

TRANSITION TO PARENTHOOD FOR FIRST-TIME FATHERS
WHOSE PARTNERS HAVE POSTPARTUM DEPRESSION

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BY JANET T. SIVERNS, BScN

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AUTHOR: Janet T. Siverns, BScN (McMaster University)

SUPERVISOR: Dr. W. Sword

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Abstract

Postpartum depression (PPD) is a mental health condition present in 13% of new mothers. It is a serious public health issue that profoundly impacts the health of mothers, their children, and their partners. While the short- and long-term implications of maternal mental health for children's growth and development have been well documented, little has been written about the impact of maternal PPD on partners. In particular, the effects of PPD on new fathers have received little attention. This qualitative descriptive study examined, through the sharing of photographs by participants and in-depth interviews (n = 10), the experience of the transition to parenthood for first-time fathers whose partners have PPD. It also compared their expectations of fatherhood with the lived reality of the experience and explored fathers' perceptions of, and access to, health services and supports. The main themes that emerged from the data analysis were: From two to three, Connecting with baby, PPD and the partner relationship, Heightened involvement with baby, and Available and desired supports. Sub-themes that captured more specific patterns in the data also were identified. The study findings have implications for establishing best practices that are inclusive of support and education for partners.

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LIST OF ABBREVIATIONS

EPDS	Edinburgh Postnatal Depression Scale
PPD	postpartum depression
PHN	public health nurse

Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression

CHAPTER 1: INTRODUCTION

Background

Postpartum depression (PPD) is defined as depression experienced by a woman during the first year after her infant's birth (O'Hara, 2009). A meta-analysis of 59 studies (n=12,810), conducted between 1968 and 1996, primarily in the United States and England, suggested that PPD affects approximately 13% of new mothers (O'Hara & Swain, 1996). Depression was assessed after at least 2 weeks postpartum using a validated or standardized measure. More recently, the Maternity Experiences Survey (Public Health Agency of Canada, 2009), a national survey of 6241 Canadian mothers who had given birth 5 to 14 months previously, found that 7.5% of women scored 13 or higher on the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987), suggesting PPD at the time of the interview. A further 8.6% of women surveyed scored between 10 and 12 on the EPDS, scores that are also suggestive of PPD (Public Health Agency of Canada).

PPD is distinct from postpartum blues, which is characterized by feelings of irritability, anxiety, tearfulness, and sadness, experiences that are common in the first 2 weeks following a birth and that generally resolve without intervention (Rondon, 2003). PPD also is distinct from postpartum psychosis, which is characterized by severely depressed mood, disorganized thinking, psychotic thoughts, and hallucinations (O'Hara, 2009). Widely viewed as the most common complication of childbirth, PPD is characterized by: feelings of sadness, worthlessness, and guilt; a decreased ability to concentrate; changes in sleep, appetite, and activity; and, in some cases, recurrent thoughts of death or suicide (Ross, Dennis, Blackmore, & Stewart, 2005).

As noted in O'Hara's (2009) overview of current knowledge regarding PPD, the literature is divided on the question of whether PPD is caused by a factor related to the birth or simply reflects a coincidence between the birth event and the onset of major depression. Three meta-analyses examining the causal factors associated with PPD identified that the following risk factors have moderate to strong associations with PPD: antenatal depression and anxiety; postpartum blues; previous history of depression; stressful life events; poor marital relationship; and poor social support (Beck, 2001; O'Hara & Swain, 1996; Robertson, Grace, Wallington, & Stewart, 2004). Other risk factors found to be less strongly predictive of PPD include low socioeconomic status, obstetric factors such as a challenging delivery or postpartum complications, and difficult infant temperament (Beck; Robertson et al.). A recent prospective cohort study that examined the relationship between mode of delivery and PPD at 6 weeks revealed additional factors contributing to PPD: unmet learning needs in hospital; maternal readmission to hospital; and urinary incontinence (Sword et al., 2011).

PPD affects not only the woman with depression, but also her infant, other children, her partner, and extended family members (Dennis & Ross, 2006; Goodman, 2004; O'Hara, 1997). It can be viewed as a systemic issue impacting a woman's well-being and ability to function as a partner and mother with profound long-term implications for family health. As such, PPD is a major public health concern (Perfetti, Clark, & Fillmore, 2004; Ross et al., 2005; Wisner, Chambers, & Sit, 2006).

PPD can affect a woman's ability to interact with her infant in healthy and consistent ways (Ross et al., 2005). Both the disruption in maternal-infant attachment and the lack of confidence in parenting skills resulting from PPD (Barr, 2006; Logsdon, Wisner, Hanusa, & Phillips, 2003) have profound implications for infants' and children's growth and development.

While infants of depressed mothers may experience difficulties in self-regulation (i.e., disrupted sleep and eating routines) and socialization (manifested as anxiety or withdrawal), the long shadow cast by PPD reaches into toddlerhood, childhood, and even adolescence (Brand & Brennan, 2009; Campbell et al., 2004; Halligan, Murray, Martins, & Cooper, 2007, Verbeek et al., 2012). Children of postnatally depressed mothers demonstrate ongoing cognitive, social, and emotional deficits (Goodman & Brand, 2008) such as decreases in IQ scores, particularly among boys (Hay, Pawlby, Waters, & Sharp, 2008), decreases in individual creative play and negative responses to friendly approaches by other children (Murray et al., 1999), and increased tendencies toward violence, evidenced by anger management difficulties, bullying, threatening, and physical fights (Hay, Pawlby, Angold, Harold, & Sharp, 2003).

Partners also are profoundly impacted by PPD. Indeed, the children in the family may look increasingly to their father as their mother's health deteriorates and the father assumes the role of nurturer and household manager (Boath, Pryce, & Cox, 1998; Seimyr, Edhborg, Lundh & Sjögren, 2004). A bleak picture of paternal losses is described in Meighan, Davis, Thomas, and Droppleman's (1999) phenomenological study of fathers' experiences of living with PPD. The predominant themes identified in this study included loss of the partner they once knew, loss of the ability to "fix" the problem, loss of time for self as caring for the family and partner took precedence, loss of control, loss of intimacy, and loss of trust in the health care system. Clinical reports suggest that partners of women diagnosed with PPD often feel excluded from infant care, confused about the nature of PPD, and fearful that their partners will not recover (Davey, Dziurawiec & O'Brien-Malone, 2006). Inevitably, the health of the partner relationship is challenged; marital/partner conflict is noted as both a predictor of (Beck, 1996; Beck, 2001;

Kung, 2000) and outcome associated with PPD (Boyce, Hickie, & Parker, 1991; Gotlib, Whiffen, & Wallace, 1991; Lilja, Edhborg, & Nissen, 2012).

One potentially devastating outcome for fathers whose partners have PPD is the onset of paternal depression (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Deater-Deckard, Pickering, Dunn, & Golding, 1998). Goodman's (2004) systematic review of 20 studies concluded that maternal depression is the strongest predictor of paternal depression during the postpartum period, and that 24% to 50% of partners of women with PPD also will experience depression. Pinheiro and colleagues (2006) noted a dose/effect pattern at work with PPD and partners: as the severity of maternal depression increased, the prevalence of paternal PPD increased. Roberts, Bushnell, Collings, and Purdie's (2006) cross-sectional survey found that men whose partners have PPD had more psychological symptoms and disturbances than comparison group men on measures of depression, non-specific psychological impairment, and aggression.

The prevalence of PPD, and its profound effect on the mother who lives through it and on her family members, point to the need for a better understanding of PPD and family health. The impact of a partner's PPD on fathers to date has not been studied extensively and therefore our understanding of the full impact of PPD is limited. In particular, a better understanding of the experiences of the transition to parenthood for first-time fathers whose partners have PPD would be valuable in guiding health professionals to design targeted interventions promoting family health. The question explored in this thesis is: How do first-time fathers, whose partners have PPD, describe their experiences of the transition to parenthood?

Review of the Literature

An exploration of relevant literature encompasses a review of studies in five areas: the process of and factors influencing men's transition to first-time parenthood; the effect of the transition to parenthood on the couple relationship; men's experiences of their partners' PPD; the effect of maternal PPD on fathers' parenting experiences; and PPD-afflicted women's perceptions of their partners' experiences. An electronic search of CINAHL, EMBASE, OVID, PsychInfo, and PUBMED databases, and of the grey literature (via Google Scholar) was done utilizing the following search terms: postnatal depression, PPD, family support, fatherhood, first-time fathers, paternal depression, paternal support, and transition to parenthood. Each database was searched for English-language articles from the years 1990 to 2012 in an effort to identify and retrieve the most up-to-date research pertaining to the study topic. See Appendix A: Database Search Strategies for more details. Additionally, citations from the bibliographies of key studies were analyzed, and relevant citations were selected for review. It is worth noting that while women's experiences of PPD and implications of this for the infant/mother relationship have been extensively studied, significantly fewer studies have been conducted with respect to the father's experience of his partner's PPD and its impact on his transition to fatherhood. However, there is an encouraging trend in that the studies published describing the father's transition to parenthood and his perceptions of his family's experience of PPD have become more common in the last 10 years.

Men's transition to first-time parenthood

Sixteen journal articles on the topic of men's transition to first-time parenthood were reviewed. A number of studies reported that men's transition to parenthood is a complicated process, beginning in pregnancy and taking place over time, that involves role transitions and

changing priorities as they became fathers (Buist, Morse, & Durkin, 2003; Chin, Daiches, & Hall, 2011; Fägerskiöld, 2008; Ferketich & Mercer, 1995; Pollock, Amankwaa, & Amankwaa, 2005; St John, Cameron, & McVeigh, 2005). Other studies characterize the transition to parenthood as a gradual mastery of the parenthood role (Hudson, Campbell-Grossman, Fleck, Elek, & Shipman, 2003) and a process of achieving competence in behaviours and child-caring skills (Ferketich & Mercer, 1994). Ferketich and Mercer's finding that paternal depression and partner relationships were predictive of inexperienced fathers' parental competence was attributed to the novelty of dealing with the complex evolving roles in the family and the redefinition of relationships as the mother/father/infant triad replaced the couple partnership.

Many fathers highlighted the competing priorities of work and home life, particularly in the early days of their infants' lives (Fägerskiöld, 2008; Halle et al., 2008; Henwood & Procter, 2003; Pollock et al., 2005; Premberg, Hellström, & Berg, 2008; St John et al., 2005). Henwood and Procter summarized the struggle as "cash and/or care" (p. 345) and reported that the fathers in their study had varying degrees of success in managing work demands satisfactorily while meshing them with a greater desire to be involved in parenting and family life. Pollock and colleagues noted that the new tension between responsibilities at work and a wish to be more emotionally available at home as involved fathers led some men to reflect on their desire to participate in shared responsibilities and to cooperate with their partners in the home. In addition, some studies described the fathers' difficulty in returning to work and accepting their partner as the primary caregiver (Chin et al., 2011; Deave & Johnson, 2008; Fägerskiöld; Henwood & Procter).

There is some agreement in the literature that men's peak period of distress (as measured by the EPDS) regarding their transition to parenthood occurs during their partners' pregnancies

(Buist et al., 2003; Condon, Boyce, & Corkindale, 2004; Morse, Buist, & Durkin 2000).

However, the time needed to resolve this distress is less certain, as evidenced by conflicting findings. Buist and colleagues showed that most men's anxieties regarding their developing roles decreased steadily following the infants' births. In contrast, Condon and colleagues expressed surprise at their finding that men's stress levels did not return to mid-pregnancy levels by the end of the first year. Two other studies described a similar pattern with respect to a more severe form of distress, notably, a later onset of PPD in fathers than in mothers, and PPD intensity rising to equal or surpass mothers' levels by the end of the child's first year (Escribà-Agüir & Artazcoz, 2011; Goodman, 2004).

One contributor to men's stress is their feelings of being insufficiently prepared for the early postpartum period. First-time fathers' adjustment to new relationships and responsibilities may be negatively impacted by lack of cultural and institutional support to help them through the transition (Bronte-Tinkew, Scott, Horowitz, & Lilja, 2009). Deave and Johnson (2008) reported that men typically felt ignorant and unprepared for the realities and practical implications of parenthood. Similarly, Fägerskiöld (2008) noted that some fathers appeared to lack preparation for fatherhood, and attributed this to the midwives' focus on the delivery and birth mother rather than on the father and his feelings. However, a Canadian study of the role of formal and informal support structures for fathers during the postpartum period (de Montigny, Lacharité, & Amyot, 2006) reported that the fathers interviewed often cited health professionals as key sources of support throughout the pregnancy and early postpartum. Gage and Kirk's (2002) phenomenological study described how men actively prepared for fatherhood by renovating and decorating their homes, mapping routes to the hospital, and budgeting ahead; however, the men

indicated that it took them longer to acknowledge the reality of parenthood as compared to their partners, and they did not feel emotionally prepared to be parents.

When describing the fathers' experiences of the transition to parenthood, a number of studies described the fathers' perceptions of lack of support beyond that provided by their partner (Deave & Johnson; Halle et al.). Deave and Johnson commented in general about fathers having few support systems while Halle and colleagues specified that half of the fathers in their sample reported a "felt lack of interpersonal support beyond the emotional and practical support of their partner" (p. 63). Morse and colleagues' (2000) longitudinal repeated measures study showed that while 67% of women reported satisfaction with their emotional support from friends, only 48% of men did so. In other studies, fathers who identify having some support typically described having male colleagues at work to whom they could turn (Deave & Johnson; Fägerskiöld).

The strength of the evidence in some of these reviewed studies (Buist et al., 2002; Ferketich & Mercer, 1994; Morse et al., 2000) is compromised by their reliance on secondary data regarding fathers' perceptions and experiences collected in studies whose main focus was postpartum mothers or overall family adjustment. While secondary data analysis provides a researcher with convenient access to a data source, biases in the research process may be introduced when the measurement approach, focus on data quality, and attention to confounders differ between the original and subsequent researchers (Grady & Hearst, 2007). In the case of the aforementioned studies, data quality and recognition of confounders compromise the results. All three studies (Buist et. al., Ferketich & Mercer, & Morse et. al.) reported high drop-out rates of participants over time. The latter two studies used the same data set, where 47% of the original participants were lost to follow-up. Ferketich and Mercer's study reported a loss of 36% of experienced fathers (from n=76 to n=49) and 29% of inexperienced fathers (from n=91 to

n=65). As well, the cohorts in this study differed with regard to age of fathers and characteristics of their partners, making the comparison between the two groups less statistically sound.

In contrast, Condon et al.'s (2004) First-Time Fathers Study is a methodologically rigorous attempt to assess the mental and physical health changes occurring in men transitioning from their partner's pregnancy to new parenthood. The authors addressed potential methodological weaknesses of sample bias, including the possibility that stressed couples may not have been recruited or may have chosen to drop out of the study, and the absence of a control group at baseline (pregnancy). While acknowledging that a control group would have ensured matching for socio-demographic characteristics and enabled clarification of whether very substantial changes in sexual function predated the data collection mid-pregnancy, the authors detailed their reasons for believing that the men were able to act as their own controls.

