too shall pass.

Conclusion

This research study aimed at describing the essence of the lived experience of men whose partners have postpartum depression. This chapter discussed the five themes identified within the data: 1) Getting Lost Within the Shuffle, 2) My Own Worst Enemy, 3) Purgatory, 4) Light Within the Dark, and 5) Putting the "Partner" in Partnership. Getting Lost Within the Shuffle demonstrated how the friends, family, and their partners forgot about participants. It also encompasses ways in which they are having physical and emotional needs go unmet. My Own Worst Enemy focuses on ways the participants served as barriers to their own relief, such as consciously putting their needs aside, holding their own stigma towards mental health, and believing certain aspects of their role in the household did not allow for them to reach out for support.

Purgatory described ways in which the participants experience suspension in this state of emotional, physical, and psychological suffering. Light Within the Dark explains ways in which the men have been able to experience hope and relief. For example, finding support from family and friends as well as having a positive outlook on postpartum depression has been helpful. Finally, Putting the "Partner" in Partnership describes ways participants have been supporting

their partners. This support has presented as empathy, compassion, and advocacy as well as friendship and connection within the relationship. The following chapter discusses the five themes within the context of extant literature, as well as the limitations of this study and the implications of these results.

CHAPTER V: DISCUSSION

The current study analyzed the lived experiences of men whose partners have postpartum depression (PPD). The previous chapter displayed the five major themes found within the data, and this chapter will provide a discussion of the results. This chapter also provides a further discussion on the implications, limitations, and recommendations for future research.

Overview

The purpose of this study was to examine the lived experiences of men whose partners have postpartum depression. While previous studies have provided useful insight into this phenomenon, the limitations include lengthy gaps between the time of the experience and data collection, which does not allow researchers to take into consideration how time influences our recollections (Griffiths, 2019; Ierardi et al, 2019; Meighan et al., 1999). Furthermore, other limitations include examining men's experiences with having a partner diagnosed with other maternal mental health disorders, such as postpartum anxiety, postpartum psychosis, and postpartum obsessions (Engqvist & Nilsson, 2011; Mayers et al., 2020; Ruffell et al., 2019). Moreover, one study focused on the men's experiences with a focus group versus their individual experience of having a partner with PPD (Davey et al., 2006). Additionally, another study analyzed the mental health of men whose partners had PPD and compared it to those whose partners did not (Roberts et al., 2006). Finally, a more recent study included both women and their male partners, which limits the insight on men regarding this experience (Maxwell et al., 2020). With these studies denying a focus solely on the men's experiences, the current phenomenological study assisted in examining the lived experiences of men whose partners currently have PPD.

I collected data via in-depth, semi-structured interviews with a total of seven participants whose partners have a current postpartum depression diagnosis from a healthcare provider. Upon the completion of data analysis, I found that men whose partners have PPD struggle with a wide variety of challenges, such as battling an expansive range of emotions, feeling trapped in their own minds, having their own needs lost, and factors within themselves that prevented them from getting support. Additionally, the results showed that despite the horrid ordeal these men face (i.e., Purgatory), they also tend to have a positive outlook on this experience and being a partner to their partners helps alleviate some of the stress of PPD (i.e., Light Within the Dark).

Discussion of Themes

This study identified five major themes:1) Getting Lost in the Shuffle, 2) My Own Worst Enemy, 3) Purgatory, 4) Light Within the Dark, and 5) Putting the "Partner" in Partnership. The remainder of this chapter provides a detailed discussion of each theme, including a comparison to existing literature. Furthermore, this chapter identifies the limitations of this study and the implications for counseling and counselor education. Finally, this chapter concludes with recommendations for future research.

Getting Lost in the Shuffle

This theme captures the essence of family, friends, and partners forgetting men whose partners have postpartum depression. Additionally, the participants have their needs forcibly pushed aside so that the focus is their partner and child(ren). Moreover, Getting Lost in the Shuffle describes ways in which participants' relationships suffered. This suffering presents primarily as a disconnect between partners in terms of communication. Furthermore, this theme encompassed the idea that PPD causes chaos within the family system, leaving men to navigate

these changes. The chaos presents itself as the men having to adapt to being more responsible for their homes and children after their partners' diagnosis.

Throughout their partners' postpartum depression, the needs of their partners and children overshadowed the participants' needs. For participants who were new fathers, this included them adjusting to their role as a father as well as having a partner with PPD. Those who had children previously had to learn how their family system was going to work with both a new addition and a PPD diagnosis. This contradicts previous literature that claimed fathers isolated from their children when their partner was struggling with PPD (Davey et al., 2006). The participants in the current study reported becoming more involved with their children as their partners struggled with PPD. The number of children and the number of times their partners have had PPD did not seem to influence the level of involvement fathers had with their children; they all became lost in the shuffle in some aspect or another. In other words, men who either had multiple children or their partners have had PPD more than once were equally as involved with their children as those who were first-time fathers or this was their first experience with PPD.

Furthermore, the participants discussed having emotional needs go unmet because the needs of their partner came first. For example, participants mentioned pushing aside their physical needs since their partners' diagnoses so their partners can focus on recovering. Most of the participants in this study admitted to disruptions in their relationships, such as feeling disconnected from their partner and having poor communication with them. For example, some reported their partners would no longer want to engage with them in any way. Their partners would not communicate or want to spend quality time with the participants since the postpartum depression diagnosis. Similarly, some of the participants respond by disengaging from their partners as well. Additionally, several fathers discussed no longer feeling emotionally connected

to their partners. These experiences of forgotten needs, emotional disconnect, and lack of communication are consistent with previous literature on men whose partners have PPD (Engqvist & Nilsson, 2011; Ruffell et al., 2019).

Finally, all the men spoke about having to take over daily tasks to keep the household running, which was a major change for them because they were not typically responsible for doing so, prior to their partners' diagnosis. The adjustment to being responsible for the house is consistent with existing literature that posits men often struggle with becoming a father due to having to balance obtaining the role of the primary parent because of the debilitating side effects of postpartum depression causing their partners to be less involved with their children (Engqvist & Nilsson, 2011; Ierardi et al., 2019; Meighan et al., 1999; Ruffell et al., 2019). Additionally, most of the participants became more responsible for household chores after their partners' PPD diagnosis. Having more responsibility within the household and the children is consistent with existing literature on men whose partners have PPD (Ierardi et al., 2019; Ruffell et al., 2019). Moreover, this supports existing literature that claims men's worlds become disrupted when they have a partner with PPD because they now must navigate their partners' diagnosis along with the added responsibilities of fatherhood and maintaining the household (Engqvist & Nilsson, 2011). Furthermore, participants also discussed ways in which they contributed to their own suffering.

