

# The Experience of Men Whose Partners Have Postpartum Depression



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## Abstract

**BACKGROUND:** The correlation of paternal depressive symptomatology to maternal postpartum depression can approach 50%. Paternal depression during a female partner's postpartum time period can include feelings of fear, confusion, frustration, anger, helplessness, and lack of support. There are only a few published studies that address the interaction between paternal and maternal mental health during the postpartum period. **AIMS:** The purpose of this study was to gain insight into the experiences of men whose partners had postpartum depression as a foundation for intervention and program development. **METHOD:** This qualitative study used a descriptive phenomenological approach. A purposive sample of 10 men who lived with a partner diagnosed with postpartum depression was recruited via flier postings in mental health clinics, a perinatal mental health email listserv, and word-of-mouth. Single, audiotape-recorded interviews were completed. Qualitative data analysis was used to reduce initial coding to final themes that described participant experiences. **RESULTS:** The participants described efforts to provide support and care for their families; their efforts not to make things worse; their fears, anxieties, and physical responses; and the isolation associated with not knowing how to ask for help. The five themes included needing to support partners, maintaining stability, experiencing mutual symptoms, feeling isolated, and providing insight for others. **CONCLUSIONS:** Depression is known to have a negative effect on all members of a family. It is imperative that fathers' experiences are understood in order to fill this gap in caring for families.

## Keywords

postpartum depression, men, fathers, partners

## Background

Paternal depression during a female partner's postpartum time period is characterized by feelings of fear, confusion, frustration, anger, helplessness, and lack of support (Schumacher, Zubaran & White, 2008). Paulson and Bazemore (2010) note that higher rates of paternal depressive symptoms during a partner's prenatal and postpartum period occur in men in the United States at 14.1% versus an international rate of 8.2%. The incidence of depression in men in the first year after the birth of a child ranges widely and has been reported as 1.2% to 25% (Goodman, 2004). For men whose partners experienced postpartum depression (PPD), the incidence of paternal depression is higher and has ranged from 24% to 50% (Goodman, 2004). Yet the men whose partners experience PPD have been described as "invisible victims," and their experiences are not well known (Harberger, Berchtold, & Honikman, 1992). To date, researchers have studied the risk factors, the prevalence

rates, and the screening and treatment methods for effective management of maternal PPD, but few have examined the issue from the male partner's perspective. Although one intervention study included men's support needs and preferences using telephone interviews (Letourneau, Tryphonopoulos, et al., 2012), only one prior qualitative study examined the men's experiences

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through individual face-to-face interviews (Meighan, Davis, Thomas, & Droppleman, 1999).

Goodman (2004) published a literature review and noted that there was a 24% to 50% prevalence rate of depression in men whose partners had PPD. The concept of the co-occurrence of symptoms of depression in men was novel at that time. Since then, literature reviews were published by researchers from Canada and Australia (Letourneau, Dennis, et al., 2012; Schumacher et al., 2008) who noted a link between PPD in women and co-occurring depressive symptoms in their male partners. Paulson and Bazemore (2010) conducted a meta-analysis of 43 studies and suggested that there is a relationship between maternal PPD and paternal depression, but they were unable to identify the cause of that relationship.

The existing literature on men's experiences with partners who have PPD is focused on quantitative studies and literature reviews (Bradley & Slade, 2011; Don & Mickelson, 2012; Letourneau, Dennis, et al., 2012; Paulson & Bazemore, 2010). In addition to U. S. studies, researchers in countries such as Australia, Portugal, China, Japan, and the United Kingdom have also explored the issue of the postpartum experience in men (Cockshaw, Muscat, Obst, & Thorpe, 2014; Figueiredo & Conde, 2011; Ngai & Ngu, 2015; Parfitt & Ayers, 2014; Paulson & Bazemore, 2010; Suto et al., 2016). The science surrounding the issues of PPD and men focuses largely on studies where multiple different screening tools have been used to identify paternal depression after the birth of a child. Cutoff scores for the many measurement tools vary among studies, making it difficult to accurately measure this phenomenon. The Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) is the most commonly used tool for screening for PPD in women and has also been validated for use with men. The authors of the EPDS have suggested a cutoff score of 12 to 13; however, different cutoff scores to screen for paternal depression have been used by researchers, such as  $\geq 8$  (Suto et al., 2016), 11 (Bergström, 2012) and  $\geq 13$  (Serhan, Ege, Ayranci, & Kosgeroglu, 2012). These researchers have not provided published rationales for the variations in their scoring criteria.