The nine qualitative studies considered in this literature review in general recognized that their sampling procedures, such as drawing on self-selected fathers from one geographic location (St John et al., 2004) or snowball sampling leading to a disproportionate representation of police officers (Pollock et al., 2005), limit transferability of the results. However, as the goal in qualitative research is to employ a sampling strategy consistent with the purpose of the inquiry (Kuzel, 1999) and elicit a rich description based on saturation or collection of data until no new themes emerge (Morse, 1995; Patton, 2002), this is not a shortcoming of these studies. Two of the studies specified that recruitment took place through the partner (Deave & Johnson, 2008; Halle et al., 2008) and three specified direct approaches to recruiting the fathers (Fägerskiöld, 2008; Gage & Kirk, 2002; Premberg, Hellström, & Berg, 2008); the method of recruiting fathers in the other studies is unspecified. Rigour is addressed by several researchers' discussions regarding study methodology: Chin on coding processes and her use of Smith's (1996) 'internal

coherence' (the extent to which the argument presented in a study is supported by the data and internally consistent) and 'presentation of evidence' (inclusion of sufficient data from the participants' discourse) criteria; Deave and Johnson on validation of the interpretation of data by study participants and the midwives who recruited the participants; Fägerskiöld on the credibility of the interview process and member-checking of the results; Gage and Kirk on data collection via focus group interviews and data analysis; and Henwood and Procter (2003) on sample selection, interview process, coding procedures, and the challenges of assimilating the results into a single interpretive frame. Alone amongst these researchers, St. John and colleagues raised the interesting point that their study on fatherhood may have been impacted by the fact that the research team, composed entirely of female researchers, likely elicited different information than male interviewers would have from the participant fathers.

The effect of the transition to parenthood on the couple relationship

Another common stressor for men is the deterioration over time of the couple relationship that is commonly experienced following the birth of a first child. Buist and colleagues (2003) noted that reported relationship quality deteriorated from the prenatal to postnatal period in all men surveyed in their longitudinal repeated measures study. However, the sample of men described as "distressed," as measured by the EPDS (Cox et al., 1987), had an overrepresentation of younger men who were employed part-time and whose relationships were of shorter duration; these factors may have confounded the results.

More compelling statistical evidence of the deterioration in the couple relationship is provided by Doss, Rhoades, Stanley, and Markman's (2009) prospective longitudinal study of the effect of the birth of the first child on relationship functioning using data from 218 couples followed over 8 years of marriage. The authors reported a small to medium negative effect on both fathers' and mothers' relationship functioning, with persistence of negative effects through

at least the first 4 years after birth. Condon and colleagues (2004) similarly found that relationship variable measures changed in the direction of deterioration from pregnancy through the postpartum period, with effect sizes in the small to moderate range. Two of the qualitative studies reviewed reported relationship stress (Deave & Johnson, 2008; St John et al.), and specifically conflict manifested as disagreements and tension caused by the negotiation of new roles as a result of the infant's birth (St John et al.). In contrast, Fägerskiöld (2008) noted that the changing relationship with the partner was not necessarily worse; some fathers reported an increased admiration for their infant's mother on realizing during the delivery just how capable their partner was, and suggested that a positive childbirth experience actually strengthened the couple's relationship.

Men's experiences of their partners' PPD

Six qualitative studies and three quantitative studies examining the experiences of the male partners of women with PPD were retrieved. Several common themes emerged in the qualitative studies. The lack of organized support for men and the limited opportunities for them to express and to have their concerns addressed was noted by Webster (2002), who stated that despite fathers' interest in postnatal depression support groups, no form of group support was offered to any of them. Closely related to this theme was disappointment in the response of health professionals who provided little support for the fathers as caregivers of infants (Boath, Pryce, & Cox, 1998; Letourneau, Duffett-Leger, Dennis, Stewart, & Tryphonopoulos, 2011; Mao, Zhu, & Su, 2011; Meighan et al., 1999) or, in some cases, increased their sense of failure as husbands (Everingham, Heading, & Connor, 2006). The fathers in Davey and colleagues' (2006) focus groups provided insight into the lack of organized support for men; their comments revealed a reluctance to reach out for help and a tendency to minimize any expression of difficulty coping with fatherhood. Similarly, the fathers in Letourneau and colleagues' study

(2011) reported that their fear of the stigma associated with PPD impeded their ability to obtain support for their partners or themselves. However, their help-seeking also was negatively affected by their own exhaustion and not knowing how or where to obtain resources to assist them in dealing with their partner's PPD.

The Effect of PPD on Fathers' Parenting Experiences

The research on the impact of a partner's PPD on fathering and on fathers' interactions with their children is limited. Only one study specifically addressed the impact of maternal PPD on fathering, and found that maternal depressed mood did not seem to influence the partner's experience of fatherhood (Seimyr et al., 2004). However, this study used questionnaires to measure psychosocial conditions such as availability of support and involvement in childcare after childbirth as opposed to the in-depth interviews and focus groups used to collect information in the qualitative studies. As noted by Webster (2002), the value of qualitative approaches lies in their ability to provide a holistic view of the individual's experiences, which can be argued to be more valid than the limited view yielded by quantitative approaches to social science research.

It is known that healthy, involved fathers contribute positively to their children's growth and development. A research summary of the evidence regarding the effects of father involvement noted that children of involved fathers show increased cognitive skills (as measured by IQ and academic records), improved psychological well-being and health, positive peer and familial relations, and improved physical health when compared to children whose fathers are absent or uninvolved (Allen & Daly, 2007). Given that healthy, involved fathers are such a positive influence on their children, an examination of the impact of maternal PPD on fathering needs to take into account the health of fathers in such relationships and whether or not fathers' level of interaction with their infants is affected by their own health or that of their partner.

Research consistently has found that partners of women who are depressed are themselves at risk for depression (Ballard, Davies, Cullen, Mohan, & Dean, 1994; Deater-Deckard et al., 1998; Matthey, Barnett, Ungerer, & Waters, 2000; Morse et al, 2000). Depression may impact a father's parenting efficacy and children's outcomes, and the mental health of fathers has been linked to children's psychosocial development (Kane & Garber, 2004; Ramchandani et al., 2008). Similarly, Pesonen and colleagues (2004) showed that the emotional state of the father alters his perception of his infant's behaviour and temperament. Fathers who rated themselves as having elevated depressive symptoms were significantly more likely to perceive their infant's behaviour in a negative fashion, reporting that their 6-month old infants were more distressed, more fearful, and less prone to laugh and smile. Goodman's (2008) descriptive study comparing two cohorts of mother-father-infant triads grouped according to the mothers' depressive status (as measured by the EPDS) found that partners of depressed women interacted in a less than optimal manner with their infants. In addition, Goodman found that maternal depression was significantly correlated with paternal parenting stress, itself a risk factor for suboptimal child development (Beck, 1998, 1999).

Many fathers described their attempts to offset the stress of their partner's PPD by assuming more responsibility for infant care and household duties (Davey et al., 2006; Meighan et al., 1999; Webster, 2002). The fathers in Webster's study described returning home from work, coming into their homes and "taking over" in order to give their partners a short period of respite (p. 392). Meighan and colleagues' study participants spoke of their sense of responsibility and willingness to sacrifice for the good of the family, despite heavy demands at work. Essentially, the presence of PPD in these fathers' partners caused the fathers to have heightened involvement with their infants and other children.

Depressed women's perspectives of their partners' experiences.

The literature on PPD says very little about the way in which depressed women perceive their partners' experiences. No studies were found that specifically address this issue; however, several qualitative studies that focused on the *woman's* experience of PPD do speak about the partner. A grounded theory study exploring the way in which Swedish women experience the first months with their children (Edhborg, Friberg, Lundh, & Widström, 2005) noted that these mothers, while struggling with the partner relationship, attempted to understand their partners' perspectives. Another grounded theory study, conducted to develop a theory of interaction with public health nurses (PHNs) in Finnish well-baby clinics, noted that couples indicated that child health clinics should address the needs of the entire family, rather than just the infant's or mother's health (Tammentie, Paavilainen, Tarkka, & Åstedt-Kurki, 2009).

A recent Canadian study provides a unique focus on women's perceptions of their partners' roles as carers (Montgomery, Bailey, Purdon, Snelling, & Kauppi, 2009). This secondary analysis of qualitative data collected in a larger study focused on women's PPD help-seeking experiences. Here again women spoke about their challenges, articulating their needs in such a way that their partners understood and were able to provide support. The availability of husbands was categorized as 'doing for', which involved physical help with child care, transportation to appointments, and administering medication, and 'being with', which involved affective support such as listening to women's concerns and speaking on their behalf to health care providers and family members. The authors concluded that the women's husbands' physical, affective, and cognitive involvement were critical factors in helping the women cope with their PPD. As well, the husbands' availability as described in the women's narratives reflected a shift over the course of their PPD from 'fixing' emerging problems to listening to, and advocating for, their wives.

Studies have found that women may have difficulty eliciting and hence receiving support from their partners (Dennis & Chung-Lee, 2006; Goodman, 2004; Letourneau et al., 2007). This is not surprising given that more severely depressed mothers may be unable to focus beyond their own suffering. Smith and Howard (2008) concurred, noting that mothers with less depressive symptoms may elicit support more effectively than mothers with high levels of symptomatology. In summary, the lack of research regarding this aspect of the partner's experience again points to a need for a study of the partner's transition to parenthood in the face of PPD, and his experience of access to the services and supports he requires.

Summary

What emerges in the review of the literature regarding the transition to parenthood and the impact of PPD on the partner relationship and fathering is that the transition is a complex process for all new fathers regardless of the emotional health of their partners. The small body of literature that on fathers' experiences of their partners' PPD points to a group of men struggling to balance work responsibilities with their emerging role as a father in the face of limited support from health professionals and others. These fathers are at risk of psychological distress themselves at the very same time that they are required to care for their partners and new babies. They express frustration at the lack of access to, and dearth of, supports designed for fathers in their situation. To date no literature has been published that specifically considers how men's experiences with their partners' PPD affects their transition to parenthood.

CHAPTER 2: METHODS

Problem Statement

A couple's transition to parenthood is severely compromised when the mother experiences PPD. There are negative consequences for the woman and her partner, their relationship with each other, and the growth and development of their children. The effect on children is compounded when both parents suffer from depression (Deater-Deckard et al., 1998, Zelkowitz & Milet, 1997). However, there is some evidence that intervention by the father may reduce the impact of maternal depression on the infant (Boyce et al., 1991; Letourneau, Duffett-Leger, & Salmani, 2009). There is a paucity of research on the effect of PPD on the father's transition to parenthood.

Research Question

How do first-time fathers, whose partners have PPD, describe their experiences of the transition to parenthood?

Research Purpose

The purpose of the study was to explore first-time fathers' transitions to parenthood when their partners have PPD. As the family system is impacted by the effect of the experiences of each of its members, the transition to parenthood for first-time fathers will be affected by their partners' PPD. Understanding the perspective of fathers as they transition to parenthood while supporting a depressed partner is critical to designing nursing interventions focused on promoting family health, facilitating the fathers' transition to parenthood, and ameliorating the effects of PPD on the mother, father, infant, and the couple relationship.

Research Objectives

- To explore fathers' experiences of the transition to parenthood when their partner has PPD
- To compare men's expectations of fatherhood with the lived reality of their experiences
- To explore men's perceptions of, and access to, health services and supports for new fathers whose partners have PPD

Definition of Terms

Postpartum depression (PPD): depression manifest as “a condition often exhibiting the disabling symptoms of dysphoria, emotional lability, insomnia, confusion, anxiety, guilt, and suicidal ideation” (Dennis & Ross, 2006, p. 589).

Transition to parenthood: the process of becoming a parent, beginning prenatally and continuing throughout the child's birth and ongoing growth and development. This process is characterized by changes in responsibilities, goals, and self-identity as one masters the behaviours and skills related to caring for a child (Ferketich & Mercer, 1995).

Family: “a living social system characterized by a small group of closely interrelated and interdependent individuals organized into a single unit in order to attain family functions or goals” (Friedman, Boden & Jones, 2003, p. 158).

Theoretical Framework

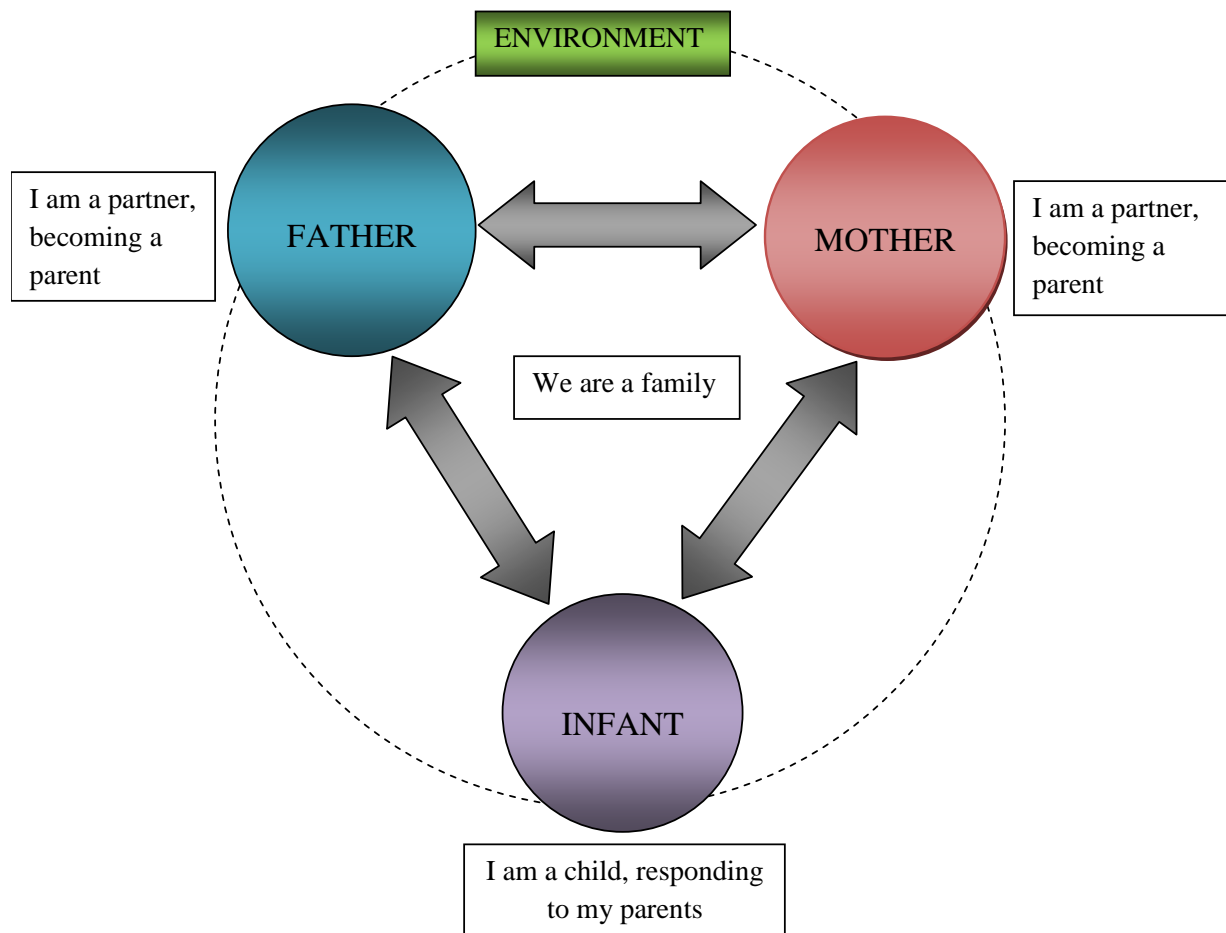
Given the importance of the relationship between the father and mother, as well as between the father and child and mother and child, family systems theory was used to guide the study. As stated by Goodman (2008), family systems theory's emphasis on the interactive and reflective shaping of individuals and relationships within the family leads to the hypothesis that one member's depression will affect other family members and relationships. Similarly, in noting that many authors view the transition to parenthood from a family systems perspective, Bell and

colleagues (2007) underlined the applicability of this framework in current family research and its particular utility in obtaining a comprehensive understanding of the behaviour and representation of various family members.