My Own Worst Enemy

This second theme encompasses ways in which participants possess internal barriers that prevent them from seeking support. One challenge the many participants revealed was they were serving as their own barriers when it came to experiencing relief. Participants spoke of ways they bought into mental health stigma and help-seeking regarding both men and women. They did not want to seek help because they did not want to experience judgment for what was happening at

home. One participant, Dean, even admitted he did not want his partner's postpartum depression to reflect poorly on him. Furthermore, participants disclosed adopting poor coping skills that contributed to their distress, such as drug use and withdrawing from their families. My Own Worst Enemy also includes participants choosing not to find help for themselves so they could focus on their partner. Unlike Getting Lost in the Shuffle where circumstances of their child's birth and partner's PPD automatically shifted focus away from the participants' needs, participants reported intentionally putting aside their emotional and physical needs, so their partners could focus on recovery.

One of the first ways many of the participants serve as their own barriers to relief is them buying into stigma regarding mental health. Mental health stigma influenced each participant in terms of refusing to seek help. All of the participants spoke to the stigma from society and family members surrounding men and mental health, including the idea men do not require assistance with coping with distress or believing others would make fun of them for needing help. Participants' fear of judgment and buying into the stigma of seeking mental health support aligns with current literature that found men are less likely to disclose any mental health concerns (de Boise, 2018; Gerrish, 2021; Jordan & Chandler, 2019; Levant et al., 2011; River & Flood, 2021; Seidler et al., 2016; Sharp et al., 2022). Additionally, this theme supports previous literature that identifies one of the largest struggles men whose partners have postpartum depression face is lack of support or having low-quality support (Mayers et al., 2020).

Moreover, participants reported their own unhealthy coping patterns as barriers to relief from the emotional and physical pain they experienced. For example, one of the participants turned towards drug use while others decided to cope by isolating themselves from their families. The participant who reported drug use admitted the substance he used increased his own anxiety

and worry related to his partner's postpartum depression. Those who intentionally isolated from family disclosed more instances of feeling alone. These results support existing literature that personal beliefs regarding mental health and poor coping skills can increase men's suffering throughout their partner's PPD (Davey et al., 2006; Engqvist & Nilsson, 2011; Ierardi et al., 2019; Ruffell et al., 2019).

Finally, some of the participants acknowledged they made the conscious decision to set aside their needs so their partners could focus on getting better. These men chose not to seek help or pursue ways to meet their emotional or physical needs because they believe their partners' needs should come first. For example, participants claimed their partners' well-being is more important and their own needs can wait. These findings are consistent with existing literature that claims men are willing to sacrifice their own well-being for that of their partner and family (Engqvist & Nilsson, 2011; Ierardi et al., 2019; Meighan et al., 1999). Getting Lost in the Shuffle and My Own Worst Enemy contributed to the major emotional and physical challenges these men experienced.

Purgatory

In simple terms, Purgatory is a world that exists between Earth and Heaven or Hell that exists for those who have died and are in a state between death and purification (Le Goff, 1981). While participants in this study are not in a literal purgatory, they are in an emotional and psychological one. Many of the participants described suffering in silence. All the participants mentioned ways in which their relationships suffered, such as detachment from their partner or not being able to recognize their partner. Purgatory also captures the psychological implications their partners' postpartum depression has on participants. Participants spoke of longing to find

answers for their partners, but not knowing how to help. For another participant, his psychological pain stemmed from verbal and physical abuse by his partner.

In terms of emotions, participants were experiencing overwhelming bouts of emotions, including hopelessness, powerlessness, and guilt. The uncertainty regarding their partners' recovery fueled this aspect of purgatory and kept the participants in a suspended state of emotional turmoil. The detachment from their partners goes beyond the disconnection in Getting Lost in the Shuffle. Detachment is a more severe severance or disruption of the relationship with their partner. Some participants even stated they felt as if the person their partner used to be is not the same individual they are experiencing now. The emotional turmoil the participants reported even had physical implications for one participant. Sam experienced a significant amount of weight loss in an abbreviated period of time. However, the suspension in the emotional aspect of Purgatory impacted participants in other ways as well.

Most participants stated they were under a tremendous amount of mental and psychological strain during this time. For one participant, this included having intrusive thoughts regarding his own death. All the men revealed they struggled with not being able to disengage from their responsibilities of being a father, partner, and running the household for themselves; they believed they had to be "on" all the time to take care of bills, their children, and their partners without a break. This sacrifice negatively affected their mental health. The participants' experiences are also consistent with current literature. Previous studies regarding men's experiences with their partners' postpartum depression highlighted similar experiences with their own participants, including feelings of guilt, hopelessness, and detachment from their partners (Davey et al., 2006; Engqvist & Nilsson, 2011; Ierardi et al., 2019; Maxwell et al., 2020). However, this study was the first of its kind to have a participant admit to suicidal ideation.

Moreover, participants revealed desperation in wanting to take away their partners' pain, but not knowing how to do it. These reports support findings from a previous study regarding men's experiences with having a partner with postpartum depression that also described desperation within their participants in terms of attempting to help their partner in any way they could but not knowing how to do so (Engqvist & Nilsson, 2011).

Lastly, despite describing his relationship as "happy" prior to his partner's postpartum depression diagnosis, one of the participants admitted to physical and verbal abuse he endured since his partner's diagnosis. This was the first time a study that analyzed men's experiences having a partner with PPD reported this experience. However, the overall claim of the emotional distress is consistent with the existing literature (Davey et al., 2006; Engqvist & Nilsson, 2011; Ierardi et al., 2019; Maxwell et al., 2020; Mayers et al., 2020; Roberts et al., 2006; Ruffell et al., 2019). However, despite these intense struggles, participants did describe positive aspects of their partners' PPD.

Light Within the Dark

This theme captures the essence of the hope these men experienced throughout their experience with their partners' postpartum depression. This includes receiving support from others, including friends, family, and coworkers. One participant found support in his own counselor. Having a positive outlook on their experience, such as recognizing PPD is not permanent, also helped alleviate some distress. For a few of the participants, their partner receiving mental health treatment (i.e., counseling or medication) aided in their ability to have a positive outlook on their experience. Moreover, having strength within their relationships provides solace during participants' experiences with their partners' PPD. For example, having a strong relationship foundation prior to their partners' PPD diagnosis made working through it

easier. In addition, an interesting discovery was that most of the participants found relief in being a part of this study.

Regarding support, participants described how they opened up to family and friends for support. For example, family members and close friends are monitoring some participants' well-being. Two participants reached out to their colleagues for solace. One participant has been receiving mental health counseling for a few months. Participants stated having outside support made a significant impact on their experience by alleviating a substantial portion of their distress. It is important to note that the claim of support is contradictory to My Own Worst Enemy, where participants made the conscious decision to not seek support. This shows that providing support to men whose partners' have postpartum depression alleviates some of the stress and overwhelming emotions they feel during this experience. This is consistent with previous studies that shared engaging in a support group helped alleviate stress in men whose partners had PPD (Davey et al., 2006). However, previous literature advised men to reach out for support with adjusting to a new child as well as helping their partner cope with PPD (Maxwell et al., 2020).