The effects of parental depression on their offspring can be long-lasting. Children of depressed mothers have exhibited issues with cognitive development and social behaviors as the mothers tend to have difficulty interpreting their infant's cues (Horowitz et al., 2013). The effect of paternal depression on children includes matters such as lack of infant bonding, emotional issues, conduct disorders, and hyperactivity (Paulson & Bazemore, 2010; Ramchandani, O'Connor, Heron, Murray, & Evans, 2008). The dysregulation of the

family unit caused by parental depression may affect the transition to parenthood as well as child development and family function.

Researchers have noted that men's support may serve as a "buffer" against women's depressive symptoms within the family unit (Grube, 2005; Pratt & Brody, 2014). However, researchers have noted that men tend to engage in negative behaviors such as avoidance, drinking, and even exhibiting violence, when their partners struggle with PPD (Davey, Dziurawiec, & O'Brien-Malone, 2006; Melrose, 2010). Since the mental health of parents is noted to have an effect on their offspring (Beardslee, Versage, & Gladstone, 1998; Paulson & Bazemore, 2010; Ramchandani et al., 2008), the family system and the experiences of all members must be considered so that an understanding of health promotion strategies can be developed. A gap in the literature is the lack of firsthand accounts from men related to the experience of living with a partner who has PPD. Therefore, the purpose of this study was to gain insight into the experiences of men in order to provide an understanding of and insight into this phenomenon.

## Method

### Design

This qualitative study used a descriptive phenomenological approach to better understand the effects of maternal PPD on their male partners and the experiences of these men as they adapt to fatherhood. Qualitative data are derived from words and narratives that describe the lived experience. This approach is fundamentally suited to gain a holistic view of the phenomenon studied (Miles & Huberman, 1994). As a philosophical paradigm, phenomenology is a way of knowing based on human experience (Husserl, 1970). Due to the gap in knowledge regarding how maternal PPD affects the experience of men in the postpartum period, a descriptive phenomenological approach was chosen as the specific research method. This methodology allowed for the men's words to develop into a description of what the essential lived experience was. Understanding how these men viewed their experience as it was lived provided insight into a complex health care phenomenon that has not been recently described in the literature.

### Participant Recruitment and Selection

A purposive sample was used in the study. Men were included in the study if they were 18 years old or older; were able to read, write, and speak English; lived with a partner who was diagnosed with PPD within the past 3 years; and agreed to meet for a face-to-face interview.

Men were excluded if they did not cohabitate with their partner or their experience with PPD occurred more than 3 years ago. A personal history of a mental health diagnosis, including depression, did not precipitate exclusion from the study.

After institutional review board approval from the researcher's university, participants were recruited from cities in the Northeastern United States. First, clinicians at four private perinatal mental health clinics were contacted by the researcher, informed of the purpose and aims of the study, and agreed to post study fliers in their offices. Additionally, one of the clinicians managed a perinatal mental health electronic mailing list, which was used to network and share information among the perinatal mental health provider community. The members included physicians, nurse practitioners, prescribers, therapists, and social workers. A recruitment notice was posted to the electronic mailing list. One participant was recruited via word-of-mouth from an acquaintance who had completed his interview.