Family systems theory has its roots in the Neuman Health Systems Model (1982) and Ludwig von Bertalanffy's (1968) work on general systems theory. The Neuman Systems Model describes an approach to client care where nurses focus on the whole person. The client, whose construct is informed by interactions amongst physical, psychological, sociocultural, developmental, and spiritual factors, interacts with the environment with the goal of maintaining stability (Neuman & Fawcett, 2002). The focus of Neuman's theory is primarily on relationships among individual family members; von Bertalanffy spoke of families being interconnected systems of individuals who impacted each other. The emphasis in family systems theory is on the whole rather than the parts such that any event or health condition affecting one member of the family affects other members as well (Friedman et al., 2003; White & Klein, 2002).

According to Cox and Paley (2003), family systems are characterized by wholeness and order, hierarchical structure, subsystems, and adaptive self-organization. In a family consisting of a mother, father, and infant, the interactions would move reciprocally in four directions, including three subsystems. The subsystems include the couple relationship, the mother-child relationship, and the father-child relationship. Within this family system, interactions would also occur within the mother-father-child relationship. The reciprocity of interactions, shown in Figure 1, highlights the complexity of family life. For instance, the father and mother are both transitioning to parenthood and responding to each other's adaptation to the new roles while adjusting to decreased couple time; the father cares for the infant and in turn receives feedback as the infant responds to him; the mother feeds the infant and may change her feeding approach or

patterns depending on how the infant responds; and the family as a whole learns to respond as a new entity when interacting with other family members or health professionals.



Adapted from Bell et al. 2007

Figure 1: Transitioning to parenthood from a family systems perspective

It is the family's ability to adapt that is particularly highlighted in this study as PPD affects first the mother, and subsequently and simultaneously the child(ren) and partner. The adaptations required by the new family to PPD occur at the same time that the couple is transitioning to parenthood. The family systems theory helps support an in-depth and holistic

approach when considering the multiple influences on new fathers' transition to parenthood when their partners have PPD.

Study Design

This study used a qualitative descriptive approach that incorporated photo-elicitation interviews. A qualitative approach was appropriate because it allowed the researcher to closely observe “patterns of interaction and the ongoing negotiations of family roles and relationships” (Daly, 1992, p. 3). Qualitative description, in particular, is appropriate for use when straight descriptions of phenomena are desired (Sandelowski, 2000) and a comprehensive summary of experiences in the participants' own words is required by the researcher to address the study question. When compared to other qualitative approaches such as phenomenology or grounded theory, qualitative description may be described as less interpretive and more “data-near” (Sandelowski, 2010, p. 78).

In qualitative research, the in-depth interview is widely used to elicit the meaning that particular life experiences and events hold for interviewees (DiCicco-Bloom & Crabtree, 2006). Data for this study were collected using photo-elicitation interviews that were semi-structured in nature. Amongst qualitative health researchers, there is agreement that combining images and text can yield important insights and understandings (Harper, 2002; Oliffe, Bottorff, Kelly, & Halpin, 2008). Photo-elicitation is a research method that uses photographs as a stimulus to elicit rich accounts of psychosocial phenomena in subsequent interviews (Frith & Harcourt, 2007). Several researchers refer to the “photo-elicitation interview” (Clark-Ibáñez, 2004; Loeffler, 2004) when describing the interplay between photographic data and interview data in order to elicit a detailed description of an experience or event.

Photographs were used as a tool to elicit discussion of the participants' experiences of fatherhood. Participant-produced photographs have proven effective in facilitating conversations rich in description and detail in other studies of fatherhood (OliFFE & Bottorff, 2007; OliFFE et al., 2008). Photographs can function to reduce the formality of the interview process as participants engage in a task akin to viewing a family photo album (Schwartz, 1989) and may especially appeal to men as visual learners (OliFFE & Bottorff). Participants also can use the photographs to facilitate unique communication of dimensions of their lives (Clark-Ibáñez, 2004).

With photo-elicitation interviews, photographs are used in three main ways: (1) as visual inventories of objects, people, and artifacts; (2) as depictions of events that are a part of collective or institutional paths; or (3) as intimate dimensions of the social (Harper, 2002). It is this last purpose that was served in this study as the participants' photographs were used to depict their day-to-day lives as fathers. The photographs were then used by the researcher as prompts for further questions and as tools for expanding the description of the fathers' experiences.

Photograph elicitation also addresses the power imbalance inherent in traditional interviews where the researcher or "expert" directs the conversation (Frohmann, 2005) by allowing the participant to shape topics discussed in the interview. This empowerment process has been effectively used in research with traditionally silenced populations, such as victims of intimate partner violence (Frohmann), and is therefore appropriate for eliciting the underrepresented voice of the partner of a PPD-afflicted mother.

Sample and recruitment

A purposeful sample of first-time fathers was sought to participate in this study. Eligibility criteria for the fathers included were: 20 years of age or over; spoke English; experienced the birth of a child for the first time and had no other children; and child 12 months

old or younger. Purposeful sampling is the selection of individuals for study based on their ability to purposefully inform an understanding of the research problem and central phenomenon being studied (Creswell, 2007). The choice of first-time fathers whose children were 12 months old or younger was made in order to reduce recall bias regarding the early days of transitioning to parenthood. Screening according to specific types of purposeful sampling prior to the interview allowed the researcher to collect a sample that reflected the effect of different factors on the transition to parenthood. For example, intensity sampling (Patton, 1990), focused on recruitment of fathers whose partners required extensive intervention for PPD (i.e., medications, counselling, or hospitalization) or fathers who had taken time off work in order to support their partners and assume primary care for their infants. As well, maximum variation sampling ensured the inclusion of fathers whose demographic characteristics (age, level of education, income) varied and served to highlight any common patterns and shared aspects of experiences when a partner has PPD (Patton). Lastly, the researcher included one father who felt PPD had little to no impact on his transition to parenthood. This disconfirming case served as a source for rival interpretations and thus forced closer attention to the data analysis (Patton).

Initially, participants were recruited by approaching their partners who attended postpartum peer support groups in Halton and Peel Regions (Ontario, Canada) or sought treatment in community health clinics. The researcher telephoned the group leaders and sent them electronic copies of the study flyer (Appendix B) to print and post in the locations where their groups met. Group leaders were asked to promote the study to group members by distributing print copies of the flyer to group members and highlighting the researcher's contact information. In this way, group leaders acted as champions (MacDougall & Fudge, 2001) who took an active interest in the research and helped recruit study participants. The researcher also

made a presentation to four support groups (three in Halton and one in Peel) over a 2-week period to provide information about the study, initiate the recruitment process, and distribute print copies of the flyers as needed. Women participating in the support groups were given paper copies of study flyers, which they were asked to share with their partners. A diagnosis of maternal PPD was not required since women with PPD are often reluctant to seek professional help or divulge the full extent of their depressive symptoms (Dennis & Chung-Lee, 2006; Sword, Busser, Ganann, McMillan, & Swinton, 2008).

In addition, study participants were asked to recommend other new fathers who met study eligibility criteria (snowball sampling as noted in Patton, 1990). People responsible for community websites for mothers/families based in the Halton area were approached and agreed to post study information (www.oakvillemoms.com, www.momstown.ca); the researcher composed a blog highlighting PPD and the study (<http://www.mumsnchums.com/blog/local-nurse-launches-ppd-study-for-affected-fathers>) and the study information flyer was tweeted on Halton Region's twitter account (<http://twitter.com/#!/haltonparents>).

When initial recruitment proved to be slow, a local women's health care clinic that provides assessment and treatment to women with PPD was asked to post study fliers with tear-off contact information (Appendix C). Care providers at the clinic also were asked to bring the study to the attention of any partners attending appointments.

Potential participants were instructed to contact the researcher by telephone or email. Study eligibility and willingness to participate were determined by the researcher using the Telephone Screening Tool Script (Appendix D) or by asking the questions via email. Email confirmation of the interview details (Appendix E) was sent to participants prior to the interview

taking place. Recruitment continued until data saturation was achieved and no new themes emerged in the analysis.

Data collection

The interview guide (Appendix F) allowed the researcher to explore the meaning of new fathers' experiences transitioning to parenthood by encouraging responses to key questions designed to reflect study aims and the family systems perspective. The interview guide was designed to move from the initial broad question asking, "What's it been like for you to become a father?" to more detailed questions, i.e., "How has (your partner's) postpartum depression affected you as a father?" The ordering of interview questions was designed to facilitate rapport with participants before asking more sensitive and probing questions (Creswell, 2007; DiCicco-Bloom & Crabtree, 2006). The interview guide was refined during several meetings with the researcher and her supervisory committee and was then re-evaluated following the first two interviews. As subsequent interviews took place and data analysis proceeded simultaneously, this iterative process informed the development of further probes. It became apparent early in the research process that while the focus of the interview was not on the birth experience, many fathers chose to share this information as part of their description of the transition to parenthood. Once this information had been shared, the fathers seemed more prepared to discuss the impact of PPD on their families and on their roles.

Each participant was interviewed once in person for primary data collection. All participants were contacted regarding a second interview conducted by telephone to confirm that the researcher's interpretation of the participant's data was accurate (member-checking), review common themes that emerged across all interviews, and seek further clarification of comments made during the first interviews. However, only one father participated in the second interview.

Initial interviews were conducted at a location convenient to the participant. The interviewer's safety was protected by conducting interviews, when possible, during daylight hours and following a working-alone policy whereby the interviewer was contacted on her cell phone by a family member at the start and projected end time of the interview. Once the interviews were completed, the electronic audio files were encrypted and sent to a transcriptionist. On receiving the written transcriptions, the researcher reviewed them word for word while listening to the original audio files and made any necessary corrections to the transcriptions. The transcriptions were reviewed once more and identifying names and information were removed before proceeding to data analysis.

Prior to the interview, participants were asked to complete a demographic (background) questionnaire (Appendix G), review study information (Appendix H), and provide signed consent to participate in the interview (Appendix I). The purpose of the demographic questionnaire was to allow the researcher to adequately describe the characteristics of the study sample. Fathers were asked to share four to six photographs of their day-do-day lives as fathers in print or electronic form during the interview (see Email Confirmation of Interview to Study Participants, Appendix E). Encrypted electronic copies of photographs were stored on the researcher's computer for later comparison to the interview data. Participants were asked to provide written consent for one of three options concerning the future use of images by the researcher: use of the unaltered photographs; use of photographs with faces obscured using Paint.net; or denial of any use of photographs (see Consent to Photograph Use, Appendix J).

Data analysis

NVivo 9.0 qualitative software was used to search, code, and store analyzed data (transcribed interviews and photographs). Content analysis, defined as the systematic classification process of coding and identifying themes or patterns (Hsieh & Shannon, 2005),

was used to analyze the text data. Content analysis is appropriate when existing theory or research literature on a phenomenon is limited (Hsieh & Shannon). After reading through the transcriptions several times to obtain a sense of the whole interview, the researcher derived codes that captured key concepts from reading the data word by word (Miles & Huberman, 1994) The initial codes were determined by the researcher and her supervisor after coding two interviews and comparing results. Coding was refined again after five interviews had been completed and the researcher and all three members of her supervisory committee met. The establishment of themes and sub-themes came later, and reflected patterns or meaningful clusters in the data (Patton, 2002). When possible, names of themes and sub-themes were derived from the fathers' words in interviews. Data analysis was conducted concurrently with data collection in order to gather additional data on emerging themes and trends in the described experiences. While the initial codes reflected questions and key concepts from the interview guide (itself informed by family systems theory), the evolving codes reflected the reflexive and interactive nature of qualitative content analysis, which is data-derived (Sandelowski, 2000). When data analysis was almost completed, the researcher and her committee met a final time to discuss refinements to the coding schema.

Strategies to promote trustworthiness of data analysis

Measures to ensure rigour, or the legitimacy of the qualitative research process (Tobin & Begley, 2004), included the notions of credibility, transferability, dependability, confirmability, and authenticity. In order to address credibility, or the 'fit' between the researcher's representation of the participants' experiences such that it is immediately recognizable by the participants (Lincoln & Guba, 1985), the researcher attempted member checking (in fact, only one participant verified via a second interview that the researcher had captured the essence of his first conversation); peer debriefing (consultations with thesis committee members who

questioned methods, meanings, and interpretations of data); prolonged engagement with new fathers in the field; and establishment of an audit trail (detailed journaling of the content and process of interactions including research experiences, issues, and insights) (Koch, 1993).

Baxter and Eyles (1997), Creswell (2002), and Patton (2002) discuss the value of “negative case analysis” or the consideration of instances and cases that do not “fit the rule”. In the study, the researcher included one case where a new father felt that PPD had minimal to no impact on his transition to parenthood in order to increase her understanding of the experiences of those fathers who felt that PPD had had a significant impact on their transition to parenthood. The goal was to include data that are credible when described and interpreted appropriately rather than to seek data that are always consistent (Krefting, 1991).

Transferability, or the generalizability of inquiry, was ensured by using detailed descriptions of methodological and interpretative strategies such that the reader can determine the degree to which constructs and hypotheses may be transferred to other contexts (Koch, 1993). This involved specific description of sampling and study participants, data collection, and data analysis, including the coding process. Dependability, which is comparable to reliability in quantitative studies, is largely concerned with documenting the research context (Baxter & Eyles, 1997) and was enhanced by a detailed audit trail including low inference descriptors (i.e., fieldnotes), mechanically recorded (digital) data, member-checking, peer examination (review of process and findings by thesis committee members), and reflexive journaling by the researcher. The researcher’s supervisor was asked to independently analyse an initial and later transcript for comparison with the researcher’s own analysis. The entire thesis committee then met and compared coding on five interviews as the coding scheme emerged. This process established inter-rater reliability.

Confirmability is comparable with objectivity in quantitative research and is concerned with establishing that interpretations of findings are derived from the data (Tobin & Begley, 2004). Confirmability was ensured by an audit trail detailing specifics of raw data, data reduction, emerging codes and themes, and the process of decisions regarding coding challenges and interpretations. Authenticity was demonstrated by attempting to fairly portray the range of different realities found in the stories of the participants' descriptions of their experiences.

CHAPTER 3: FINDINGS

The data for this study were drawn from interviews with ten participants. One participant chose not to answer the demographic questionnaire but noted during the interview his age, his child's age, and the fact that his wife had been diagnosed with PPD. The mean age of participants was 32.6 years (SD 6.3 years), with a range from 23 to 42 years at the time of the initial interviews. The mean age of their children was 6.2 months (SD 2.6 months) with a range from 3 to 11 months. Eight of nine fathers described their racial background as white (Caucasian) and one identified himself as Chinese. Eight of nine fathers stated that the first language spoken at home was English. The majority of participants, six of nine (67%), noted the highest level of education attained as either some (33%) or completed (33%) community college/technical school. Three of nine participants (33%) reported the highest level of education completed as a bachelor's degree. Six of nine (67%) participants reported the estimated income of all household members before taxes and deductions was greater than \$49,999 while three of nine (33%) reported their household income as less than \$40,000.

Six participants stated their partners had been formally diagnosed with PPD; one said that he was unsure and three said that their partners had not been diagnosed with PPD. In these latter three cases, the women had presented with symptoms that limited their ability to function and had independently chosen to seek support for depression or anxiety. The frequency of therapies received by partners as reported by study participants is as follows: 6 of 9 (67%) mothers received counselling; 6 of 9 (67%) mothers were on medication; and 3 of 9 (33%) mothers attended a support group. One of nine mothers (11%) was reported as having all three therapies, while 4 of 9 (44%) received both medication and counselling.