According to Maxwell et al. (2020), finding others (e.g., family, friends, or healthcare providers), who can help with the emotional or even physical tasks of parenthood and dealing with postpartum depression can alleviate the distress related to having a partner with PPD. Having outside support helped contribute to participants' positive outlook on their experiences. Furthermore, this theme supports the idea that mental health support is crucial to help alleviate distress experienced by men whose partners have PPD. Having someone to share their experiences with made a positive impact on participants' experiences. Sam, the only participant actively in counseling due to the physical and mental toll his partner's diagnosis has taken on

him, as well as the physical abuse he has endured from her, was able to report a significant impact being in counseling had on his experience.

Moreover, a few participants disclosed their partners are either in counseling, taking antidepressants, or both. It is important to note that the participants who reported having an optimistic mindset were not the ones whose partners received a recent postpartum depression diagnosis. Rather, their partners received their PPD diagnosis a few months prior to the interviews and had begun treatment and/or medication. However, one participant whose partner received her PPD diagnosis two weeks prior to participating in this study interview shared he was staying positive because he knew PPD was not permanent. Once their partners were receiving treatment from mental health professionals and progressing, the light became brighter, and they started identifying the positive aspects that exists within their experiences.

Additionally, having a positive outlook on their experiences proved to be helpful for participants. However, this was not true for all the participants. Rip, whose partner received her postpartum depression diagnosis several months prior to his interview, did not share anything related to him being hopeful. Participants who noticed a positive change in their experiences spoke about the difference between when their partner initially received the PPD diagnosis and what the experience is like after some time passed. Participating in the study allowed them the space to reflect on what they have overcome individually and as a family unit. More often than not, participants spoke of improvements within their relationships in terms of communication and feeling more connected to their partners. Regarding PPD literature, one previous study on men reported they experienced relief over time (Engqvist & Nilsson, 2011). However, other previous studies regarding men's experiences with PPD have not reported this light or hopefulness (Davey et al., 2006; Ierardi et al., 2019; Maxwell et al., 2020; Mayers et al., 2020;

Meighan et al., 1999; Ruffell et al., 2019). However, other studies related to trauma and resilience indicate that people can experience growth and learning moments during exceptionally trying times (Jenkins et al., 2022; Kizilkurt et al., 2021; Tuck & Patlamazoglou, 2019; Wagener Cramer, 2018; Yehuda et al., 2006).

Despite participants experiencing relational hardships, they also revealed having a strong connection with their partner before the postpartum depression diagnosis has helped them through this experience. Those who mentioned having effective communication and love in their relationship stated it made getting themselves and their partner through the PPD easier. Through open communication between the partners, the PPD was easier to manage even with the negative implications it had on the relationship. Existing literature also provides evidence that PPD may cause relationship distress (Engqvist & Nilsson, 2011; Ierardi et al., 2019; Maxwell et al., 2020; Ruffell et al., 2019). It appears there are no studies that directly highlight how the strength of the relationship influences the experience of PPD for men. However, existing literature does imply having effective communication in a relationship increases marital satisfaction (Heavy et al., 1995; Heene et al., 2005; Kellas et al., 2017; Uebelacker et al., 2003; Yazar & Tolan, 2021). In turn, the assumption that effective communication positively influences marital discord is likely.

Perhaps the most interesting piece of information that the participants provided was the comfort they felt at the end of their interviews. Without a question or prompting, five out of the seven participants claimed that talking about their experiences during their interview provided them with a sense of relief. They also mentioned that this experience was good for them because it provided them a chance to speak freely about what they have been encountering. Previous studies have not reported relief from distress due to participating in a study. However, existing literature supports men discussing their challenges helps to alleviate distress (Aslund et al., 2014;

Herron et al., 2020; McKenzie et al., 2018; Sharp et al., 2022; Staiger et al., 2020). Furthermore, participants were also able to discuss ways in which they supported their partners during this time.

Putting the "Partner" in Partnership

The fifth and final theme highlights ways in which the participants attempted to support their partners since their postpartum depression diagnosis. This included displaying empathy and compassion toward to their partners. Serving as advocates for their partners in diverse ways also contributes to Putting the "Partner" in Partnership.

Supporting their partners seemed to be incredibly important to the participants. All the participants mentioned doing whatever they could to give their partners a break, especially since all the partners are currently stay-at-home mothers. In terms of empathy and compassion, the participants talked about trying to be understanding of what their partner was going through and not take any attacks personally. Some of the participants claimed they did not blame their partner for the distress because postpartum depression is not something that they wanted to develop. Furthermore, previous studies have not highlighted ways in which empathy and compassion can positively impact the influence PPD has on couples. However, the importance of empathy, compassion, and support within relationships exists. More specifically, literature supports the claims that having characteristics such as empathy and compassion increases the chances of relationships being successful and working through discord (Dijkstra et al., 2014; Dodell-Feder et al., 2016; Peloquin & Lafontaine, 2010; Ramezani et al., 2020; Wlodarski & Dunbar, 2014).

In addition, this theme also encompasses ways in which the participants served as advocates for their partners. A few of the men went with their partners to the doctor the day they received their postpartum depression diagnosis. They reported they spoke to the doctor about

what was going on with their partners because they knew something was not right. One participant shared he had to contest the doctor because they claimed everything their partner was going through was normal. The advocacy did not stop at the professional level; some of the participants even had to advocate for their partners within their relationships. For example, one mentioned his partner never believed she was doing a good job as a mother, so he made a point to tell her every day about how great she was doing. Furthermore, these participants expressed admiration for their partners by recognizing how hard they are working to get better. Like other positive aspects, such as empathy and compassion, previous research regarding men's experiences having a partner with PPD did not address advocacy. However, medical advocacy is not new in the literature. According to Griffiths et al. (2022), medical advocacy is a set of behaviors that allow physicians to address patient concerns and social determinants of health, such as active listening and inquiring about potential barriers to access of care. Existing literature has focused on different aspects of medical advocacy, such as identifying what it is, how it is done, and how it relates to patient outcomes (Brender et al., 2021; Earnest et al., 2010; Griffiths et al., 2022; Hubinette et al., 2017; McDonald et al., 2019). Nonetheless, it appears there is a gap in research focusing on partners advocating for each other.

Limitations

This study is not without limitations. Participants must have a partner diagnosed with postpartum depression by a healthcare professional in order to participate in this study. I did not allow self-diagnosed PPD because self-diagnoses are often inaccurate. However, I did not request proof of a diagnosis, so there is no way to confirm the participants' partners' diagnoses, which means I relied on participants' honesty regarding an official diagnosis. Furthermore, in terms of race, the participants were mostly homogenous; six out of the seven participants

identified as White. The lack of racial diversity may make it difficult to transfer the results to different cultures. Furthermore, an additional limitation of this study exists within the participants' demographics; they are all in heterosexual marriages. It is possible that conducting a study on couples who are not married but are in other forms of committed relationships (i.e., dating, engaged, cohabitating) may produce different results. Moreover, examining the lived experiences of lesbian partners whose significant other has PPD might also yield diverse findings. An additional limitation of this study is the use of phone interviews. I only had one phone interview during this study, and it was the shortest interview I had. Despite the flexibility to speak to participants outside of my geographical area, I was unable to respond to nonverbal cues on the phone. Since I could not see the participant, I might have missed body language that would have prompted me to ask a follow-up question that would have provided me with more insight into their experience. According to Drabbel et al. (2016), not responding to nonverbal communication can cause the loss of contextual data, which potentially impacted the results. Despite the existing limitations, this study possesses important implications for counseling and counselor education.