### **Procedure**

Recruitment took place over a 7-month period from June to December 2016. The study purpose and recruitment fliers were posted to the electronic mailing list, and reminder emails about the study were sent monthly until recruitment was completed. Over the course of 7 months, 10 men contacted the primary researcher by email or telephone and were evaluated for their fit with the eligibility criteria. All men met the inclusion criteria, and a date and time for the interview was determined.

### **Data Collection**

After reviewing and signing the informed consent, the participants completed a brief demographic questionnaire. Participants were informed about the aims and procedures of the study. They were told that they could withdraw from the study or end the interview process at any time without any negative effect on their health care. Each of the participants agreed to be audiotaped, and the interviews were 40 to 60 minutes in length. All participants completed the interviews. None of the men reported distress with the interview process, subject matter, or asked to have the audio recording terminated.

The interviews took place in a mutually agreed upon location such as the participant's home, coffee shop, or the primary researcher's home office. Each interview began with the same overarching question: "What is it like to live with a partner who has PPD?" This was the only broad, overarching question to allow the participants to guide the conversation in a way that was important and meaningful to them. Prompts such as "can you

elaborate" and "can you tell me more about that" were used when appropriate to elicit details. Participants were allowed to end the interview with any additional thoughts they wished to share. Time was allowed for thought and reflection. In appreciation of their time, participants were remunerated with a \$10.00 coffee shop gift card at the conclusion of the interview. Saturation was approached after the sixth interview, but additional participants were enrolled to confirm findings and to increase the richness of the descriptions of these men's experiences. Recruitment ended with data saturation when it was evident that no new information contributed additional insights into the experience of men whose partners had PPD.

### **Privacy and Confidentiality**

Pseudonyms were assigned to the participants as well as to all individuals mentioned in the interviews. Privacy of all written materials was maintained according to the procedures related to the ethical conduct of research. All data were stored in locked file cabinets in the primary researcher's private office. The consent forms were stored separately from the demographic forms and transcripts so that no identifying data could be connected. All electronic data were stored on a private, password-protected computer in the primary researcher's office. The data will remain securely stored for a period of 3 years poststudy and then will be destroyed in compliance with the institutional review board requirement.

### **Data Analysis**

The interviews were transcribed verbatim by the primary researcher. After transcription, the initial step in data analysis involved reading the transcripts multiple times to achieve immersion in the data. During this time, "bracketing" separated the personal feelings of the researcher from the study so that the researcher's clinical experience with postpartum women did not influence the analysis. The primary researcher kept a reflective journal in which to record any personal thoughts both prior to and after each interview. The data analysis procedures followed Colaizzi's (1978) seven-step method. According to Colaizzi's method, significant statements were extracted from the interviews, which allowed the researchers to develop clusters of initial themes that were placed in a chart for organizational purposes. Units of meaning were assigned to groups of statements, and then final themes emerged. The final five themes contributed to the exhaustive description of the experience of living with a partner with PPD. A sample of the process of data analysis is shown in Table 1.

**Table 1.** Sample of Coding Analysis.

In vivo units/significant statements	Meaning units	Theme
"I tried to do as much housework as I could." "If I could fold the laundry, it might fix the sorrow." "You want to help, but you don't know how." "It was very difficult." "I tried not to be annoying." "I didn't know what to do." "I didn't want to make things worse." "I was skipping meals." "It's dark and it's real." "I know I was depressed." "The reality is we are very isolated." "There's no support for men." "I don't have a support group." "There are other people going through this." "The father's group really helped me." "Take more time to stay at home." "Pay more attention." "It would be really helpful to understand postpartum."	Trying to cope Providing support  Confusion  Unsure  Physical changes  Psychosocial changes Social isolation  Community  Education	Keeping the Top Spinning   Walking on Eggshells   Mirroring Each Other's Symptoms  Shivering in a Corner  Pearls of Wisdom