Of the ten participants, one was a second-time father. He had responded affirmatively to an email message from the researcher noting that she wished to interview only first-time fathers. However, he stated at the beginning of the interview process that he was the father of two children. The decision to include this interview was based on the participant's eagerness to participate and willingness to be interviewed on short notice. The researcher began the interview process by noting that the study's focus was on the transition to parenthood and asked the participant to reflect on his experiences with his first child (who was less than 12 months old).

Initial interviews lasted approximately 1 hour. Eight of the initial interviews were held in the participants' homes, one was conducted in a room at the participant's workplace, and one was conducted at a community park. For interviews conducted in the home, the researcher discussed in advance with participants the need to secure a private room for him to freely share his experiences, should his partner be in the home. In three cases the partner was at home and simply went to another room. In three cases, interview participants also were caring for their infants while being interviewed. As per the consent form, participants were informed that their interviews were being digitally recorded and later would be transcribed, and that they could see a copy of their interview transcript should they choose to do so.

Every participant was emailed information about participating in a second interview (Interview Consent Form), reminded of this at the interview, and then contacted by email and/or telephone to arrange it. One of the original 10 participants had moved out of the area and did not respond to emails. Two others expressed interest in being part of a second interview but did not respond to successive attempts to confirm timing. The other six participants did not respond to emails or telephone calls.

The researcher completed member-checking with one participant father using a follow-up interview conducted over the telephone. Its purpose was described to the participant as an opportunity to share themes derived from analysis of the interview data and check with the participant if this made sense. Also, the interview was used to complete collection of the participant's demographic data. The interview took approximately 30 minutes.

Five main themes emerged from the analysis of interview data. These themes, reflecting the primary content in the interviews as it related to study objectives, are: (1) From two to three; (2) Connecting with baby; (3) PPD and the partner relationship; (4) Heightened involvement with baby; and (5) Available and desired supports. Sub-themes that captured more specific patterns in the data also were identified. Table 1 lists the themes, sub-themes and descriptions of sub-themes. For the most part the names of the sub-themes are in-vivo codes derived from the participants' own words. The themes and sub-themes describe characteristics of the transition to parenthood for the study participants (first-time fathers whose partners had PPD) rather than the process or steps individuals moved through when becoming fathers.

Table 1: Study themes, sub-themes, and descriptions of sub-themes

Themes	Sub-themes	Descriptions of Sub-Themes
From two to three	<p>Baby is the priority</p> <p>From spontaneity to planning</p> <p>The balance of home life vs. work life</p> <p>Thinking differently now that I'm a dad</p>	<p>All decision-making, parental behaviour, and activities are determined by the baby's needs</p> <p>Shift in thinking/action to individual/couple/family activities being deliberate rather than spontaneous</p> <p>Energy/priority given to work activities vs. being involved fathers at home</p> <p>Change in priority setting and self-concept now that there is a child in the household</p>
Connecting with baby	<p>Right from birth</p> <p>Pride in watching baby develop</p> <p>The most amazing feeling ever</p>	<p>Immediate bonding with baby from the moment of delivery</p> <p>Gratification fathers take in observing their infants achieve developmental milestones</p> <p>Intense emotional impact of becoming a father and attachment to baby</p>
PPD and the partner relationship	<p>Walking on eggshells</p> <p>Suffering when she suffers</p> <p>Taking care of two people instead of one</p> <p>Taking charge</p> <p>Wanting baby's life to be normal</p>	<p>Examples of and strategies for coping with partner's volatile moods</p> <p>Distress experienced by fathers as they witness their partners' anguish</p> <p>Dual responsibility of partner and child care</p> <p>Assuming responsibility for child care and protecting partner from potential stressors</p> <p>Desire to create normalcy in routine and</p>

		household despite partner's PPD
Heightened involvement with baby	Protecting baby	Shielding baby from effect of partner's PPD by monitoring partner's mood and own mood and intervening with partner when necessary
	Stepping up	Increasing responsibility for child care
	Expectations vs. reality	Differences between hopes for fatherhood and the lived reality
Available and desired supports	Family and friends	Examples of family members and friends who provided practical and emotional support
	The guys at work	Explaining how co-workers could be either seen as supportive or as people to not share information with
	Different professionals we worked with	Describing health and community professionals who supported the family
	On my own	Feelings of isolation and not having anyone to share struggles with re: partner's PPD
	What I wish had been in place	Suggestions for supports for fathers that would have assisted in their transition to parenthood when their partners had PPD

From Two to Three

The theme *From two to three* includes reflections by participants on the transition to first-time parenthood, specifically, the change in priorities that come with fatherhood. Responses were elicited when participants were asked the following questions: What has it been like for you to become a father? What's different from when you and your partner were (just) a couple? As participants described their transition to parenthood, major shifts were identified in four main areas: priority setting; level of spontaneity; determining the balance between work and home life; and thinking patterns. Hence, four sub-themes subsumed under this main theme are: (1) Baby is the priority, (2) From spontaneity to planning, (3) The balance of home life and work life, and (4) Thinking differently now that I'm a dad.

Baby is the priority

Participants spoke about a change in priorities since their child's arrival, and, in particular, the aspect that the infant's needs and activities were prioritized within the family context. As one father said, "Baby is in the steering seat" [Dad 4]. Fatherhood seemed to awaken in these men the need to re-evaluate their choices regarding how they spent their time, energy, and resources.

For some participants, this onset of the shift in priorities coincided with the birth of the baby. As one father commented, "Ever since he was born it's just like whatever happened before ... got switched and suddenly I'm in baby mode" [Dad 6]. Other participants clearly noted that the shift had occurred for their partners as well; the parenting relationship took priority over the couple relationship. This was reflected upon by one participant who spoke of his and his partner's desire to shift plans and priorities in order to meet her unspoken needs:

Now, our baby can't really communicate what she wants right now but you know, we're not going scuba diving this year, for obvious reasons ... because there's a baby. It's not that the baby's saying, "Don't go scuba diving." It's that I don't think the baby would

want one or both of her parents disappearing off. You know? So, it's ... it's that kind of thing. That's the single biggest difference – that every consideration now has that third person in it. [Dad 4]

Several participants chose to illustrate the differences in their lives caused by the birth of the baby by sharing pictures that captured some of the changes. For instance, one participant shared a picture of life “before the baby” by a photo of him with his two dogs (Figure 1). He commented on what the weekends had previously represented and his love for his dogs:

This is just before [the baby was born]. So, I've got a grin for ear to ear for not having to go to work or not having to be up at five in the morning ... Before [the baby was born] ... they were my ... my pride and joys basically. My two sons. [Dad 5]

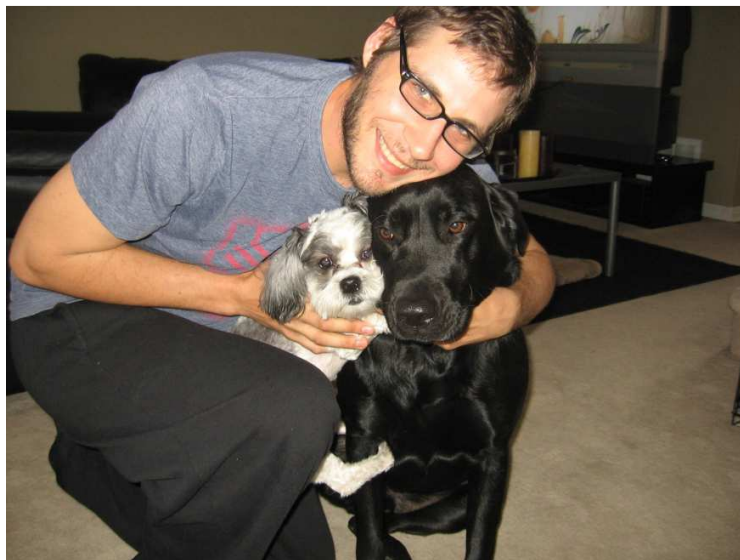


Figure 2: "Before the baby...they were...my two sons."

Another father described how his house had changed since the birth of the baby:

I took a couple that were ... in effect just pictures of ... what the house looks like with the ... you know, the mix of baby toys and postpartum depression books ... things showing life with Dad ... More clutter in the house ... Yeah, well I was just saying there was, typically, you know, one or two of those [PPD books] lying around at any one time. [Dad 2]



Figure 3: “The mix of baby toys and postpartum depression books”

From spontaneity to planning.

Study participants spoke about the decrease in spontaneity and increase in needing to plan ahead when a baby joined their family. They noted the impact of this shift in three ways: a decrease in the ability to pursue unplanned activities; an increase in the amount of planning needed to go out as a family (preparing and packing baby’s “stuff”); and a change in the nature of the activities themselves, when consideration of the baby’s needs were taken into account.

One participant described how he and his partner had previously lived spontaneously:

You know, picking up and ... [on the] spur of the moment just saying, “Let’s go for dinner. Let’s go see a movie” ... you know, and uhThat was sort of our life. We just flew by the seat of our pants. And if we felt like doing something, we just picked up and went. [Dad 6]

This spontaneity changed after the baby was born. As the same study participant noted:

Now, we have to make sure we have the diaper bag... uh packed and stocked and...Um, you know, we - we carry a cooler with food and extra milk and ... stuff like that ... definitely keeping tabs on everything – what’s going on, what’s around us, our surroundings. [Dad 6]

Another participant commented on the time required for the family to prepare to go out:

Well, [to] go out for dinner ... go to a friend's easily ... just go anywhere on a whim just can take an hour to make sure we've got a vehicle full of stuff. You know. {laughs} There's the toys, and things to do. [Dad 2]

Several participants commented that their fatigue levels were the biggest barriers to spontaneity. For example, one father, whose day involved a significant commute, 12 hour shifts, and caring for his child at home, stated:

It's been 5 months of, you know, really not too much spontaneity. A lot of it's been my fault just ... just from just being tired. I mean, you know, you work 14 hours. You come home and you take care of [the baby] for another 4 hours. And it's 18 hours out of the day that you're working in a sense. You know? And then basically you fall asleep. [Dad 5]

Another barrier to spontaneity was consideration of the baby's needs when trying to plan an outing. Participants talked about planning around baby's schedules, feedings, and temperaments. In order to accommodate these requirements, many couples chose not to go out at all or to decrease the length of their outings. One participant, whose premature daughter he described as being "difficult to get down for naps and sleep", noted:

We can't be out for as long as we would like. Um, we have to be choosy about the things we want to do. You know, like we can't just decide, "Hey, let's go to a movie." You know? ... We used to like going to the movies a lot. Now we can't do those things. We have to get someone to babysit. And the only person we trust is my mother-in-law ... We don't let anyone else babysit. But that's just a comfort thing 'cause her mom knows our routine, and she's spent a lot of time with us. [Dad 3]

The balance of home life and work life

Participants commented on their struggles with the competing priorities of home life and the workplace. It was evident from comments that there was, at times, a precarious balance between doing what was required on the job and responding to the needs of their partners for support and respite. When asked what had changed for him since becoming a father, one participant stated:

I'm at work and I do my best to focus on work and so on. But uh...with my wife, she's had a few rough times or days when she needed me to come home and uh I had to make a

way to get myself home. So...It's just again the balance of home life and work life and making that work. That's changed. [Dad 1]

Most of the participants described the pull between these two areas of responsibility and the overwhelming exhaustion they felt while trying to meet the needs of their partners at home and their superiors and colleagues at work. In fact, some related the toll that their exhaustion was taking at work. As one father noted:

I'm a supervisor at work and ... I'm also [the] health and safety representative. So, I have to set an example for the rest of the people at work because I'm the representative. And I would find myself going in and forgetting to wear my safety glasses on the floor. And that's just because I'm so f... tired ... have so many other things on my mind about my home life that I couldn't concentrate on my work. [Dad 8]

The exhaustion not only was felt by the participants but also was commented on by their co-workers. This led to another dilemma because the participants did not want to reveal the depth of the stress at home and had to deflect questions and suggestions from others. One participant stated, "I was very tired. Yeah. Just sleeping when I can and ... People at work noticed it and it was brought to my attention a couple of times. You know, 'Are you okay?' 'What's going on?' " [Dad 3]. Another participant commented:

Here I am dying at work and everyone's like, you know, what ... "Why didn't you sleep last night?" "The baby was crying." You know, "Okay, well, why didn't your wife deal with it?" You know, how do I explain that ... that I'm doing ... You know, I'm doing everything so my wife can get the most sleep even though I'm the one who's going to work for 9 hours. [Dad 7]

For some participants, the cost of choosing to support their partners at home was very high. These new fathers turned down better job offers, used vacation time, sacrificed income, and were threatened with job loss while trying to meet the demands at home. One father spoke about his predicament:

I was missing days of work and I was being told like my ... I could lose my job. But I was in this incredibly difficult place where I was at work. I've got my wife crying into my ... my cell phone and I'm ... You know, here I am, do I go back to work so I can provide for my family or go home? I had to go home. There's ... you know, if I have a

crying wife on the cell phone and, you know, I know the baby's screaming, and I knew my wife was at that point where there was nothing more she was capable of doing until she had a chance to re-centre herself. I had no option, so I came home. And I lost a lot of hours at work. And I lost ... I lost a chance at a couple of promotions because I lost those hours. And I've also lost a lot of money losing those hours. And that's only just added financial burden. [Dad 4]

For one participant, the cost of trying to cope with the stress at home and the demands at work was his self-respect:

For the first month I would ... I mean pardon my language ... but get shit on at home, then go to work and I'd be stressed out from home. I wouldn't want to talk about it to anybody. I'd get shit on there. And then I'd ... I'd just basically snap at times on people or just And that's not who I am. That's not what I ... I want to see myself as. So, when I looked at myself in the mirror I hated it. I hated the person I'd become. [Dad 5]

Thinking differently now that I'm a dad

Participants shared how becoming a father made them more introspective. When asked what the best thing about becoming a father was for him, one participant commented on the excitement of watching his 5-week old son learn and grow, and then said:

He's definitely brought out a side in me that I don't think I've ever had. I see things a little differently now. I think a little differently. He's made ... I guess you could say he's just sort of made me think and see things a lot differently, in a certain perspective. Sort of brought some clarity and focus and ... just, you know, trying to be a better person for him in his environment. [Dad 6]

Part of this introspection involved increased awareness of the long-term implications of one's health, something that one participant readily admitted was previously of no concern to him:

It's all about what's going to be best for her. For the baby. Uh, and health issues and that. You start to think about your own mortality and, you know? You know, it ... maybe I should get that checked out whereas before it seemed like it just seemed like it was devil-may-care kind of thing. [Dad 2]

Similarly, participants reflected anew on the nature of their work. One participant clarified this increased focus on how he earned his living:

I'm one of the ... the biggest passive people you'll ever meet ... especially with work ... It's just a job. You know? They'd crap on me and I'd just say, "Ah, don't worry about it. It's just ... just a paycheck." It's just this. Now that my wife ... or the baby's around it's ... you know, it's ... more than a job; it's ... a career. It's for my family ... I don't put anything on the side burner anymore. [Dad 5]

“Thinking differently” with respect to employment was echoed by another participant, who emphasized the need to think long-term:

In terms of work the decisions I've made for work, my decisions are now longer-term [okay] rather than, "Hey, this is a good job. I'm doing good. Everybody likes me. I'm getting my annual pay raise. This is all good." Now, I want to take it up a notch, you know, and ... and make it uh advance. [Dad 4]

Connecting with Baby

This theme focuses on the developing relationship between the new father and his infant son or daughter. This aspect of the transition to parenthood was revealed through the sharing of photographs and answers to the interview questions: “What has been the best thing for you about becoming a father?” and “Is there anything else you would like to share with me about becoming a father?” Participants provided evidence, through photographs and comments, of close emotional ties with their infants, pride in their accomplishments, and increasing comfort in interacting with them. The four sub-themes subsumed in this theme are: (1) Right from birth, (2) Pride in watching baby develop, and (3) The most amazing feeling ever.