Implications for Counseling

All the participants in this study discussed at least one way in which they experienced problems within their relationship after their partner received their postpartum depression diagnosis. For example, most of the participants described ways in which they felt disconnected from their partner, such as their partner not being able to communicate with them, or their partner being unrecognizable. These results are consistent with previous literature that also showed relationship distress when one partner possesses a PPD diagnosis (Davey et al., 2006; Engqvist & Nilsson, 2011; Ierardi et al., 2019; Maxwell et al., 2020; Mayers et al., 2020; Ruffell

et al., 2019). Therefore, it is important for counselors who work with couples to know of the signs of PPD and how it may negatively affect relationships. Given that positive communication was one of the aspects of the participants' relationships that has helped them and their partners get through this experience, it seems necessary for counselors to develop a deep understanding of and implement communication strategies for couples. Counselors who treat couples that have one partner with PPD should be able to incorporate interventions into counseling sessions that focus on positive communication to help the couple work through PPD. For example, using interventions such as Gottman and Gottman (2022)'s speaker-listener technique aids in managing conflict. I would also recommend counselors incorporate Sue Johnson's (1998, 2008) Emotion-Focused Therapy (EFT) by utilizing the emotional mental models intervention which helps clients increase their emotional awareness. By increasing emotional awareness of men whose partners have PPD, the clients learn how to acknowledge their emotions, which allows for the discovery of how to cope with them (Johnson, 2008). Furthermore, an additional intervention that I recommend is Bowen's (1978) I-statement, which allows partners to openly express their emotions in a non-threatening manner. Although this study holds significant implications for couples counseling, there are other areas of counseling in which these results can be useful.

This study demonstrated the importance of support for men whose partners have postpartum depression. The current study identifies sharing their experiences of having a partner with PPD with others attributes to participants' relief. Because sharing difficult experiences can be helpful, it is my recommendation that counselors create support groups for men whose partners have PPD. Groups offer participants benefits, such as instillation of hope, universality, and peer connection (Guttmacher & Birk, 1971; Sternbach, 2001; Yalom, 1985; Yalom & Leszcz, 2020). In fact, a recent study found group counseling for fathers to help lower symptoms

of depression and anxiety (Mohammadpour et al., 2022). Moreover, I would recommend these support groups use Dialectical Behavior Therapy (DBT) as two of the main focuses of DBT are interpersonal effectiveness and distress tolerance (Linehan, 2015). Interpersonal effectiveness allows individuals to assert their own needs in a way that contributes to healthy relationships (Linehan, 2015). Teaching clients distress tolerance skills such as DEARMAN, FAST, and GIVE can help them assert their needs to their partners. In terms of distress tolerance, men whose partners have PPD may benefit from skills such as radical acceptance, self-soothing with senses, and ACCEPTS. These skills will teach men whose partners have PPD how to manage their distress in a healthy way (Linehan, 2015).

Furthermore, even though this study focused on the men as individuals, I examined the study through a family systems framework. I recommended that individual counseling for men whose partners have postpartum depression include a family systems perspective as well. For instance, having clients complete a genogram, which is a common technique in Bowenian family systems therapy, can allow them to identify cross-generational patterns regarding their relationships (Bowen, 1978). Moreover, extant research shows men whose partners have PPD can mimic PPD symptoms themselves, including anxiety and low moods (Fisher & Garfield, 2016). Due to the overwhelming number of emotions PPD can elicit within an individual, I recommend counselors working towards self-differentiation (Bowen, 1978). Self-differentiation allows clients to identify their emotions as well as help them understand their role in the family unit.

More specific to men's mental health, some of the participants in this study admitted to having unhealthy coping skills, such as drug use and withdrawing from their family. One even disclosed his distress caused him to have intrusive thoughts related to his death. These results

imply it would be useful for counselors to be aware of ways in which men with partners who have postpartum depression cope to provide appropriate treatment and support. Furthermore, counselors should also be mindful of the emotional effects a PPD diagnosis can have on men. I recommend counselors monitor the coping habits of men whose partners have PPD along with examining the extent to which they may withdraw from their partners, family, and friends. I also recommend counselors inquire about suicidal ideation and conduct a lethality assessment if necessary.

The second theme in this study, My Own Worst Enemy, found that men whose partners have postpartum depression have a tendency to feed into mental health stigma. The majority of participants in this study believed in stigma, such as men should not talk about their problems, and women who have postpartum depression have something "wrong" with them. This belief caused participants to not seek outside support from family, friends, or healthcare professionals. It is my recommendation that counselors address mental health stigma in their sessions, so clients are more willing to discuss their experiences with stigma. Counselors can practice broaching, or the process of exploring contextual dimensions of a variety of factors, is a proven method that enhances the extent to which clients disclose in counseling sessions (Day-Vines et al., 2020; Gim et al., 1991, Zhang & Burkhard, 2008). By encouraging counselors to broach the topic of mental health stigma in counseling sessions, it is safe to assume that clients would be more willing to disclose their own beliefs consistent with that stigma. Providing the opportunity and encouraging clients to discuss mental health stigma may allow counselors to demystify it. Moreover, the demystification of stigma may reduce societal stigma of mental health. By reducing societal stigma of mental health, personal barriers created by the individuals may be

removed. Removing the barriers may allow for the increase in treatment seeking among men whose partners have PPD.

Lastly, counselors who are knowledgeable about this phenomenon and understand how to treat it in counseling sessions can partner with local OBGYN offices, midwives, doulas, and pediatric offices to offer support to those affected by postpartum depression by using an integrated behavioral healthcare approach. Previous research and medical guidelines emphasize various check-ups for both the baby and mother post-partum (Office of Disease Prevention and Health Promotion, 2021; World Health Organization, 2015). However, the results of this study posit that it is also imperative to check on the father's well-being. In addition to providing insight into the well-being of the father, monitoring dads during the postpartum period can provide insight into how this disruption affects the family system. Participants in this study reported seeing both positive and negative impacts their partners' PPD had on the family system. They often noticed consequences, such as lack of communication, feeling disconnected from their partner, and their partner not being as engaged with the family. Because women with PPD are easier to identify, I recommend facilities such as OBGYN offices, midwives, doulas, and pediatrician offices provide information on where men and women can receive support after receiving a PPD diagnosis. Placing information about various forms of support in these locations can make it more accessible to men, ultimately leading to the increase in support men receive. With respect to an integrated healthcare approach, I recommend counselors to partner with OBYNs, midwives, doulas, and pediatricians in order to bring awareness of how their partners' PPD affects men. Research shows that women and babies are the top priority for the professionals who treat them (ACOG, 2018; Office of Disease Prevention and Health Protection, 2021; Stuebe et al., 2021; Warren, 2020; WHO, 2015). Partnering with and training other

healthcare professions that work closely with PPD holds the potential to increase advocacy for men whose partners have PPD. Increasing advocacy can lead to the enhancement of extended services to men, ultimately resulting in the reduction in the distress these men experience.