### Validation and Rigor

The participants had an opportunity to validate the researchers' analysis and description through the process of member-checking. It was important for the rigor of the study that participants validated that the description of their lived experience was accurately represented. The primary researcher emailed each participant individually and offered the opportunity to review the themes and the exhaustive description. The men could comment if they wished to do so, and 3 of the 10 men responded to the researcher's offer to review and comment. One participant added subsequent data after his review and indicated that he used prayer and his faith to aid in his coping. The remaining participants did not respond. The primary researcher maintained a journal of field notes, pre- and postinterview notes, and debriefed with a mental health clinician during the data analysis period. Additionally, transcripts, coding, and themes were validated by two doctorally prepared nurse researchers with expertise in qualitative research, women's health, and perinatal mental health.

## Results

### Sample

Ten men ranging in age from 31 to 45 years (mean age = 35) comprised the purposive sample. All men described themselves as married with the exception of one who stated that he was engaged to his partner. Four of the 10 men described previous histories of anxiety as a mental

health concern, and one of those men related a significant history of mental illness, which included bipolar disorder and post-traumatic stress disorder. Previous mental health issues of their own did not exclude the men from the study because no assumption was made that this would bias the results of the study. Participation was voluntary; thus, the men chose to disclose this on the demographic questionnaire. The men in the sample had either one or two children, and their partners had given birth within the past 7 to 18 months. Two of the men stated that their partner's symptoms were resolved at the time of the interview, and the remaining eight men indicated that the women were still in treatment and that their PPD symptoms were improving. Two of the participants were dealing with the issue of their partner's PPD for the second time. Table 2 displays additional demographic characteristics.

### Themes

Analysis of the 10 transcripts yielded significant statements from which meanings were formulated. The formulated meanings were arranged into clusters of themes. A total of five overarching themes were identified, which describe the men's experience of living with a partner who had PPD.

**Theme 1: Providing Support: "Keeping the Top Spinning."** The men described their efforts to provide support to their partners. They struggled to manage their responsibilities toward work and home life as they provided instrumental support in the form of assuming childcare duties, cooking

**Table 2.** Demographic Characteristics of Study Sample.

Characteristics	Participants, <i>n</i>
Age, years	
31-35	7
36-40	2
41-45	1
(Range = 31-45, mean = 35)	
Marital status	
Married	9
Single/engaged	1
Race	
White	9
Hispanic	1
Education level completed	
High school	1
Associate degree	2
Bachelor's degree	2
Master's degree	1
Doctoral degree	4
Income	
0-\$50,000/year	2
\$50,000-\$100,000/year	2
>\$100,000/year	6
Occupation	
Attorney	3
Scientist	3
Automotive repair	1
Office worker	1
Disabled (due to issues with mental health and partner's PPD)	2
Number of children	
One	5
Two	5
Times partner diagnosed with PPD	
Once	8
Twice	2
Medical problems	
None	9
Diabetes	1
Mental health problems (not mutually exclusive)	
None	5
Depression	1
Anxiety	4
Bipolar disorder and PTSD	1

Note. PPD = postpartum depression; PTSD = posttraumatic stress disorder.

meals, and doing laundry and household chores in an effort to decrease the burden on their depressed partners. David (as noted, all names are pseudonyms) said, "I was so focused on trying to live . . . trying to help in little ways . . . like it would fix the sorrow. If I could fold the laundry,

it might fix the sorrow." Jason described his struggles in trying to get everything done when he said,

I was making sure that the jobs kept happening and making sure I didn't bring work stress home and home stress to work. I would clean up the house. . . . I felt like I had to get it all done. . . . I was just keeping the top spinning.

The men described the stress and exhaustion they felt in trying to juggle all their responsibilities in adjusting to new family life while their partners experienced depression. Richard stated, "There are times when I wonder 'how am I doing this? I'm kind of propping us up right now, and how much energy . . . ? Where's my limit? How much can I do?'"