Right from birth

The majority of participants shared photographs of themselves with their infants in the delivery room or shortly after birth. This was not requested by the researcher; instead, the directions were to “share four to six photographs showing my day-to-day life as a father whose partner has postpartum depression” (Photograph Consent Form, Appendix I). However, it was clearly important for the participants to “begin at the beginning” and share these early records of

their transition to fatherhood. As one participant stated while sharing the photograph shown in

Figure 3:

I think for me it's one that captures being a new dad ... I mean to snuggle in and to ... to meet my son for the first time. It's uh ... I don't know, it was a big deal for me to become a dad [Dad 1]



Figure 4: “To snuggle in and ... meet my son for the first time”

Another participant described the first meeting with his son as a culmination of the expectations during the pregnancy: “It was just a really proud moment. You know the 9 or 10 months that we'd been through and all that had led up to this and, you know, here he was.” [Dad 6] (Figure 4, face obscured on request)



Figure 5: “All that had led up to this and...here he was”

The sheer emotion of the early moments of fatherhood was described by another participant as he shared a photograph showing him holding his newborn son [Figure 5]:



Figure 6: “[I was feeling] ... every emotion that you could possibly think of”

He’s not even a day old in the picture. [I was feeling] ... every emotion that you could possibly think of. I mean I don’t think there was ... In 14 years I never cried in front of my wife’s parents until that day. That was probably the first time they’ve ever seen me really cry - and my mom as well. [Dad 5]

The intense emotional attachment between new fathers and their infants was evident by the positioning shown in photographs and comments the participants made. The infants were cradled in their fathers' arms and shown sleeping on their fathers' bare chests. The photograph shown in Figure 1 depicted a father next to his infant on the hospital bed. He reflected, "We had kind of curled up for a little bit [in the bed] because there was no bedside area for me to sleep [on], so one night I slept on the floor". [Dad 1]

One participant stated he did not realize the extent of the emotional attachment he had formed with his new son from birth until he had to return to work:

I was with him for a good chunk of time before I went back to work. And it wasn't until I went back to work that I realized the emotional pull he had on me already ... [because] I had spent so much time with him beforehand. [Dad 9]

Pride in watching baby develop

This sub-theme encompasses participants' descriptions of their infants' growth and development. All the comments reflected the fathers' sense of delight in watching their infants learn new developmental tasks and master new behaviours. As with the previous sub-theme, photographs reflecting this progression were not specifically requested but most participants chose to include these as part of their sharing regarding their transition to parenthood. For one participant, pride was an integral part of fatherhood:

I think when I asked my friends who had my kids, "What's it like to be a dad?" they said, "I can't really describe it; you'll just know it once you are." And I think that's very true. Because it's so strong emotionally and you get such pride watching him [son] develop. [Dad 1]

The researcher viewed photographs of infants in car seats, pools, activity centres, and high chairs. Infants were shown sitting, standing, moving, smiling, interacting with adults, and exploring toys and food. In each case the participant stressed that the photograph demonstrated

his child's progress in growing and developing rather than just a representation of a single event.

Changes seen in the infants were reported as evidence of growing up and independence.

One participant, on sharing the photo shown in Figure 6, specifically commented on his son's developing strength:

In that one he's actually on our bed, and... He is sitting on his own there. At first I thought he was going to be lying forward but uh... he's sitting there and... It shows you he's getting a little bit stronger through the core. And uh just a little bit more independent. [Dad 1]



Figure 7: "He's sitting on his own there...a little bit more independent"

Another participant shared a photo of his daughter eating in her highchair [Figure 7], and spoke of how her ability to feed herself was evidence of meeting a developmental milestone and increasing independence:



Figure 8: “She’s starting to figure out how to feed herself”

We just finished feeding her lunch at this point ... she’s starting to figure out how to feed herself.... So, we give her crackers. They’re ... the baby mum-mums.... You talk about developmental milestones; she knows how to feed herself and hold onto her food and ... those bigger things she can ... she can handle on her own. [Dad 3]

As their infants grew and developed, participants described not only pride in their accomplishments but also a greater sense of connection with their evolving personalities. One participant commented on the contrast between his daughter’s current skill level (she was 6 months old at the time of the interview) and what she could do in the earlier months:

You know, on a day-to-day, week-to-week ... she learns another skill and, you know, she’s developing that personality. You know what, for the first few months they’re just a lump, basically. They eat, sleep, cry. But as they start to smile, get a ... get a sense of humour ... it’s such a neat thing to see. [Dad 2]

A similar comment was made by another participant who described how his daughter reached out and touched his face after she was a month old. Previous to this, he noted, “I mean honestly she was a log for the first month. She ate, slept, needed to be cleaned“. [Dad 4]

The most amazing feeling ever

This sub-theme of *Connecting with baby* includes descriptions of the participants' close emotional attachment to their infants. Participants made these observations when asked to respond to the questions: "What has been the best thing for you about becoming a father?" and "Is there anything else you would like to share with me about becoming a father?" One participant described the power of this intimate connection as follows:

I've had moments where he'd grab my finger or I'd be holding him and he'd fall asleep on my chest or he'd look up and smile at me or ... or stuff like that, that really um It's hard to describe. It's just been the most amazing feeling ever. There's ... there's nothing like it. [Dad 10]

One participant was eager to share with the researcher a photograph of his 2-day old baby cuddling on his chest in the hospital. Although this father originally commented on how his baby liked to snuggle, the researcher asked him what meaning the photograph held for him as a father. He responded, "It was nice. You know, the different feelings." [Dad 6]



Figure 9: "It was nice...the different feelings"

Another participant, whose son had been in the NICU following his birth, was asked to describe what fatherhood was like for him since he had brought his son home. He stated:

It's a lot of moments that have been like just amazing since he's come home. And um feeding him and changing his diaper and making sure he's okay and he falls asleep on my chest and ... It's just, you know, just amazing. [Dad 10]

This same participant described the close emotional connection with his son as being “comfortable”: He's really comfortable with me. I'm really comfortable with him. And uh it's just ... yeah; it's like teaching him stuff and reading to him. [Dad 10]

Similarly, another participant commented on “getting comfortable” as he shared a photograph [Figure 7] showing him holding his newborn son: “I'd say he's probably less than a month here. And It just...shows me and him getting a little more comfortable with one another. And he's just ... kind of resting himself on my shoulder” [Dad 1].



Figure 10: “Me and him getting a little more comfortable with each other”

Other participants noted that their attachment to their infants was transformative, and enabled them to have a unique emotional experience that previously was missing in their lives. One participant stated, “The best thing ... about becoming a father {sighs} is that a whole new part of my heart and my mind has opened up. And it’s not a part I suspected was there.” [Dad 4]

Another participant made a similar observation:

I just really enjoy spending time with my little girl. She kind of fills that void in my life that There was always this empty hole in a sense to where I never knew what to do with myself. [Dad 8]

PPD and the Partner Relationship

The theme *PPD and the partner relationship* encompasses descriptions of the effect of PPD on the couple relationship, including changes in how the couple related to each other and caretaker roles the father assumed in order to help his family function. This theme emerged early on in the analysis as participants responded to questions about what was the same and what was different for couples now that they had a child. Not surprisingly, the viewing of photographs and questions about the impact of PPD on fathering also yielded responses that fit into this theme. Four sub-themes were subsumed under this category, and will be defined below: (1) Walking on eggshells, (2) Taking charge, (3) Taking care of two people instead of one, and (4) Suffering when she suffers.

The majority of participants noted a shift in their relationships with their partners as a result of the PPD. New fathers were thrust into experiences that they had not anticipated, such as dealing with emotionally volatile partners, developing different communication strategies, having to function as protectors of their partners and infants, and feeling powerless to alleviate their partners’ anguish. The previous focus on work, social activities, and independence crumbled in the face of their new reality: ongoing stress and caregiver responsibilities.

Walking on eggshells

This sub-theme refers to the participants' attempts to deal with the changing and at times unpredictable moods of their partners. For many participants this involved learning new strategies for communication. These included being very sensitive to the concerns of their partners and aware of the messages they (the fathers) were communicating. As one participant stated:

I think you have to be a little bit more sensitive when she's going through that because if you say the wrong thing you feel as though you're sometimes walking on eggshells because you know that if you say something that it could set off some more bad thoughts or some, uh, insecurities [Dad 1]

Previously used strategies, such as using humour with a partner to diffuse tension, were seen to suffer in the face of the partner's mood changes. One participant reflected on the loss of humour in his communication with his wife: "We used to ... I mean we still, you know, joke around and are very witty with each other. In the beginning it wasn't taken too well." [Dad 6] In contrast, a strategy incorporated into the new "sensitive" communication by participants was the provision of some response to their partners' comments, even if it was just a non-verbal response. One participant described his calculated approach to responding to his wife as follows:

I don't know what to say and, you know, even though if I do know, I say something, is it the right thing? Is it ... Is it um ... is she going to take it the wrong way. It's hard to ... It's hard to know what kind of mood she's in sometimes. {chuckles} Um, so I kind of... Sometimes I just sort of sit back and don't say anything and ... sort of nod my head. {laughs} [Dad 6]

At other times, participants noted that sensitive communication meant avoiding conflict by not expressing their actual thoughts or feelings:

You do walk on eggshells. And I've walked on eggshells tons of times, where you just don't want to really say what you're feeling. She wants you to and she gets mad at you and she tells you, "I want you to tell me. I want you to tell me." And you just kind of, "Oh, that's okay. You know, don't worry about it. Nothing's wrong. Nothing's wrong." [Dad 4]

However, conflict did erupt in some cases, and participants noted that their partner's mood changes could be rapid and unpredictable. One father stated, "She can snap at the drop of a dime." [Dad 5] Another participant reflected on the change in his partner since the onset of PPD, and suggested that previously she was much more even-tempered:

Before it would kind of take a bit of time to get her into a bad mood or to get her down or to get her feeling anxiety, but now it seems like it can be the tiniest of things. And her mood changes instantly. And I mean instantly. [Dad 8]

In addition to describing their partners' mood changes as rapid and unpredictable, participants expressed their own bewilderment while witnessing these changes and bearing the brunt of their partners' anger. One participant described not knowing who he was responding to: "At the beginning her mood kind of was like a wave graph. You know it would go up and then come down. And it's kind of like a Jekyll and Hyde kind of thing; I didn't know who was there." [Dad 6] In one case, the participant reported that the rapid mood change was accompanied by violence: "I have a scar on my hand from one of the times my wife got so upset she started off crying, then she got angry and things started flying. And I have a scar on my hand from that." [Dad 7]

It may be that these participants' best attempts to communicate sensitively and to minimize conflict with their partners came as a result of fights or arguments that had occurred previously. The learning from these previous conflicts also happened for the partners as their mental health improved and insight deepened. One participant noted:

[My wife's] also a lot more emotional. The tiniest little argument can turn into a huge fight on a dime. And now we're at the point where she's starting to realize when she's doing it, and to control it more. But for a long time there it was, you know, any given moment could be an explosion. [Dad 7]

Taking charge

Another way in which PPD affected the relationship between participants and their partners was that the fathers took on a new protective role. *Taking charge* for participants meant attempting to control stressors that were impacting their partners and potentially making the PPD worse. These stressors included external influences such as the media, interactions with family members, and access to medical care. For example, one participant, whose wife suffered from severe anxiety and had vivid images of something terrible happening to their child, said the following: “Facebook is bad. Uh, one thing has been to try to not ... We don’t watch the news anymore at night.” [Dad 1]

The extended family could be either a source of support and respite care for the new parents or a source of criticism and contributor to the partner’s escalation of symptoms. In many cases the participants had to act as interpreters or educators who would explain their partners’ needs and concerns to family members, and limit interactions and visits. In this sense the participants also acted as “bouncers,” choosing whom to allow into their homes. One participant noted that this ultimately meant ignoring repeated invitations to visit a family retreat:

A lot of our extended family, they really don’t understand it, and it really upsets my wife to a point where she can’t or doesn’t want to talk about it. And uh so it’s a driving issue. It’s been kind of left on me to sort of educate the family ... it seems to work for maybe a week or two after having a conversation with them about what’s going on. And, for instance, my parents want us to come to the cottage every single weekend. We never did. [Dad 1]

Taking charge also meant that this protective role extended into the realm of interactions with health care providers. While there were contrasting interactions described with respect to this role, in all cases the participants described their belief that they were advocating for the best health care for their partners and children. One participant described taking on the role of convincing his partner to seek professional help:

At first like when she was having thoughts of harming the baby, uh which started almost, you know, the first week we were home even, and I had to convince her like we can't keep living like this. Like, I can't go to work not knowing what I'm going to come home to. So, I eventually managed to talk her into talking to the family doctor. [Dad 7]

Another participant used his “taking charge” role to help convince his wife that the medical advice they were receiving was not in the best interests of their child. His perception of the family doctor being “pushy” in recommending medication for his partner and continued breastfeeding of their infant, and his wife’s negative reaction to this, led him to reinforce the belief that he and his partner should decide what is best for their child:

I'm still very unhappy with our family doctor. Um, she was very much in favour of pushing medication, which wasn't a path that we wanted to go down 'cause my wife was still trying to breastfeed at that point, and she didn't want to take anything. And the doctor was very pushy. She was very pushy about medication and very pushy about breastfeeding um as far as to say if we didn't breastfeed our daughter wouldn't be bonded with us and she wouldn't be smart, and all sorts of stuff ... it was upsetting. Very upsetting for my wife. Um ... So, you know, then it's on me to assure my wife that, you know, this is okay and this is the right decision. You know, sometimes we have to do what's right for us so we can take care of the baby. [Dad 3]

Ultimately, “taking charge” involved not only protecting their partners from stressful external influences, but stressors within the home as well, such as the inevitable exhaustion that new parenthood brought. Several participants described looking for signs of emotional exhaustion as a cue to intervene. One father explained:

If my wife started getting emotional ... I had to take over, take control of the baby, let my wife go take a minute to calm down. You know, let her take 5, 10, 20 minutes even sometimes to just go take care of herself while I took care of the baby. [Dad 7]

Other participants described in detail their household routines in the early days of parenthood. “Taking charge” usually began with a decision that the father made about his partner requiring more sleep at night. He then assumed an active role in controlling access to the infant’s room, either by feeding the baby or bringing the infant to the mother for feedings. The

goal was to allow his partner to have uninterrupted sleep. In many cases this routine continued after the father returned to work:

I decided that, you know, she ... if she was going to start feeling better, she needs to get sleep at night. Uh, so for the first three months she would go to bed at 9, 10 o'clock and I would stay up and I would feed our daughter at about 11:30 and I would sleep in another room or sleep on the couch. And then I would get up 3-1/2 hours later and I would feed her again. And then go back to sleep and then my wife would get up for about, you know, the 7:00 a.m. feeding. So, I made sure she was getting a good night sleep with no monitor in the room, the door closed and quiet. Um, so even when I went back to work, I was still the one that was getting up at night and doing those feedings [Dad 3]

Interestingly, “taking charge” was also reflected in the way in which participants provided study data. One participant in particular was clear about not conducting the interview in his home, and about wanting to ensure that published data did not reveal the name of his partner or child. Another participant insisted at the beginning of the interview that he would not share any photographs of his child or partner. Other participants offered explanations about controlling access to images of their partners. One stated, “I don't have any of those pictures where you can actually see any kind of suffering because the camera never came out at those times”. [Dad 8] Another participant elaborated:

I didn't send you pictures of him with my wife because one person in that picture would be very sullen and very unhappy or very, uh, not excited. You know? Maybe that's my own personal defence against telling people what's going on, is that ... I mean if you can't send it to somebody who's actually studying this, then who really can you send it to, right? [Dad 9]

Taking care of two people instead of one

Several participants reflected on the difference between what they had expected life as a father to be like and what it actually was like. One participant commented that the surprise was not that he had to care for his infant, but that he had to care for his partner as well: “Suddenly it's like I'm taking care of two people instead of the one.” [Dad 6]

Participants found it easier to care for their infants than for their partners, as one participant explained: “Sometimes I feel like I have two babies. And the younger one is easier to deal with 'cause the older one's more complex.” [Dad 4] This is an interesting comment, given that this participant had no previous experience looking after infants and the partner relationship had been in place for several years. Another participant alluded to his own resentment of his partner's inability to help herself as he described arriving home after work:

I would come home and I'm ... not only would I have to help looking after the baby, but I would have to deal with the stress of her all night ... Like, she would sit in this chair and stare ... stare at a spot on the floor for an hour. [Dad 8]

One participant spoke of the challenge of juggling roles given his responsibilities, energy levels, and available supports. He described his struggle when he would awaken to hear his wife crying in the night, knowing he had to be up early in the morning:

Unfortunately, I can only stay awake so long, and I know that I have to be up at 5:00 or 6:00 a.m. to look after him and then to be at work for 10:00 or whatever it happened to be that day so ... I want to help her as much as I can but I know that we have these other resources to help in the day so ... You know, I my kind of had to ... I can plan and manage my time that way as well as to how much I can support my wife versus how much time is really needed to look after my son and work. [Dad 1]

Suffering when she suffers

In describing the extent of their partners' PPD, participants consciously or perhaps unconsciously revealed the trauma that resulted from being an observer of the emotional struggle. This sub-theme reflected the anguish that fathers endured in the face of their partners' suffering. In one case, the participant expressed guilt that he might have been sleeping while his partner was crying:

As I said, the exhaustion that she's gone through because she didn't sleep at all because of these thoughts, she would have nights where she's up at three, four in the morning crying ... her heart out ... I felt bad that she might be still dealing with it in the night ... it's hard to see the person you love suffer that much. [Dad 1]

Another participant noted that his attempt to intervene and give his distressed partner a break from their crying infant did little to relieve her misery:

Whenever anything escalated, it was very difficult. I found myself multiple times just sitting, rocking the baby, the baby screaming her head off, and my wife in another room crying. 'Cause my wife couldn't separate, you know, just babies cry. [Dad 7]

Many participants expressed feelings of helplessness in the face of their partners' suffering. One father explained that he was powerless to reassure his wife, who was suffering extreme postpartum anxiety: "No matter what I said I couldn't help because [her] thoughts override any rationale that I can give to her." [Dad 7] Another participant commented on the nightmarish scenario of watching his partner decline: "It was kind of like ... I wouldn't say watching someone deteriorate but pretty close. You know, it's like ... You want to help but you don't know if it'll help or if it'll work." [Dad 6]

In addition to expressing guilt, powerlessness, and anguish, participants grieved the loss of the partner they had once known. One participant commented, "I um ... kind of miss having my perky, happy wife because ... she's tired and she's scared of what the next awful vision's going to be." [Dad 1] Another participant connected the feelings of loss and helplessness:

I don't think I've ever seen that side of my wife before. I've always known her to be um very upbeat and happy and ... You know, happy-go-lucky. And to see someone sort of go through that, it's kind of like ... like did I cause this or is it something I did or um is it You know, and sometimes I feel kind of helpless. [Dad 6]

Heightened Involvement with Baby

This theme emerged in response to questions about becoming a father and the effect of PPD on fatherhood. Essentially, participants had devised parenting strategies that they felt helped to protect their infants from the effect of their partners' PPD. Four sub-themes comprised this category: (1) Wanting baby's life to be normal (2) Protecting baby, (3) Stepping up, and (4) Expectations vs. reality.

Wanting baby's life to be normal

Several participants spoke of their desire to create a sense of “normalcy” in the household at the same time their partners were suffering from PPD. This goal seemed to be driven by the desire to shield their children from the effects of PPD. It is not clear whether these fathers were advised to do this by other family members or health care professionals, or whether the fathers themselves had access to information indicating the potential effects of PPD on the entire family. One participant expressed his desire to have his son led a normal, happy life as follows:

That's one thing that I've tried to sort of make sure that happens so that he does have at least some normalcy in the house because uh he doesn't know that his mom isn't a hundred percent in the way that she would normally carry herself day-to-day ... I'm sure that's not the same for everyone but for me that's something that I've tried to do just ... to let him be a normal, happy guy. [Dad 1]

He then elaborated on what it was he wanted to protect his son from:

I did my best to ... to shield him from the difficulties that my wife was having. I wanted to make sure that he grows up to be comfortable and hopefully this will be something that ... I don't so much want to sweep it under the rug that it's happened because I ... think it's important that he eventually know about it but uh I also want him not to feel uncomfortable in any way because of the anxiousness that's going on in the household. [Dad 1]

For another participant, creating normalcy involved exposing his baby to new experiences, such as going out for a walk, which his partner was unable to provide:

Obviously kids pick up what their parents do because that's all they ever see, all they ever know, so to speak. So, something different: “Oh this is new, this is different, it's not the same.” So, I try ... to take the baby out to show him that, “You know what? You don't have to stay inside all the time. You can come out and have fun”. [Dad 9]

One study participant shared a photograph of himself swinging his child up into the air (Figure 10). This father explained that this was a “bit of a freedom shot” because it was taken during a family vacation when he was able to convince his partner, who suffered from postpartum anxiety, to travel to California for a family vacation. The photograph captured a

happy interaction between father and infant son and reflected a moment of “normalcy” in the middle of a stressful family time.



Figure 11: “A bit of a freedom shot”

Protecting baby

Several participants described providing infant care as a way not just to give their partners a break from the babies, but also as a way to give their babies a break from their partners. They developed an emotional “radar” that allowed them to determine when and how to intervene as their partners’ moods deteriorated. The father in the following quote described the way in which he monitored the interactions between his infant and his partner:

Being supportive ... [means] taking the baby in when I can see that my wife...the baby’s been fussing during a feed. Or, you know, is getting ... the baby’s getting a little more

irritated, and I can see my wife getting irritated - and just watching for ... for things like that. [Dad 2]

Another participant talked about his daughter reacting well to him on his arrival home from work, even though his partner stated the infant had been fussy all day. This participant postulated that the infant might have been reacting to tension in the household. For him, “protecting baby” meant that he attempted to read the atmosphere in the home once he arrived home from work, and then took over with the baby:

My partner will say, "Oh, you know, be careful she's really irritable today and she's having a terrible day." But yet I'll take her out on my own and she'll be all smiles and all giggles and all laughs and she's fine. And then as soon as I come back and hand her off to my partner again she gets irritable and she gets cranky and she gets crying. And I think that's because she can feel how her mother's feeling. And she's kind of feeding off that ... off of that vibe ... As I come home the first thing I do is go straight for the baby. I come home, I wash my hands, I change my shirt, you know, and then I usually pick her up and I ... I play with her and talk. And she tries to talk back and makes noise and we talk back and forth to each other, and I giggle with her, make her laugh. [Dad 8]

This same participant commented on his own childhood experience with a mother who battled mental illness and his determination to not expose his own child to something similar. For him, “protecting baby” carried the additional weight of wanting to not repeat negative parenting patterns from the past:

I don't get frustrated with the baby. I don't get angry. I mean I don't show that around her because I mean when I was raised I think my mother was probably bi-polar but she was never diagnosed with it. And I listened to a lot of yelling and screaming and temper tantrums and nervous breakdowns and stuff like that. And I refuse to have my little girl subjected to that. [Dad 8]

Stepping up

Another strategy employed by participants to help them cope with the effect of their partners' PPD was taking on more responsibility for infant care. Their language reflects the responsibility they felt, and their desire to do something to help the situation. One father

explained: “She’s totally exhausted a lot of the time. And it means that I have to ... step up more to look after [the baby].” [Dad 1]

One participant alluded to a history of sharing responsibilities with his partner, but noted this new role involved an increase in effort:

Because of the condition she has and she’s just feeling like garbage all the time, I have ... I’ve had to do a bit more ... Originally we ... do most things roughly equally, fifty-fifty. But uh I think just based on her feeling of helplessness ... I’ve maybe had to do a bit more than that. [Dad 1]

In a manner similar to the way in which participants “took charge” with their partners, fathers described “stepping up” to increased involvement in parenting duties. One participant described what this meant for him as follows:

I’d like to think that I would have been just as involved anyways. Um but yeah I think ... Especially those first couple of months I think I took on a huge ... a huge role. You know, leaving work early and like really just focusing on them and putting everything else kind of on the backburner. [Dad 3]

Another participant noted that, once he arrived home, he was wholly focused on caring for his infant son:

I’m back home for 5 o’clock in the evening. But the second I walk through the door in the evening it’s have a shower and then I grab [the baby]. I take him for a walk. I, you know, bathe him. I feed him. I put him to bed at night. So, I’m kind of the ... the guy responsible in the evenings. [Dad 4]

This heightened involvement came at some personal cost, as one participant noted: “After around 5 months when he stopped breastfeeding, I was the one pretty much exclusively to wake up with him in the middle of the night even if I was working the next day.” [Dad 1] This is similar to the pattern of doing the night feedings and then getting up to go to work adopted by Dad 3, as described under the sub-theme *Taking charge*.

Expectations vs. reality

Several fathers commented on the difference between what they expected fatherhood to be like and what the reality was. This was not always related to their partners having PPD. In one case, the comment about the difference between expectations and reality was made after a father discussed his expectations of having his newborn in the NICU and how staff treated his family:

When a baby goes into an NICU, the baby's not the only patient because the mother and father are just as worried. And to be sort of pushed aside ... that's not right. They should include the parents. They should say "Listen, this is what you can do." [Dad 10]

One participant reflected on his preconceived notions about fatherhood, before his wife was diagnosed with postpartum anxiety:

I don't know where these expectations or ideas come from but maybe seeing other parents or other families or TV uh movies, you know, media. You know, the perfect family, you know, and ... You think, oh okay, you know, if that ever happens to me, that's what it's going to be like. [Dad 6]

Another participant stated that he felt prepared for the physical work of parenting but had not anticipated the emotional stress:

I thought it would be a lot of hard work and a lot of ... Well, I thought it'd be easier and harder. Like, I thought there'd be a lot of hard work with the diapers, the feeding, the three o'clock feedings and stuff like that but then I ... I never realized how hard it is when a baby's crying and you can't figure out what's wrong. [Dad 10]

Other participants commented on how the gap between expectations and reality may have contributed to challenges in the adjustment to new parenthood. One father described a watershed moment when he and his partner reflected on how their lives had changed as a result of their 3-month old:

We looked around and we realised "Well, it's only been 3 months. And holy cow, look what's happened in 3 months. It's not been as joyous as we thought." ... maybe that has to do with our moods and temperaments feeding off of each other but ... it was such a drain on ... on ... on the two of us to just stay happy and upbeat when ... when the baby was waking up every 2 or 3 hours. [Dad 9]

Similarly, one participant described how his wife's struggles with breastfeeding contrasted with her dreams for motherhood and contributed to her discouragement:

She had expectations that she was going to be able to breastfeed anywhere, at any time ... he was struggling and he was crying and he wouldn't latch...it kind of all went out the window and I think that's kind of brought her self-esteem down and her ... What's the word I'm looking for? Um, it just brought her whole idea of motherhood down. [Dad 6]

Some participants reported having some knowledge about PPD prior to the birth of their child. However, the real lived experience proved to be quite different from what they had read about in pamphlets or books. One participant spoke about the difference between what he expected his partner's postpartum mood to be like and what actually happened:

I thought it just meant that there was a little bit of a chemical imbalance because of your hormones after you had the baby. Yeah, you ... you know, it takes a while for your body to go back to normal. But then after you balance out, you're fine. And that's all I thought it was, which is it's kind of like that but I ... I didn't realize that it could be this bad or the ... the extent of it or, you know, Like, I had no idea. I just thought she might be a little grumpy off and on and that's all I'd have to deal with. I didn't think I'd be dealing with a belligerent girlfriend who acted like she didn't want to be with me anymore. [Dad 8]

Available and Desired Supports

This theme contains responses to the interview questions "What support have you had in dealing with postpartum depression in your family?" and "What has been the most difficult thing for you about becoming a father?" The interview guide contained prompts for enquiring about support from partners, family members, health professionals, and friends or co-workers. The participants' responses were further organized into five sub-themes: (1) Family and friends, (2) The guys at work, (3) Different professionals we worked with (4) On my own, and (5) What I wish had been in place. The levels and sources of support varied from family to family.

Family and friends

Family members and close friends were identified as key sources of support by several of the participants. In general, relatives or friends provided consistent, practical help, such as meal

preparation, housework, and child care over a period of weeks to months. In some cases, family travelled long distances in order to provide assistance with child care and household duties. One father described an extended stay by his mother-in-law:

Because I had noticed that my wife was having all of these issues, my wife's mom came from [a community over 4 hours away], and she was originally was going to stay with us for a week or two. She stayed 4 months at our house ... her grandma came down from Nova Scotia for a couple of weeks to help look after [baby]. [Dad 1]

Other support was located closer to the couple's home. One participant relied upon his sister, who lived next door, as a sounding board:

Now that I've moved in here, I find myself really kind of confiding in her and asking her, you know, like, "Don't know what to do. Like, this is what she's doing and it's driving me crazy, blah, blah, blah". So, she's kind of been that middle man for [my partner] and I. [Dad 8]

Another couple with limited financial means and no family nearby devised an ingenious solution to the dilemma of the health care provider's recommendation that the mother not be left alone with the baby:

We have a friend who's been on kind of hard times. She hasn't had a job in a bit and she hadn't ... didn't have a place to stay. She's also ... the baby's godmother. So, she's now staying with us. We have an extra room. And she's a live-in nanny, basically. [Dad 7]

Emotional support was provided in person and over the telephone by friends and relatives. One participant described how his mother, who lived in another country, provided the emotional support he required:

When I go on my first night shift I usually give her a call because that's when I can talk to her without interruptions of the baby or ... or my wife ... she's always been helpful. And from the beginning she's always been helpful. She's the only one, I have to say, 'cause she's your mom, who says, "How are you doing?" [Dad 9]

Another participant related how the support and perspective of a friend who had children was helpful to him and his wife as first-time parents:

A friend of ours has two young children as well ... her youngest is 2 years old so it's still fresh in her head and ... You know, she's ... again she's a phone call away. And so she's been a great help to us just saying, "Listen, you know, it's normal" or "This is normal." [Dad 6]

The guys at work

This sub-theme emerged as a result of participants being asked specifically if they received any support from co-workers. Participants either provided examples of supportive interactions at work or stated that they did not want to share details about their partners' struggles with their co-workers. Co-workers provided emotional support (listening) or instrumental support (i.e., granting time off or switching shifts so that participants could spend some time at home). One participant commented on the extent of the emotional support he received, and how lunch and break time afforded him the opportunity to be heard:

The guys at work are ... are very open ... We're in one of the biggest macho kind of industries but there's probably about four or five of us that we're all married, and they all have young kids – not as young as [the baby] but ... you know, 2- or 3-year old kids. And we all just, at break time and at lunch time, pretty much every day get outside and talk about our wives or, you know... Some days my wife will frustrate me, and I'll go into work and at break I'll be talking to a guy, "Oh man, my wife did this." or, "My wife made me do that." And he'll turn around, "Oh yeah, my wife made me do this." [Dad 5]