Implications for Counselor Education

In addition to holding implications for the counseling profession, this study also contains implications for counselor education. The task of counselor educators is to provide knowledge to counselors-in-training. According to the Council for the Accreditation of Counseling and Related Educational Programs [CACREP] (2016), programs that have an emphasis on marriage, couple, and family counseling provide foundational information on theories and models related to family systems and dynamics. I viewed this study through a family systems lens, which states that multiple systems occur naturally, and the focus is on patterns that previous generations pass down. These patterns will continue to cross generations unless rectified by the current generation (Bowen, 1966; Kerr, 1988). With respect to the family systems perspective, it seems necessary for counselor educators who teach courses related to family, couples, and marriage to cover the implications of postpartum depression on the family, couple, and marriage. This study shows PPD affected the family unit and couple in numerous ways. Counselors-in-training who plan to work with families and couples should be well informed of this phenomenon, so they are prepared to address having a partner with PPD in their counseling sessions using suggested interventions in the previous section.

Furthermore, counselors-in-training should also be able to provide appropriate interventions to families, couples, and men who experience implications of postpartum depression discussed in this study and provide appropriate interventions in their counseling sessions. Providing appropriate treatment to clients also coincides with the American Counseling

Association's [ACA] (2014) Code of Ethics which states that counselors are responsible for the welfare of the client and includes counselors practicing within the scope of their competence. If counselors are not knowledgeable of this phenomenon, it is unethical to treat clients that present with this concern. To avoid potentially unethical situations for students or counselor educators, I would recommend that family and couples courses, such as couples counseling, introduction to family and marriage counseling, and strategies for family and marriage counseling include treatment of men whose partners have PPD. Within these courses, I also encourage students learn about appropriate interventions and have the opportunity to practice them. For instance, having students work through case studies that focus on the effects PPD have on a family, couple, or individual can provide them with a deeper understanding of how PPD influences the family system as well as help ensure students are more prepared to address this issue in future sessions. Additionally, having students engage in role-play activities will provide them the opportunity to practice working with clients who PPD has affected.

Future Research

While this study added to the literature regarding men's experiences having a partner with postpartum depression, gaps remain that future research can fill. One of the first recommendations is to complete a similar study that seeks a diverse population and examines marginalized populations. Previous literature, including the current study, lacks the experiences of men from marginalized populations; most of the participants involved in similar studies reported their demographics identified as White and non-Hispanic (Ierardi et al., 2019; Roberts et al., 2006). However, despite existing literature reporting findings from primarily White participants, future research should continue to focus on men's experiences with PPD. This study identified aspects of this phenomenon that previous research has not found, inferring that there is

more to uncover by examining men's experiences. Moreover, not only do we need more research on men, but research on diversity is also lacking. This includes research focusing on diversity within race and ethnicity, sexuality, socioeconomic status, and rural communities.

Due to cultural differences across race and ethnicities, it is important to analyze the experience of each culture versus attempting to transfer the experiences of a homogenous population. It is my hypothesis that there may be differences in the results based on cultural differences. For example, Black men place significant values on family and romantic relationships (Jones & Mosher, 2013). Their culture emphasizes the importance of family, which makes them more likely to focus more on family-oriented activities, such as eating as a family, playing with their children, and spending quality time together (Jones & Mosher, 2013). Due to the cultural emphasis on family, researchers can assume that a study conducted on Black fathers might not yield a theme related to feeling disconnected. Similarly, Asian culture places an emphasis on the importance of marriage and family, with marriage being the most important focus (Keum & Choi, 2021). However, Asian culture typically does not recognize hardship in males, such as depression or relationship distress; Asian culture views it as a dishonor (Keum & Choi, 2021). Because this culture deemphasizes male mental health, a study that focuses on the experiences of Asian men whose partners have postpartum depression might not report instances of support serving as a light for them. It is likely they either are not getting support, or if they were to reach out for it, they might find themselves in a dishonorable position within their culture. Similar to Black and Asian cultures, most Hispanic cultures view mental health issues and help-seeking as a weakness (Interian et al., 2010; Keum & Choi, 2021; Ward et al., 2013). Holding this stigma allows for the inference that Hispanic males might report experiences that differ from those that currently exist in terms of having a partner with PPD. Furthermore,

marginalized populations hold stigmas surrounding mental health and receiving treatment from mental health professionals for a number of reasons. As noted, most minority cultures discourage seeking outside support for mental health concerns (Interian et al., 2010; Keum & Choi, 2021; Knifton et al., 2010; Ward et al., 2013). Additionally, marginalized populations are also concerned with the prejudice and discrimination they may face from mental health providers (Gary, 2005; Zoubaa et al., 2021). By including marginalized populations in the literature, decreasing the stigma related to minorities and mental health is possible.

Moreover, research that focuses on diverse participants can reach beyond racial variety. The purpose of this study is to examine the lived experiences of men whose partners have postpartum depression, so I had to require all male participants. However, it is important to document the experiences of lesbian women whose partners have PPD as well. This study shows individuals whose partners have PPD experience emotional turmoil. Unfortunately, sexual minorities are at a greater risk for experiencing mental health problems and are less likely to report their concerns than heterosexuals (Eaton et al., 2021; Pachankis et al., 2021; Zhao et al., 2020). By examining the experiences of women whose partners have PPD, researchers may find that these women are not willing to reach out for support. Researchers might also assume that women whose partners have PPD might share similar experiences in terms of having to advocate for their partner due to discrimination from healthcare professionals (Tzur-Peled et al., 2019). Research focusing on sexual minorities, such as lesbian partners can help fill in the gap that exists within the literature.

I viewed this study through a family systems lens (Bowen, 1966; Kerr, 1988). It is only appropriate that future research focus on different types of families. All participants in this study are the biological father of their children, therefore it is unclear if studies including men with

blended families will reveal similar results. Approximately 50% of American families are blended (Gonzales, 2009; The Step Family Foundation, 2021), and blended families can experience additional hardships, such as familial instability, decline in emotional well-being, and confusion in the expectation of stepparent roles (Raley & Sweeny, 2020). Due to the potential of added stress, research focusing on men whose partners have postpartum depression should include men who also have stepchildren. This study found that the participants were experiencing a disruption in their lives and had to adjust to new responsibilities. Due to the confusion surrounding the roles of a stepparent, it is likely that stepfathers will report having a harder time adjusting when their partner has PPD.

In addition to race and sexual orientation, examining diversity in terms of relationship status is important. For example, the participants in this current study all live with and are married to their partners. Future studies can examine men's experiences having a partner diagnosed with postpartum depression while they are living separately. Furthermore, researchers can assume the experiences described may differ in terms of relational connections; a strong connection with the mother of their child may not exist if the participant is not in a relationship with the mother of their child. Moreover, future studies can focus on the experiences of low-income participants. The current study utilized participants with an average income of $95,000 per year. For these participants, they have been able to afford to take extra time off work if they or their partners needed it and had health insurance that covered mental health treatment for both them and their partners. Another presumption is that men who are of a lower income might not be able to report being able to support their partners the way these participants have. The men in this study shared that their partners receiving treatment for their PPD made a positive difference

in the overall experience; those who cannot afford treatment are likely to report something different.