The men did their best to provide support to their depressed partners in two main ways. The emotional support they provided was expressed in their concern and empathy for their partners. Darren stated,

She was so depressed and anxious . . . we had this thing where she would say . . . if she could just wiggle his (the baby's) foot and that was all she could do for the day, would that be okay? And I would tell her "that's fine, if that's all you can do."

The other form of support, such as household tasks and childcare duties, is described in previous literature as "instrumental support." This type of support added to the burden for the men. Dylan appeared distraught, and he shook his head when he recalled all he did to help his partner. He said, "I kept the house clean, I kept the kids fed, I took our son to preschool and I took care of the baby." The men felt conflicted about their responsibilities at home and at work. Peter described the conflict between being needed at home and needed at work: "In the new job, I was the new guy in this very high powered office. I was trying to make an impression, so I wasn't leaving at 5 o'clock either."

*Theme 2: Maintaining Stability: Walking on Eggshells.* The men responded to their partner's PPD by trying not to make things worse, by worrying about their partners and their children, and often by choosing negative coping strategies in an effort to manage. They described their partners as irritable, unpredictable, short-tempered, and anxious. Often, the men said that they knew something was wrong, but they did not know what. Jason described his efforts to cope and talked about drinking and feeling violent. "It was like I would try just to get everyone asleep and I'd go downstairs and slam a beer. I tried not to be violent, but there were definitely times when I might've broken a plate or two." Jason worried that his wife might commit suicide when he described,

She would lament about how she (the baby) would be better off without her . . . and that would make me think, do I need to call the police? Is she going to be okay when I get home? I never did actually call the police.

Mike described his fear and concern when he said,

She would have dark thoughts. The kitchen knife would pop into her head. She was saying “I’m having bad thoughts.” I was thinking what am I going to do? Do I need to quit my job and stay home? Can I trust her with the kids?

The men described their responses to their partner’s irritability and unpredictability. They were often unsure of what would tip them off or make their partner upset. They described things as fine one moment, then just the opposite in the next moment, and expressed anxiety about their partners and children. Despite the confusion about what was happening with their partners, they did not reach out for help or verbalize their concerns to others.

*Theme 3: Mutuality: “Mirroring Each Other’s Symptoms.”* The participants described physical symptoms such as either gaining or losing weight or their own feelings of depression, discouragement, and anxiety. Although only one participant disclosed a prior history of depression, 3 of the 10 men (30%) discussed depressive symptoms during the interview. Carlos stated,

I was skipping meals. . . . I’ve also been struggling with a mood change . . . not feeling like myself . . . it feels very similar to what she’s going through. It’s literally like we are mirroring each other’s symptoms.

David noted,

I binge eat when I am stressed and with all that stress, my binge eating was out of control. Definitely I used food to medicate . . . it wasn’t Monica’s fault . . . as far as the depression rubbing off, but it’s easy to get trapped in it.

Dylan, who had a prior history of mental illness said,

It brought my anxiety and stress levels up . . . like my own depression started kicking back in. . . . I wanted to start hurting myself.

These accounts explain how there was mutuality in the experience of symptoms of PPD in the women and in the men. Most commonly, the men discussed sleep disturbances and changes in their eating habits. The most common emotional change for the men was the tendency for them to develop a generalized feeling of sadness. David described how men’s emotional responses in the postpartum period seemed unimportant to others. He said, “It’s like men get brushed off. It’s a woman’s issue, but I know I was depressed.”

*Theme 4: Isolation: “Shivering in a Corner.”* The men described their response to their partner’s PPD as difficult and isolating. They discussed how gender and sex-specific role expectations for them included the need to manage household tasks, and they often did not turn to others for help. Some men discussed being isolated from friends and family due to a move or a job location, and some of the men reflected on the way in which they were “fathered.” They confided that they often wondered if their situations would get better. Carlos said,

I don’t really have much of a support system. The isolation is very real. When I went back to work, that was when things became very difficult for her . . . that’s when I started to see the change in her. So, it’s like we’re both just shivering in a corner trying to make it through, and unless you are a trained professional, unless you’ve dealt with kids before. . . . NOTHING can prepare you for this.