Not all of the support was provided by other fathers or male colleagues. One participant found it helpful to talk to a colleague who had lived through PPD herself, and another discovered his boss's wife could offer helpful suggestions:

I'll talk to [name] who's my boss's wife and she ... 'Cause she'll see that something's wrong. And I'll wait for people to leave the office and I'll say, "Oh you know, [my partner] was like this last night and I don't know what to do. I'm almost at my wits end and, you know, blah, blah, blah." And then ... and she kind of gives me some reassuring words or tells me, you know, "This is ... "you know, "You've got to do this or maybe you should do this." [Dad 8]

Participants sought support in an intentional way, often being selective about what details were revealed to provide rationale for the request. One participant described his approach to requesting time off from work as follows:

My supervisor was expecting [his own baby], and I said, “Eh, [name], we’ve got some stuff going on. I’d like to take ... I don’t want to use any personal time but this is what I would like to do” ... He’s been around the bush a couple of times, so he ... he knows what’s going on ... I didn’t have to explain explicitly what was happening. [Dad 9]

Another participant, who chose not reveal the extent of the difficulties at home, offered his reasons for not seeking support from co-workers:

From co-workers, they wanted to support me but they didn’t understand. And I didn’t really make an effort to explain it all that well either because ... my wife is very personal and private, and I respected that. I’m not going to tell everyone our problems. [Dad 7]

Different professionals we worked with

In general, participants readily volunteered information about support from health professionals as they told the stories of their partners’ illnesses. In cases where they were not forthcoming with this information, the researcher asked them to talk about the support they had had from health professionals. Three of the participants stated that their main source of support had been the PHN who had visited their families at home or had connected with their partners via the peer support groups. For one participant, the health teaching provided by the PHN regarding PPD had a dramatic effect:

Our public health nurse [has] come to ... visit a couple times now. And it’s just been ... like someone opening up the blinds to the windows and ... light coming through and just saying, “Hey, listen, you know, this is what you have.” Or, “This is what you’re dealing with. And this is how to deal with it. “... no one prior to that really said, you know, "This is what you have." They kind of just danced around it, and said, “Well, you might have it, you might not.” [Dad 6]

Several participants highlighted the importance of contact with a clinic specializing in women’s reproductive mental health. Access to such clinics was gained by referrals by the women themselves, a PHN, midwife, or family physician. Two of the participants noted that the referral to the clinic took place during the pregnancy in an effort to avoid probable escalation of symptoms, given their partner’s risk factors:

She was not on medication before the delivery but ... she felt her depression getting worse ... plus she was nervous of post-partum. So, she went to the ... the [specialty clinic] and ... asked to be put back on her Prozac ... We understood that there could be a chance of [PPD] ... so actually being with the social worker and ... therapist ... it actually gave us a tool or the tools to ... to see the signs and to regulate and to make sure that it doesn't go too far. [Dad 10]

Participants who were able to attend appointments with their partners at the specialty clinic found this to be a helpful experience because they received education about the nature of and treatment for PPD. Participants also expressed receiving validation of their concern for their partners and hearing that their PPD was not their partners' fault, or theirs. One participant reflected:

[The psychiatrist] told me it's because of the chemical imbalance that she's suffering from right now. It's ... not her fault. When she gets that way and she's ... says, you know, "I'm fine" or when ... when she's outright lying to your face because she doesn't want to tell you, that's not her doing that, that's the sickness doing that. When she gets up while you're talking and is blatantly rude, and goes and slams the bedroom door, and goes to lay down on the bed right in the middle of your conversation, that's not her doing that, that's the condition that's doing it. That's what wrong with her. That's why we have to fix this. So, he kept telling me it's not her fault. What she's doing and how she's treating you and everything that's happening right now is not her fault. You know? So, that kind of made me feel better about it because I thought she was just not caring about our relationship anymore. [Dad 7]

Some participants expressed disappointment in the support offered by health care providers, specifically some family doctors and psychiatrists. Complaints included not feeling heard, having difficulty making appointments, and having medication offered as the only option for treatment. One participant stated:

I think she went to one ... one meeting [at the specialty clinic]. And uh ... and that was really it. I guess she didn't find it too helpful and ... I think it was more of "Well, you should really be taking something." And it just wasn't the path we wanted to go down. [Dad 3]

In contrast, other participants described feeling heard and having their concerns validated by midwives, PHNs, social workers, and physicians. Practical help included suggestions of

strategies to promote maternal sleep, provision of supplies such as a baby wrap and a swing (through a Children's Aid Society worker), and free samples of medication to a family with no drug benefits. One participant emphasized the family-centred approach of the specialty clinic his wife attended, and noted he was able to get his own care needs met with their help:

With the [specialty clinic], not only ... were they helping [my partner] but they would help myself out because they didn't see [my partner] as ... as a pregnant mother, they saw us as a unit. So, I actually got a lot of help because with depression and OCD, it ... for... for um ... well, for anybody it's very, very, very hard to get to see ... in to see a psychiatrist ... unless you're willing to pay. So, they got me in to see a therapist, which they just ran through an orientation session. That was it. [Dad 10]

On my own

This sub-theme emerged when several participants stated that no assistance or information had been in place for them as fathers to ease their transition to parenthood and to assist them as partners of women with PPD. This was reflected in comments such as, "I don't really have anybody to talk to about any of this" [Dad 8] and, "Everything was focused on keeping [my wife] going. For supports for me there was nothing, no one." [Dad 7] Another participant explained:

There's nothing in place for ... for the dads. I know for me I felt very on my own this whole time ... 'Cause I don't want to burden my wife with, you know, how I'm feeling ... And again family just doesn't understand ... I feel that the dads are just kind of on their own – out of sight, out of mind. Kind of an afterthought of it all. [Dad 3]

One participant described his surprise at seeing a flyer for the researcher's study:

When I was at the hospital I saw all these flyers on the bulletin board about, you know, "Are you suffering from post-partum and have a child between 6 and 24 months old?" ... And they were all geared ... or they were all focusing on women and how women are dealing with these problems. And then the only one that I saw was your "First time father." And I thought, "Wow!" You know, I was surprised to see that because they always seem to, you know, offer a lot of things for the women, which I mean is true because they're the ones that have ... are going through the brunt of it, but at the same time... there's really no where for me to go. You know? There's nobody for me to call. [Dad 8]

What I wish had been in place

The interview guide did not have a question about what resources participants would like to have had, but several participants volunteered thoughts about wished-for supports as they responded to questions about supports and descriptions of how PPD had affected their roles as fathers. Suggestions included the possibility of additional time off without having to take vacation, access to a male counsellor who “thinks the way I do being just simply a male ...” [Dad 9], broadcasting of a public service announcement that says, “This affects guys too” [Dad 9], and availability of an online chat that fathers could access from work during their lunch hours. Another notion that emerged in these comments about desired resources was the need for information about PPD for family members and for the fathers themselves. Frustration was evident as one participant commented on his lack of knowledge:

I think that there should be something for guys. Like a ... like a toll free number or some kind of education that you can gain through this because when I ... Like, when I heard the word ... first heard the word “postpartum, “What’s that?” I hadn’t even heard of it before. And here I am a 40-year old man, and I had never heard of postpartum before. [Dad 8]

Another participant expressed his frustration with a book that was recommended, stating it offered him little hope. He suggested instead the potential usefulness of sharing stories about fathers surviving PPD:

Personally I didn’t get a lot out of that book. It was just, “Life will eventually get better.”...What you’re doing, I think, it actually has a lot of promise to it - to hear from dads who have gone through this to... just get a few more references rather than just “life will get better” because that ... I can get that out of a fortune cookie. I don’t need that ... I’d rather have it out of ... some tales like this to ... to hear how bad it was to know that eventually there ... there will some positive results at the end of it. [Dad 1]

CHAPTER 4: DISCUSSION

The purpose of this study was to explore the transition to parenthood for first-time fathers whose partners have postpartum depression (PPD). As the focus was on the effect of PPD on new fathers, broad characteristics of this process have been described and the intent of the study was not to develop a theory describing the transition process first-time fathers' experiences. As noted earlier in the review of the literature (Chapter 1), the transition to parenthood for first-time fathers is a complex process beginning during pregnancy and continuing after the child's birth. This transition is characterized by gradual mastery of the parenthood role and increased comfort with parenting behaviour manifest in infant care (Hudson et al., 2003). Men transitioning to fatherhood experience both moments of extreme joy, such as pride in the new baby and a stronger bond with the partner (Fägerskiöld, 2008; Premberg, Hellström, & Berg, 2008; Tammentie, Tarkka, Åstedt-Kurki, Paavilainen, & Laippala, 2004), and moments of alienation and discouragement, such as feeling overlooked in prenatal classes and not knowing how to respond to a crying infant (Deave & Johnson, 2008; Halle et al., 2008). Novice fathers also experience the pull of competing priorities: providing an income vs. staying at home with their new child (Chin et al., 2011; Henwood & Procter, 2003) and wanting to spend time exclusively with their partners but recognizing the precedence of infant care and its potential effect on the couple relationship, including stress, disagreements, and tension (Halle et al., 2008; St John et al., 2004). When considering the above literature, the fathers in the researcher's study seem, on the surface, to experience many facets of a typical transition to parenthood. The next section will explore the similarities and differences between this study and a metasynthesis of studies concerning transition to parenthood in the absence of PPD.

Comparison of Transitions to Parenthood

Chin and colleagues' (2011) metasynthesis of fathers' experiences of their transition to fatherhood identified three themes derived from a review of six qualitative studies published between 2002 and 2008. The overarching themes identified were: (1) emotional reactions to phases of transition: 'detached, surprise and confusion'; (2) identifying their role as father: the 'approachable provider'; and (3) redefining self and relationship with partner: the 'more united tag team.' The first theme encompasses the fathers' changing emotional reactions as they move through transition to parenthood: feeling like outsiders during prenatal classes, appointments, and the labour and delivery (Deave & Johnson, 2008; Draper, 2003; Premberg et al., 2008); excitement and amazement at the birth of their child (Deave & Johnson); and reflections on what the return to work meant for them as fathers. The second theme included: fathers' reflections on their own upbringing and their new fatherhood roles (Deave & Johnson; Fägerskiöld, 2008; and St John et al., 2005); a gradual decrease in anxiety regarding infant care over time (Deave & Johnson); and discussion of the importance of financially providing for their families (Premberg et al., 2008; St John et al.). The third theme refers to the fathers' changing sense of self and relationship with their partner following the child's birth. Fathers described an increasing sense of maturity and responsibility (Premberg et al.), and increased motivation to care for themselves and take less risks (St John et al.). Many fathers experienced positive changes in their relationship with their partner resulting in increased closeness (Fägerskiöld; Premberg et al.; St John et al.). For those fathers who experienced some conflict with their partners attributed to fatigue and the demands of the new infants, many developed strategies to reduce relationship tensions and were able to discuss concerns with their partners (Deave & Johnson; Fägerskiöld, 2008; St John et al.).

By comparing Chin and colleagues' (2011) common themes with those that emerged in this study, similarities and differences in the transition to parenthood for first-time fathers whose partners have PPD can be highlighted. In general, the participant fathers whose photographs and interviews formed the basis of this study's data analysis told stories of a gradual shifting in sense of self and responsibilities. See Table 2 for a summary of the comparison of themes.

Chin and colleagues' (2011) metasynthesis highlighted some challenges for fathers in achieving a work/life balance but also noted that fathers were able to negotiate different working hours and reprioritize activities. Unique to the researcher's study, however, were the fathers' struggles to balance home and work life responsibilities in the face of their PPD-afflicted partners' demands and needs for increased support. As noted in the findings, many of the fathers interviewed described extreme fatigue that affected their work performance. Some also noted negative consequences such as being passed over for promotions.

Chin and colleagues' (2011) second major theme found in the qualitative studies was "identifying their role as father: the 'approachable provider'". While the participants in the researcher's study reflected on their roles, no comments were made whereby they compared their fatherhood experiences to that of their own fathers. Also, perhaps as a result of the study participants having to "step up" and provide more infant care, the interviews did not contain references to decreasing anxiety about this ability over time, beyond becoming "more comfortable". In fact, this study described fathers having heightened involvement with their infants as a result of their partners' PPD. Fathers responded to the dysfunction in their homes by assuming many of the parenting duties and did not have the luxury of the fathers described in Chin and colleagues' metasynthesis who adopted a more playful role with their infants or viewed their partner as the primary caregiver (2011). However, the conscious consideration of the new

fatherhood role described by Chin and colleagues also was reflected in the researcher's study, in which study participants reflected on their roles as "providers" and what this now meant in view of the transition to parenthood:

Chin and colleagues' (2011) third and final theme described in their meta-synthesis was "refining self and relationship with partner: the 'more united tag team.'" Some participants in the researcher's study reflected on changes in their sense of self by showing a decrease in risk-taking (for example, Dad 4 saying he shouldn't go scuba diving). Participants in this study likewise reflected on changes and stress in the partner relationship that accompanied the transition to parenthood.

However, there was little sense of what Chin and colleagues (2011) described as the 'united tag team,' or positive changes in the couple relationship, and time spent talking with partners to decrease tension. For first-time fathers whose partners had PPD, the partner relationship was more often characterized by the mothers' irritability and avoidance of discussions of how to improve the relationship. As noted under the theme *PPD and the partner relationship* (sub-theme: *Walking on eggshells*) participants learned to tread carefully in their conversations with their partners and often avoided dialogue altogether rather than take the risk of saying something that might provoke a negative reaction. This finding about the partners' irritability and unpredictable reactions also was highlighted in a recent pilot study by Letourneau and colleagues (2011) on the support needs of fathers affected by PPD. In that study, one participant described his worry for his partner and relationship uncertainty: "...we would actually just walk around the house on eggshells wondering if (wife) is going to have one of these episodes and what is the effect going to be on her and on our little guy (DAD_08)." (Letourneau et al., p. 44)

To summarize, the findings of the researcher's study agreed with many of the aspects of the transition to parenthood noted in the literature and described in Chin and colleagues' (2011) metasynthesis. How the study described in this thesis differs, however, is in the participants' descriptions of the challenges in the couple relationship (*Walking on eggshells*), the increase in father involvement as a result of PPD (*PPD and the partner relationship*), and the reflections on desired and required support (*Available and desired support*). The effect of PPD on the transition to parenthood for fathers is not surprising given the impact PPD has on others within the immediate family: his partner and their infant. As stated in Genosini and Tallandini's literature review (2009) of men's psychological transition to fatherhood, variability in the transition to parenthood is dependent on the father's own personal characteristics and the quality of the relationship he has with his partner.