Similarly, research should focus on men from rural areas. It appears that men who live in rural areas do not have easy access to healthcare; they typically must travel lengthy distances to receive treatment. Another assumption is that access to mental health is equally difficult. Due to this location barrier, men who live in rural areas might report different experiences than those who have more convenient access to mental health services. For example, one participant in this study discussed the relief he experienced after attending counseling for themselves. The expectation is that those who cannot access counseling services are not as likely to experience that same relief. Providing insight into the experiences of more diverse participants can allow for the creation of counseling interventions.

Furthermore, to add to the existing literature regarding men and postpartum depression, future research should focus on the creation of interventions that are useful to men whose partners have PPD. In the last 16 years, only one study has focused on treatment for men whose partners have PPD (Davey et al., 2006). This treatment intervention allowed the men to learn useful information on PPD as well as give them a chance to discuss their experiences free of judgment while learning skills to enhance their functioning. According to Davey et al. (2006), engaging in this type of intervention was helpful because it allowed the men to have an open space to share their experiences with others. However, as counselors, the knowledge that counseling does not have a "one size fits all" theory is universal; counselors use different theories to treat different clients. Not all men whose partners have PPD will respond positively to interventions like Davey et al. (2006). Thus, research should focus on the creation of a variety of intervention for these men.

Alongside increasing the literature on men and postpartum depression, another suggestion for future research is to examine the experiences of existing children while their mother has PPD. Research shows that infants of mothers with PPD can experience birth deficits and poorer health while children of varying ages with mothers of PPD experience emotional, social, psychological, and developmental concerns (Asmussen et al., 2022; Guerrero et al., 2021; Hedegaard et al., 1993; Hoffman & Hatch, 2000; Lundy et al., 1999; Oh et al., 2020; Rini et al., 1999; Somers et al., 2019; Woolhouse et al., 2016. However, literature surrounding older siblings' experiences of having a mother with PPD is nonexistent. The recommendation for future literature to focus on older siblings is because children are a salient part of a family system. By understanding what having a mother with PPD is like for them, further examination of the full extent the implications have on a family system. The discovery of ways to help combat the implications of PPD exist within a better understanding of them.

Furthermore, research on integrated health has the potential to help create more effective means of treatment for men whose partners have postpartum depression. I mentioned before that I recommend informing other healthcare professionals, such as OBGYNs, midwives, doulas, and pediatricians, of the results of this study. By informing other healthcare professionals, men's access to treatment can increase. If integrated healthcare starts to incorporate the results of this study, future research can analyze and compare the experiences of men whose partners have PPD between those who have access in integrated settings to those who do not. My research found that support is one of the most significant ways participants found relief to their distress. Research measuring the impact of early support is needed to help fill the gaps in the literature.

The final avenue to explore with future research is to utilize a grounded theory approach for a similar study. Grounded theory allows researchers to generate a theory based on a

phenomenon by analyzing existing and subsequent data (Hays & Singh, 2012). I mention in a previous chapter that the themes emerged in a parallel process with the participants' partners' postpartum depression diagnoses. By utilizing a grounded theory approach in future studies, the identification of a theory surrounding men's experiences with PPD and how it is parallel to their partners' diagnosis might be possible. The creation of theory regarding the experiences of men whose partners have PPD could open new opportunities to further understand this phenomenon.

Conclusion

This study analyzed the lived experiences of men whose partners have postpartum depression. After an extensive literature review, I identified the current gaps that exist in research surrounding PPD, specifically regarding men. I viewed this from a family systems perspective consistent with the work of Bowen (1966) and Kerr (1988). I recruited participants from local obstetrics and gynecology (OBGYN) offices, pediatrician offices, and mental health facilities alongside various social media platforms to obtain participants.

Through the use of van Manen's (1990, 2014) hermeneutic phenomenological approach, I analyzed transcripts collected from seven interviews with men whose partners have a current PPD diagnosis. From that data, I identified five major themes: 1) Getting Lost in the Shuffle, 2) My Own Worst Enemy, 3) Purgatory, 4) Light Within the Dark, and 5) Putting the "Partner" in Partnership. The identified themes emerged from the in-depth, semi-structured interviews. I also utilized participants' own words to aid in the development of themes. I presented a discussion of the identified themes, including a connection to existing literature. Finally, I presented the limitations of this study, implications for counseling and counselor education, and recommendations for future research.

This study provides insight into the experiences of men whose partners have postpartum depression. The data from the interviews showed these participants struggled emotionally and physically. However, they also experienced some positive aspects of their partners' PPD. Moreover, this study found available support for men whose partners have PPD is crucial to alleviating the distress they experience.

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LIST OF TABLES

Table 1.

Participant Demographics

Participant	Age	Race	Relationship Status	Length of Time in Relationship (years)	# of Times Partner diagnosed with PPD	# of Children in Household	# of Biological Children	Date of Most Recent PPD Diagnosis
Sean	45	White	Married	3	1	4	4	12/2021
Jacob	24	White	Married	4	2	2	2	03/2022
Dean	37	White	Married	11	2	3	3	11/2021
Sam	33	White	Married	5	1	1	1	01/2022
Steve	31	African American	Married	6	1	1	1	4/2022
Rip	26	White	Married	17	3	4	3	10/2021
Cory	26	White	Married	8	1	1	1	02/2022

Note. All participants were assigned a pseudonym to protect their identity.

APPENDIX A

PARTICIPANT RECRUITMENT FLYER

Department of Counseling and Educational Psychology
Texas A&M Corpus Christi

PARTICIPANTS NEEDED FOR RESEARCH IN men's experiences with having a partner diagnosed with postpartum depression.

We are looking for volunteers to take part in a study The Lived Experiences of Men Whose Partners Have Postpartum Depression.

As a participant in this study, you would be asked to:
Sign an informed consent form and complete a demographics survey. You will also be asked to participate in 45–60-minute interviews that will ask questions related to your experience having a partner with postpartum depression.

Your participation would involve 1 interview, each of which is approximately 45-60 minutes. You will also be asked to provide feedback on the interview as well as the results of the study.

For more information about this study, or to volunteer for this study, please contact:

Melanie Moseley
Texas A&M University- Corpus Christi Department of Counseling and Educational Psychology
at
Phone: 361-494-0830
Email: mmoseley1@islander.tamucc.edu

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APPENDIX B

SUPPORT LETTER- TAMUCC COUNSELING AND TRAINING CLINIC

11/5/21

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley.

We are aware and support this research at Texas A&M University-Corpus Christi's Community Outreach Collaboration at the Counseling Training Clinic.

For all other questions or if you would like additional information, please feel free to contact

Kimberlee Mincey, Ph.D., LPC
Clinical Assistant Professor
Office: 361-825-3995 / Email: kimberlee.mincey@tamucc.edu

Thank you for your assistance with this project.