David reflected on societal expectations when he noted, “We (men) have this machismo attitude of like ‘I’m a man,’ I have to be strong. . . . I’m the one that makes her feel okay.”

The men described that they felt that they had to manage and stay strong, but they didn’t seek help from others. Darren, who was the only participant who mentioned his faith, stated,

Whenever I would get really stressed out or things would get bad, I’d take a moment to pray, and that really helped. I never actually made it to mass or talked to a priest or anything. It was more of just my internalized sense of faith that helped me through. Most men aren’t going to reach out for help, especially to other men in the community.

*Theme 5: Insights: Pearls of Wisdom for Others.* The men expressed a strong desire to participate in the study in an effort to help others and to share their ideas about what might assist other men who are in similar situations. They stated that information about PPD, the specific ways in which they could support their partners, the ways by which they could receive support for themselves, as well as more time off work would benefit them, their partners, and their families. Mike discussed the financial stressors of his mortgage, student loans, car payments, medical bills, and daycare costs. His recommendations for other men were, “know how to spot it, take more PTO (paid time off) and stay home as much as you can, and make sure she gets some sleep.” David addressed the role of health care providers when he commented,

I know that they came in and talked about it [PPD]. I still don’t remember what they said. The pile, the stack of papers they give you . . . it’s the last place I go when I’m trying to focus on getting the baby not to cry . . . to get Monica not to cry.

The Internet was a source of help for some men, and Jason commented, "WebMD was my source of information. What are the signs of PPD? Google . . . please help me." Carlos said, "I love that you're even mentioning this because there are no resources for guys . . . there's no support for this."

Mike laughed as he reflected on the advice of other men whom he met in a hospital-based father's group. His comment denotes the change in the dynamics of the family as a child is born. He said, "You are useless! You are going to be bossed around! You'll never know what to do!" I found it very helpful to talk to the other dads." Richard felt that advice from other men might have helped him deal with his situation: "I think I could've used a bit of coaching, like what to expect. At times, I feel like I am kind of guessing."

## Discussion

The participants described their efforts in providing instrumental and emotional support to their partners as "keeping the top spinning" while struggling to figure out what was wrong. This is consistent with previous researchers who described the "buffering" effect of the father's support as a mitigator of the mother's PPD (Beestin, Hugh-Jones, & Gough, 2014; Chang, Halpern, & Kaufman, 2007; Grube, 2005; Hossain et al., 1994). The men expanded their roles within the family to include household and increased childcare duties. Balancing their work responsibilities and adjustment to new fatherhood served as a "buffer" between their partner's symptoms and daily life (Grube, 2005; Pratt & Brody, 2014). The participants in the study were often confused and dismayed by their partner's behaviors as they observed changes at different intervals in the postpartum period. This finding is similar to results from a phenomenological study published nearly 20 years ago (Meighan et al., 1999). These earlier researchers noted that men in their study described their actions as "attempting to fix the problem" and "making sacrifices." Men in that study also assumed additional responsibilities of household duties, childcare, as well as attending to their work.

The theme of "Mirroring Each Other's Symptoms" links depression in men with PPD in women. The correlation between the mother's and father's depression in the postpartum period is discussed in the literature (Chung, Yip, Lok, & Lee, 2011; Goodman, 2004; Paulson & Bazemore, 2010), and that aspect of the experience was described by the majority of the men in this study. Schumacher et al. (2008) noted a 50% correlation of depression in men with PPD in women. The men in this study articulated the effect of their partner's PPD on their own health. Other studies support this notion

(Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Bradley & Slade, 2011; Don & Mickelson, 2012; Meighan et al., 1999), but the cause of the relationship is yet to be determined (Singley & Edwards, 2015). Although the cause of similar symptoms is not known, the emotional health of one partner appears to influence that of the other as both mothers and fathers navigate the transition to parenthood.