Yours sincerely,

Kimberlee Mincey, Ph.D., LPC
Clinical Assistant Professor
Clinical Director, Community Outreach Collaborative
Department of Counseling and Educational Psychology
College of Education and Human Development, NRC 2700
Texas A&M University-Corpus Christi
6300 Ocean Drive, Unit 5384
Office: 361-825-3995 / Email: kimberlee.mincey@tamucc.edu

APPENDIX C

SUPPORT LETTER- ANTONIO E. GARCIA ARTS & EDUCATION CENTER

11/5/21

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley.

We are aware and support this research at Texas A&M University-Corpus Christi's Community Outreach Collaboration at the Antonio E. Garcia Arts and Education Center.

For all other questions or if you would like additional information, please feel free to contact

Kimberlee Mincey, Ph.D., LPC
Clinical Assistant Professor
Office: 361-825-3995 / Email: kimberlee.mincey@tamucc.edu

Thank you for your assistance with this project.

Yours sincerely,

Kimberlee Mincey, Ph.D., LPC
Clinical Assistant Professor
Clinical Director, Community Outreach Collaborative
Department of Counseling and Educational Psychology
College of Education and Human Development, NRC 2700
Texas A&M University-Corpus Christi
6300 Ocean Drive, Unit 5384
Office: 361-825-3995 / Email: kimberlee.mincey@tamucc.edu

APPENDIX D

SUPPORT LETTER- C2 COUNSELING

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley

We are aware and support this research at C2 Counseling.

For all other questions or if you would like additional information, please feel free to contact

Elisa Flores 361-334-1437

Thank you for your assistance with this project.

Yours sincerely,

Elisa Flores

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APPENDIX E

SUPPORT LETTER- OBGYN ASSOCIATES

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley.

We are aware and support this research at OBGYN Associates.

For all other questions or if you would like additional information, please feel free to contact

OBGYN Associates of Corpus Christi

5920 Saratoga Blvd Ste 200

Corpus Christi, TX 78414

361-994-5454

Thank you for your assistance with this project.

Yours sincerely,

MaryJoy Weathersby

MaryJoy Weathersby, MD

APPENDIX F

SUPPORT LETTER- NURSE-FAMILY PARTNERSHIP

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley.

We are aware and support this research at the Costal Bend Women's Center.

For all other questions or if you would like additional information, please feel free to contact

Nurse-Family Partnership

4659 Everhart Road

Corpus Christi, TX 78411

361-882-2529

Thank you for your assistance with this project.

Yours sincerely,

Laura Drummond

Laura Drummond, RN

Program Director

APPENDIX G

SUPPORT LETTER- FAMILY COUNSELING SERVICE

3833 S. Staples, S203
Corpus Christi, TX 78411
361-852-9665
361-852-2794 (fax)

603 E Kleberg
Kingsville, TX 78363
361-852-9665, ext. 1234
361-592-7843 (fax)

2251 W. Wheeler Ave. #2
Aransas Pass, TX 78336
361-852-9665
361-852-2794 (fax)

www.fcsctx.org

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley.

Family Counseling Service is in support of this research.

For all other questions or if you would like additional information, please feel free to contact:

Kristi Phillips
Maria Graciano
3833 S Staples St S203
Corpus Christi, TX 78411
361-852-9665

Thank you for your assistance with this project.

Sincerely,

K. Phillips, MA, LMFT-S

Kristi Phillips, MA, LMFT-S
Executive Director

APPENDIX H

SUPPORT LETTER- ALMOUIE PEDIATRICS

Dear Texas A&M University-Corpus Christi IRB,

Texas A&M University-Corpus Christi is conducting a study in Corpus Christi, TX in the area of Counseling and Counselor Education. This study focuses on men's experiences with having a partner with postpartum depression through the Department of Counseling and Educational Psychology under the supervision of Melanie Moseley.

We are aware and support this research at Almouie Pediatrics.

For all other questions or if you would like additional information, please feel free to contact

Almouie Pediatrics

277 Buddy Ganem Dr A

Portland, TX 78374

361-777-3900

Thank you for your assistance with this project.

Yours sincerely,

Kendra Jenkins

Kendra Jenkins, FNP

APPENDIX I

INFORMED CONSENT

Consent to Participate in a Research Study at Texas A&M University-Corpus Christi

The Lived Experiences of Men Whose Partners Have Postpartum Depression

Introduction
The purpose of this form is to provide you information to help to make the decision on whether to participate in this research study. Please read the information below and ask questions before you make a choice.

Who is doing this study?
A study team led by Dr. Kristina Nelson is doing this research study. Doctoral candidate, Melanie Moseley will serve as the student investigator on this study. Other research professionals may help them.
Why is this research being done?
The goal of this research study is to explore the current experiences of men whose partners have PPD in order to develop a further understanding of that experience. Further understanding of this phenomenon will allow clinicians to provide better and more frequent mental health support to men during the postpartum period.

Who can be in this study?

We are asking you to be a part of this research study because you are in a relationship with someone who has postpartum depression.
To be eligible to be in this study, you must:

- Be over the age of 18
- Identify as male
- Be in a current, heterosexual relationship with the mother of your child
- Have a partner with an official diagnosis of postpartum depression
- Live with your partner
- Be the biological father of your child

Up to approximately 15 participants will be asked to be in this study.
What will I be asked to do?
If you agree to be in this study, the following things will happen: you will be asked to complete a demographics survey that will take approximately 5 minutes to take. You will then schedule a 45–60-minute interview either via phone, in person, or Zoom. The recorded interviews will ask you about your experiences having a partner with postpartum depression. If you choose to be interviewed, I ask that you fill out a brief demographics form attached to this document. The student investigator will then email you to schedule an interview time. Your individual interview will be audio/video-recorded with your permission.

If you agree to be in this study, you will be in this study for approximately 3 months. You will be asked to provide feedback to the student investigator after your individual interview and prior to the dissemination of the results of this study.

What are the risks involved in this study?
This research involves minimal risks (risks that you may experience in everyday life even if you do not participate in this study).
Because we are asking about your current experience with having a partner with postpartum depression, you only need respond based on how you perceive that experience. Potential risk may include:

Confidentiality risk: Your participation will involve collecting information about you. There is a risk of loss of confidentiality. Your confidentiality will be protected to the greatest extent possible. You do not have to give any information to the study that you do not want to give.

1. Interview Questions: Some questions may be embarrassing or uncomfortable to answer. Sample questions that you may be asked are: What can you share about when and how your partner was diagnoses with postpartum depression? You do not have to answers questions you do not want to.

Audio/Video Recording: If you choose to participate in this study, your interview will be audio/video recorded. Any audio/video recordings will be stored securely in a password-protected file. Any recordings will be kept until it has been transcribed and de-identified. After transcription, the recording will be permanently deleted.
If you have any of these problems or changes in the way you feel about being in the study, you should tell the study team as soon as possible.
What about protecting my information?
This study is not anonymous. You will be requested to provide your name and email address for this study.

Your information will be protected by:

- The interview once transcribed will be anonymized (a process by which identifying information is removed) by using pseudonyms (a fictious name). The interview recording will be deleted after transcription.
- No identifiers linking you to this study will be included in any report that might be published or presented.

Once data collection is complete, your identifiers will be removed from the research data. Your information collected as part of this research, even after identifiers are removed, will not be used, or distributed for future research studies.

What are the alternatives to being in this study?
Instead of being in this study, you may choose not to be in the research study.

What are the possible benefits of this study?
There are no direct benefits to you from being in this study.

Do I have to participate?

No. Being in a research study is voluntary. If you choose not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled.

What if I change my mind?
You may quit at any time. There will be no penalty or loss of benefits to which you are otherwise entitled. Your decision not to participate or quit will not affect your current or future relations with Texas A&M University-Corpus Christi or any cooperating institution.

If you withdraw from the study early for any reason, the information that already has been collected will be kept in the research study and included in the data analysis. No further information will be collected for the study.
The information that already has been collected will be de-identified (the information cannot be traced back to you individually). Because you cannot be identified from the information there is no further risk to your privacy. This information will continue to be used for research even after you withdraw.

Taking part in this study may lead to added costs to you, such as parking costs if you wish to interview in person. There are no plans for the study to pay for these costs.

Who can I contact with questions about the research?
Dr. Kristina Nelson is in charge of this research study. You may contact Dr. Kristina Nelson at kristina.nelson@tamucc.edu or 361-825-3039, or Melanie Moseley at 361-494-0830 or by email at mmoseley1@islander.tamucc.edu with questions at any time during the study.

Who can I contact about my rights as a research participant?
You may also call Texas A&M University-Corpus Christi Institutional Review Board (IRB) with questions or complaints about this study at irb@tamucc.edu or 361-825-2497. The IRB is a committee of faculty members, statisticians, researchers, community advocates, and others that ensures that a research study is ethical and that the rights of study participants are protected.

CONSENT TO PARTICIPATE

If you do not agree to participate in the research study, please select the “Do Not Agree” button below.

To participate in this research study, please click “Agree” button below and you will be directed to a new page to fill out a survey.

By clicking “Agree and Continue” and filling out the survey, you are agreeing to participate in the study. By participating in this study, you are also certifying that you are 18 years of age or older.

Do Not Agree Agree

APPENDIX J

DEMOGRAPHICS SURVEY

1. Age _____
2. Race
    a. White
    b. Black or African American
    c. American Indian or Alaska Native
    d. Asian
    e. Native Hawaiian or Pacific Islander
    f. Other ___
3. Ethnicity
    a. Hispanic/Latino
    b. Non-Hispanic/Latino
4. Gender/ Gender Identity
    a. Cisgender male
    b. Cisgender female
    c. Transgender male
    d. Transgender female
    e. Non-binary
    f. Two-spirit
    g. Other _____
5. Relationship Status
    a. Married

b. Dating

c. Cohabitating

6. How long have you been in your current relationship? _____

7. Does your partner have a current diagnosis of postpartum depression that was provided by a healthcare or mental health professional?

    a. Yes

    b. No

8. How many times has your partner been diagnosed with postpartum depression in their life?

    a. 1

    b. 2

    c. 3

    d. 4

    e. 5

    f. 6+

9. How many children are in your household? _____

    a. How many of those children are biologically yours? _____

10. What is your highest level of education?

    a. Some high school

    b. High school graduate/GED

    c. Some College

    d. Associates degree

    e. Bachelor's degree

f. Master's degree

g. Doctorate

11. What is your current occupation? _____

12. What is your total household income?

a. $15,000-$25,000/year

b. $25,000-$35,000/year

c. $35,000-$45,000/year

d. $45,000-$55,000/year

e. $55,000-$65,000/year

f. $65,000-$75,000/year

g. $75,000-$85,000/year

h. $85,000-$95,000/year

i. $95,000-$105,000/year

j. $105,000-$115,000/year

k. $115,000-$125,000/year

l. >$125,000/year

13. How did you hear about this study? _____

APPENDIX K

INTERVIEW QUESTIONS

1. Tell me about your partner's pregnancy and birth. How was it for your partner? How was it for you?
2. Describe your family relationships and interactions among members.
3. Describe your role and responsibilities in the family.
4. Describe your partner's role and responsibilities in the family.
5. How would you describe your relationship with your partner?
6. What can you share about when and how your partner was diagnosed with postpartum depression?
    a. When was the diagnosis?
    b. What prompted the diagnosis?
7. Tell me what it has been like for you while your partner has postpartum depression.
    a. How would you describe your experience when your partner had postpartum depression?
8. Describe your feelings regarding your experience with your partner having postpartum depression.
9. What is the most impactful part of your partner having postpartum depression for you?
10. Tell me about the needs you have had while your partner had postpartum depression.
    a. How, if at all, are your needs as a partner met?
11. How would you describe your social support in relation to your experience with your partner's postpartum depression?
12. What has changed, if anything, since your partner has had postpartum depression?
13. What else, if anything, would you like to share about your experience with having a partner that has postpartum depression?

APPENDIX L

RESOURCES FOR PARTICIPANTS

Organization	Phone	Address	Email/Website
C2 Counseling	361-334-1437	4818 Everhart Rd Corpus Christi, TX 78411	https://www.yvonnecastillophd.com/
Nueces Center for Mental Health and Intellectual Disabilities	361-886-6900	1630 S Brownlee Blvd Corpus Christi, TX 78404	https://www.ncmhid.org/
STCH Ministries Family Counseling	361-991-8680	4438 S Staples St Corpus Christi, TX 78411	https://www.stchm.org/family-counseling/
Family Counseling Service	361-852-9665	3833 S Staples St S203 Corpus Christi, TX 78411	http://www.fcscb.org/
Coastal Bend Psychological Associates	361-442-4024	4639 Corona Dr #37 Corpus Christi, TX 78411	https://www.cb-pa.com/
Texas A&M University-Corpus Christi Counseling and Training Clinic	361-825-3988	TAMUCC Natural Resource Center 6300 Ocean Dr Suite 2700 Corpus Christi, TX 78412	https://www.tamucc.edu/education/departments/cnep/counseling-training-clinic/index.php

Antonio E. Garcia Arts & Education Center	361-825-3600	2021 Agnes St Corpus Christi, TX 78405	https://www.tamucc.edu/education/departments/garcia-center/programs/counseling.php
Better Help	n/a	n/a	https://www.betterhelp.com/helpme/?utm_medium=Search_PPC_c&utm_source=AdWords&utm_term=online+counseling+services_e&utm_content=123791157045&network=g&placement=&target=&matchtype=e&utm_campaign=14131345604&ad_type=text&adposition=&gclid=Cj0KCQiAk4aOBhCTARIsAFWFP9Fg-7Oq323FJZdR5S-0g_C0liItbOEe3iDBMDTocgNfSPynHqUEdzkaAtwBEALw_wcB&not_found=1&gor=helpme
TalkSpace	n/a	n/a	https://www.talkspace.com/