Melrose (2010) summarized the signs of depression in men during their partner's postpartum period as withdrawal from social situations, indecisiveness, cynicism, avoidance behavior, drug use, having extramarital affairs, and exhibiting violence with a partner. The negative manner in which some of the men coped with their situation was also consistent with the findings of previous literature. The men's responses and efforts to cope with were described as avoiding being at home, excessive sleeping, immersion in work and projects, drinking, and becoming angry and violent.

"Shivering in a Corner" described the men's feelings of isolation and the lack of understanding of what was happening to their partners. They described feelings of segregation from friends and family, and they sometimes hid their situation from the rest of the world. Cultural and environmental expectations of men as fathers differ in countries around the world; therefore, the man's involvement in the childbearing process and childrearing may be viewed from vastly different perspectives (Linn, Wilson, & Fako, 2015). In the current study, all men were present and involved in the birthing process of their children, and they made conscious efforts to carve out what they determined to be effective parenting practices, despite how they had been fathered themselves. The men in this study perceived themselves as equal partners to their female counterparts, and they shared in the duties of childrearing. However, the men were clear that they viewed their masculine roles as "macho" or "the strong one," and they had difficulty expressing their struggles to others, including health care providers. Many of the men sought to gain information and knowledge about PPD and coping strategies for partners with PPD by turning to Internet sources.

## Limitations

This study has limitations that must be considered. This was a homogeneous sample that lacked racial, ethnic, and socioeconomic diversity. The men self-selected to participate in the study, and the majority of the participants were Caucasian, college educated, and employed; therefore, their views may not be representative of those of men from different racial, educational, and socioeconomic backgrounds. All the men had access to health care and mental health services and were recruited from one

geographical area of the United States. Consistent with all qualitative research, the results cannot be transferred to men beyond this sample, yet their concerns and stories highlight the negative impact of living with a partner with PPD even with access to care and resources. Additionally, the time points of the women's depression, within the previous 3 years, differed among participants and could have been a contributing factor in how the participants recalled experiencing this phenomenon.

Despite these limitations, the study had notable strengths. This is the only recent qualitative study to examine the lived experience of men whose partners had PPD. The important insights gained from this research provide information for health care providers who work with families during the transition to parenthood. Although qualitative results cannot be generalized, they can be transferred. These results highlight findings that the effects of maternal PPD can extend beyond the woman and may affect the immediate family. The themes generated from the men's experiences reveal emotions and concerns that have not been fully explored. Health care providers can utilize the insights from this study when providing care to families during pregnancy and the postpartum period.

### *Implications for Future Research, Education, and Practice*

Describing the lived experience from the man's point of view is the first step in understanding this phenomenon. Continued research using qualitative methods should be conducted with men from diverse backgrounds to add to the understanding of the phenomenon. Health care providers should further investigate the link between PPD in women and the correlational relationship to depression in men. Longitudinal research with larger samples would add to the knowledge base by providing information on depressive symptoms over time during the first few years of the infant's life. Same-sex couples were not the focus of this study, and including both female and male same-sex couples in future research is necessary to understand how this phenomenon affects all families. Intervention research should be conducted to determine effective support interventions for men. Additionally, it is important to investigate effective education strategies by which health care providers could inform mothers, fathers, and extended families about the topic of PPD.

According to the recommendations from the men in this study, efforts should be made to increase education and awareness of the signs, symptoms, risk factors, and effective treatment modalities for PPD. Increased identification of the symptoms of PPD in women and co-occurring depression in men may increase the numbers of those formally diagnosed and able to receive

treatment. Nurses and other health care providers could increase education and awareness by including men in prenatal care discussions, childbirth education classes, and hospital discharge teaching sessions as well as postpartum and well-child visits. Support should be offered to men in the form of men's/father's groups as well as from reputable, vetted Internet sources and providers themselves. Health policy initiatives must begin to inform employers of the need for extended parental leave policies for the safety of families affected by PPD. Men whose partners experience PPD may need additional time off to assist with care and support of their partners and children.

Men should be included in screenings for PPD in an effort to promote the health of entire families, not solely that of mothers and children. Family assessment programs, home visitation programs, as well as men's groups, online blogs, and chat groups may be beneficial resources for men. Fisher, Kopelman, and O'Hara (2012) examined the psychometric properties of the Edinburgh Postnatal Depression Scale by Proxy (EPDS-P). This tool could be used to screen for depression in men in the postpartum period by proxy report of the mother for those men who have limited access to health care. Since depression in parents is known to affect their offspring, fathers must be included in the screening, diagnosis, and treatment in order to promote health for entire families.

Proactive interventions from health care providers are important. Although the men in this study were well-resourced, had health insurance, and had access to health care, they did not formally seek out help. Other than one man who participated in a father's group, the remaining participants either searched for information on the Internet or attempted to work through their feelings independently. However, during the interview process, the participants expressed wanting to help others. Candid discussions during the prenatal period and again after delivery can move this topic to the forefront and assist in reducing stigma and lack of information.

Additionally, four of the men in this study also reported a preexisting diagnosis of anxiety. These men acknowledged a worsening of their own symptoms as a result of their partner's experience with PPD but described needing to prioritize their partner's needs over their personal symptoms. Previous studies note the correlation between a woman's PPD and depression in her male partner (Goodman, 2004; Schumacher et al., 2008); therefore, it is imperative for providers to consider men's prior mental health history when discussing depression during the postpartum period. Enhanced screening and education of both parents can highlight the importance of recognizing symptoms and seeking mental health services.

## Conclusion

This study described the lived experiences of men whose partners had PPD within the past 3 years. Men described their experiences and how they coped with their partner who experienced the disorder. The participants described their efforts to provide support and care for their families, their efforts not to make things worse, their own fears, anxieties and physical responses, and the isolation associated with not knowing how to ask for help. The men expressed the need to be included in the follow-up care provided by health care providers in the postpartum period. When they felt excluded from or were unable to attend the postpartum health care visits, they often turned to the Internet for information to fill the gaps in their knowledge about the changes in their partners and about PPD. The men all wished to be included, along with their partners and children, in the assessment and evaluation of the health of the family by members of the health care team. Since depression is known to have a negative effect on all members of a family, it is imperative that fathers' experiences are understood in order to fill this gap in caring for families. Continued research on men's experiences, and support interventions for families who deal with PPD, would ensure that families have adequate support during this critical period.

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## Author Roles

JAI conceived the study, determined the methodology, and collected the data. JAI and HCF took the lead in writing and organizing the manuscript. All four authors reviewed the data and reviewed the final manuscript before submitting for publication.

## Declaration of Conflicting Interests

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### Continuing Education

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**Target Audience:** Registered nurses and advance practice registered nurses

**Learning Outcomes:** Upon completion of this article, the participant will be able to:

1. Recognize that a woman's postpartum depression may affect the mental health of her male partner.
2. Identify common themes related to a man's experience of living with a woman who has postpartum depression.
3. Explain the need for education and support for men who have a partner with postpartum depression.

**Cost:** There is no fee for continuing education credit.

**Contact Hours:** 1.0 CE The ability to earn contact hours for this article expires December 31, 2021.

**Continuing Education Information:** *In order to receive contact hours, you must read the entire article, complete an evaluation, and earn a passing score on the post-test. You will have 5 tries to correctly answer the questions on the post-test and a score of 80% is required to pass. You will be able to print or email a CE certificate once all steps are completed. Go to [www.apna.org/JAPNA-CEDec2019](http://www.apna.org/JAPNA-CEDec2019) to access the posttest, evaluation, and certificate.*

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