Table 2 Comparison of Themes Found in Transition to Parenthood Studies

Chin: Fathers' experiences of their transition to fatherhood: a metasynthesis	Siverns: Transition to Parenthood in First-time Fathers Whose Partners Have PPD
<p>Theme 1: Emotional reactions to phases of transition: 'detached, surprise and confusion'</p> <ul style="list-style-type: none"> • In pregnancy: distant, overlooked • At birth: amazement • Return to work: challenge with balance between home & work and occasional conflict with partner re: this; negotiating with employer 	<p>Themes: From two to three, Connecting with baby</p> <ul style="list-style-type: none"> • In pregnancy: not addressed • At birth: amazement • Return to work: challenge with balance between home & work and much conflict with partner re: this; overwhelmed with care of partner and not always able to negotiate with employer
<p>Theme 2: Identifying their role as father: the 'approachable provider'</p> <ul style="list-style-type: none"> • Conscious reflection of own upbringing • Decrease in feelings of anxiety as fathers gained confidence in their ability to provide infant care • Some fathers see mothers as primary caregiver • Perception that fathers are more playful and physically active with their infants than mothers are • Focus on providing income for family 	<p>Themes: From two to three, PPD and the partner relationship, Heightened involvement with baby</p> <ul style="list-style-type: none"> • Little reflection on own upbringing • Little time to reflect on anxiety re: providing infant care as fathers had to 'step up' • Fathers see themselves as joint or primary caregivers due to PPD • Physical activity with infants is compensation for mothers not doing this • Joint focus on providing income for family and providing infant care
<p>Theme 3: Redefining self and relationship with partner: the 'more united tag team'</p> <ul style="list-style-type: none"> • Increased sense of maturity • Redefined relationship with partners: 'more united', 'stronger' relationship post-birth • Fatigue causing irritability with infant and partner • Fathers developed strategies to help them cope with difficult emotions: taking turns with infant care ('tag team' approach), talking about concerns with partner 	<p>Themes: From two to three, PPD and the partner relationship, Heightened involvement with baby</p> <ul style="list-style-type: none"> • Increased sense of maturity • Redefined relationship with partners: "walking on eggshells" and "taking care of two people instead of one" post-birth • PPD causing partner to be irritable. Fathers' fatigue exacerbated by increased responsibility for infant care • Fathers developed strategies to help them cope with difficult emotions: taking charge with infant care and talking to other family members & co-workers, not partners
<p>Theme not addressed: available and desired supports</p>	<p>Theme: Available and Desired Supports</p> <ul style="list-style-type: none"> • Supports identified included family/friends, guys at work, and different professionals • Fathers shared about feelings of aloneness and what supports they wish had been in place

The changes in the couple relationship and increase in father involvement also are consistent with family systems theory, which posits that what affects one member of the family affects all, as relationships interactively and reflectively shape each other (Goodman, 2008). Bell and colleagues' 2007 study examining the interrelatedness of the mother-infant and father-infant relationships over the first 4 months postpartum found that the addition of a new family member tended to disrupt the existing dyadic family system (parent-parent) and create disorganization before the system reorganized into its new triadic form (parent-child-parent). In fact, early family relationships and parenting have been characterized as “messy processes” out of which a new family system evolves (Bell et al., p. 196).

Given that the transition to parenthood in couples *not* affected by mood disorders can be described as a “messy process”, it is little surprise that the researcher's interviews elicited responses from new fathers who described belligerent conversations (*walking on eggshells*) and frequent conflict with their PPD-afflicted partners. Clearly, the partner relationship was impacted by the unpredictability of the mothers' reactions and interactions as these women struggled through PPD. Indeed, commonly reported symptoms of PPD may include feelings of extreme anger, often directed at the partner, decreased libido and desire for physical contact with the partner, and fear of being rejected by the partner (Kowalenko, Barnett, Fowler, & Matthey, 2000), all of which were reported by study participants regarding their partners. Hence this study confirmed what is already known about PPD: that it can negatively impact the quality of the couple relationship (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006) and contribute to marital dysfunction (Boath et al., 1998; Meighan et al., 1999).

In describing the extent of their partners' PPD, study participants consciously or perhaps unconsciously revealed the trauma that being an observer of the emotional struggle entailed.

Comments collected in the sub-theme *Suffering when she suffers* reflected the anguish and helplessness that fathers endured in the face of their partners' suffering. There is a documented link between the experience of helplessness during a traumatic event and the later development of post traumatic stress disorder (Bedard-Gilligan, Zoellner, 2008; Brewin, Andrews, Rose, 2000; Roemer, Orsillo, Borkovec, & Litz, 1998) but to date no research exists linking the fathers' experiences of caring for their PPD-afflicted partners with later development of post traumatic stress disorder.

What also emerged in this study was the tenacity and resourcefulness of participant fathers as they learned new roles, coped with caring for their infants and partners, and secured social supports needed by the mothers of their infants. The sub-themes *Taking charge*, *Protecting baby*, and *Stepping up* highlighted learned strategies such as limiting access of unhelpful family members, taking the infant out when the mother couldn't, feeding the infant throughout the night, and taking over with infant care in the evening on arriving home from work. Dimensions of social support include instrumental (practical) assistance, information provision, and emotional understanding or empathy (Crnic, Greenberg, Ragozin, Robinson, & Basham, 1983). The learned strategies noted above are examples of instrumental assistance. Information was sought out by fathers on behalf of their depressed partners during visits to or by health care providers.

The emotional aspect of support offered by participant fathers to their depressed partners was not focused in one particular theme or sub-theme of the data but rather was woven throughout the data. In addition to listening to their partners, study participants learned to respond verbally or non-verbally to their partners' cues and to hold or feed their babies as the situation warranted. While some might state that these are examples of instrumental support, it

could be argued that the fathers' quick and focused response to their partners' distress showed attunement to their emotional needs. As noted in a study on couples' experiences of postnatal depression, it is critical for men to understand the way their partners feel as "initially women prefer emotional support to instrumental support, because this latter type of support may heighten their feelings of failure" (Everingham et al., 2005, p. 1754).

What Men Want: Fathers' Suggestions for Supports

Study participants provided several suggestions about preferred supports that they did not receive. What they wished for could be summarized as greater acknowledgement of the importance of their role prenatally and postpartum, more information to share with family members, and more opportunity to have their voices heard and stories shared. This desire for validation, information, and communication is growing as new fathers increasingly seek more opportunities to be involved in raising their children (Fletcher & StGeorge, 2011). Fathers in Letourneau and colleagues' (2011) pilot study on the support needs of fathers affected by PPD concurred, identifying the importance of access to information about PPD and professional health services, and especially important, "having someone who would listen" (p. 44).

Prenatal support

The new fathers in this study spoke of wanting clear messaging during prenatal classes about PPD and the father's role. This comment reflects the finding that antenatal education primarily focuses on the experiences and needs of women during labour and delivery (Deave & Johnson, 2008; Fägerskiöld, 2008; Premberg, Hellstrom, & Berg, 2008; Thomas, Boner, & Hildingsson, 2011) and that resources, images, and the language used in health education programs may be more appropriate for mothers (Bayley, Wallace, & Choudry, 2009). Men's initial experience during their transition to parenthood may be the awareness during pregnancy that parenting is a "woman's domain" within a gendered order (Eriksson & Salzman-Erikson,

2012, p. 2). Best Start's (2012) resource on engaging fathers in programs stresses that fathers must see a program as practical, goal-oriented, and valuable in order to want to be involved, and language needs to be direct and focus on the way in which families and fathers can benefit by taking part or learning a particular strategy.

Men supporting men

Other suggestions from fathers included the establishment of a toll-free number to call for information and support about PPD and male social workers to speak with. The desire for male counsellors, facilitators, and supports is noted in several studies of new fathers' needs (Bayley et al., 2009; Eriksson & Salzman-Erikson, 2011; Fägerskiöld, 2008; and Fletcher & StGeorge, 2011). Best Start's (2012) *Guide for Engaging Fathers in Programs* emphasizes the value of having male facilitators connect with dads, organize events, and represent fathering programs. Furthermore, "a male facilitator gives a common point of connection and encourages conversations on issues guys share" (Best Start, p. 26). Letourneau and colleagues' (2011) study also highlighted new fathers' desire for male support when impacted by their partner's PPD.

Use of social media

Some fathers in the study suggested that a media campaign and website highlighting the fathers' experiences when their partners have PPD, and an online chat forum where they could discuss their experiences and exchange ideas for coping with other men, would have been helpful as they struggled to support their partners. The Canadian Fatherhood Involvement Initiative (CFII) (www.cfii.ca) recognizes that fathers spend time accessing media such as radio, websites, and TV, and has as a result created a tool kit that describes how to promote services for fathers using different forms of media. It is estimated that one third of adults use social media to access health information (Neiger et al. 2012). Men and women are equally likely to use social

media for public health enquiries, post their own health experiences, or access posts by others (Hughes, 2010).

There is an increasing body of literature evaluating the use of the Internet and effectiveness of online chat forums as modes of obtaining support. Plantin and Daneback's (2009) literature review of research on parenthood, information, and Internet support noted that parents' online activities are driven by the need for more experience-based information and the ability to find and connect with others in similar circumstances. StGeorge and Fletcher (2011) stated that support for new fathers can occur in virtual spaces where fathers can informally share information, offer mutual encouragement, and validate each others' experiences. A recent analysis of communication about caring using an online forum for fathers noted that communicated support took the forms of encouragement, confirmation, and advice in an atmosphere characterized by openness, humour, and practicality (Eriksson & Salzman-Erikson, 2012).

Family leave

Nurses need to advocate for family leave time that includes the possibility of extra time off for fathers when the mother has PPD. One study participant said he would have welcomed the opportunity to take time off work without penalty in order to care for his family. The suggestions points to the need for legislation governing a form of family leave because it is unlikely individual businesses would want to assume the cost associated with such a leave.

Study Strengths and Limitations

Recruitment

The scope of this study is limited to first-time fathers whose partners were currently seeking help for PPD, and findings cannot be generalized to other populations. Limiting recruitment initially to finding the fathers via their partners attending PPD support groups proved

difficult for a number of reasons. Despite the posting of study information and provision of flyers, most fathers who were recruited were done so shortly after posters went up and individual practitioners spoke to the moms attending the group, who then relayed the information to their partners. When relationships between partners are characterized by conflict as they are in many families affected by PPD, group attendees may have been unwilling to pass on information about the study. Study recruitment increased when research ethics board approval was given to post information in a specialty reproductive mental health clinic and health care workers approached and informed couples directly about the study.

One of the study's strengths is the limitations set for inclusion criteria, which helped define the population and focus the data collection. Because the sample was focused, it enabled the researcher to quickly reach consensus on the key themes and aided achievement of data saturation. Several potential participants were excluded because it was not their first child or the child was older than 12 months of age. The age limit for the child was set in an effort to reduce the effect of recall bias as retrospective studies may be hampered by memory decay and selective recall, and this effect appears to increase the farther away one is from the event being recalled (Hatch et al., 1999).

Another possible barrier to recruitment is the stigma associated with mental illness, and particularly PPD (Davey et al., 2006; Everingham et al., 2005; Letourneau et al., 2010). The men in Meighan and colleagues' (1999) study described a tendency to suffer silently through their partners' illness for fear of the reaction of others. While potential participants may have noticed or been told of the study flyer, they may have chosen not to respond because doing so would also have forced them to acknowledge the extent of their partners' illness. This reluctance

to name the illness was alluded to by participants who reported that they were uncomfortable sharing their partners' diagnosis with others.

Use of photo-elicitation

While many of the fathers shared photographs, some were unable to specifically relate the pictures to their partners' PPD. Most of the photographs featured the fathers holding their infants as newborns and then pictures of the infants alone at various stages of development. While the pictures of older infants were often accompanied by expressions of pride on the part of fathers, there was not a clear link to what these pictures meant against the backdrop of their partners' PPD. This was a limitation of the photo-elicitation process and perhaps could have been overcome by providing more specific directions to study participants about which photographs to share.

However, there were several benefits to using photographs participants provided to enhance data collection. Firstly, the sharing of photographs allowed the researcher to step back from directing the interview and allow the participants the lead in constructing and talking about their stories of new fatherhood. As noted previously in the Methods chapter, this dynamic helped address the power imbalance typically present in an interview (Nunkoosing, 2005). Secondly, trustworthiness of data was enhanced with the opportunity for the researcher and participant to clarify meanings and “explore previously ‘taken for granted’ understandings held by both researcher and participants” (Mannay, 2010, p. 97).

Thirdly, the use of photo-elicitation enabled the researcher to further explore the participants' emerging sense of themselves as fathers (as noted in the theme *Connecting with Baby*) and their relationships with their partners (in the theme *PPD and the Partner Relationship*) by viewing and discussing the photographs with them. The photographs were

instrumental in the exploration of the fathers' transitions to parenthood and their emerging relationships with their infants, and for that reason alone contributed to the strength of this study.

Personal reflections on strengths and limitations as the interviewer

As a PHN working in Burlington, Ontario, interviewing families is something I have done frequently while completing assessments for the Healthy Babies, Healthy Children program. With the program emphasis on client-led goals and family service plans based on clients' needs and wants, I have practised listening carefully and asking questions to clarify a client's meaning. However, in analyzing and reviewing the early interview transcripts it became clear that I, as the researcher, struggled to stay solely within the researcher/data collector role. This occurred particularly when parents related challenges with breastfeeding or infant care; my tendency was to comment on successes that had occurred, revealing my immersion in the Baby Friendly Initiative in the local health unit, rather than exploring how this information related back to the experience of parenthood and PPD. In early interviews I also asked participants to elaborate on details of the birth and maternal postpartum adjustment rather than focusing on the father's perceptions – again revealing my clinical background in maternal/child health nursing. Another challenge was focusing on the study objectives when asked by participants to provide answers to questions about health information, a dilemma that many nurse-researchers face (Jack, 2008).

As the interviews progressed I improved in focusing on the study objectives, largely due to feedback from my committee members, reflexive journaling, and the process of interim data analysis. For example, my thesis supervisor suggested deferring requests from participants for health information until after the recorded interview was completed. The process of reflexive journaling encouraged me to reflect on lessons learned in the interviewing process as well as on

the interview content. Interim data analysis afforded the opportunity for further consideration of my interviewing expertise. In addition, preparation for the interviewer role by reviewing literature on qualitative research on sensitive topics (Cowles, 1988; Kavanaugh & Ayres, 1998) decreased my anxiety and contributed to my ability to set participants at ease and elicit detailed descriptions of their experiences.

Implications for Policy, Practice, and Education

Early screening for PPD

As study participants reflected on PPD and their role in supporting their partners, it became evident that the fathers wanted more information about the risk factors, symptoms, and treatment of PPD prior to their infant's birth, immediately post-birth, and later in the postpartum period. Fathers were specific about wanting knowledgeable health professionals (nurses, midwives, social workers, and physicians) to access, and education delivered via classes, pamphlets, and websites. The potential impact of PPD on the entire family highlights the need for early screening, diagnosis, and intervention of this disabling illness. McKay and colleagues (2009) described a family model for treating PPD, noting that early screening for PPD and involvement of the whole family system in the evaluation and treatment of maternal PPD are critical factors in the improvement of infant outcomes. A true family model system that takes into account the needs of all members would extend to include provision of appropriate support to each individual member, thereby preventing the likelihood of compromised health outcomes.

The EPDS has been validated for use in pregnancy (Murray & Cox, 1990) and could easily be self-administered by expectant women during routine prenatal appointments. Midwives Breedlove and Fryzelka (2011) noted that, compared to the cost treating of undiagnosed mental illness, screening for possible risk of depression in prenatal visits is straightforward and cost-efficient. Additionally, maternal care nurses could routinely administer

the EPDS prior to new mothers' hospital discharges and share this information (with consent) with the woman's family doctor and PHN (if she has consented to follow-up).

There is some discussion in the literature about whether or not targeted screening with the EPDS is preferred to universal screening. When the tool is used improperly, and unvalidated cut-off scores are used, the effect on the overall rate of PPD is substantial, resulting in inflated or deflated EPDS scores and an inaccurate reporting of the actual overall rate of probable depression in postnatal women (Matthey, Henshaw, Elliott, & Barnett, 2006). In contrast, Milgrom, Mendelson and Gemmel (211) stated that screening with the EPDS appears numerically worthwhile at a population level, given the relatively low number of false negative scores and its ability to correctly identify women at risk of PPD. However, they stressed that optimal use of the EPDS as a screening tool necessitates in-depth professional training such that those who administer the tool understand the purposes and limitations of the EPDS and how to accurately interpret and share its results. Given the current pressures to reduce health care spending at the local and provincial levels and the ongoing discussion favouring targeted screening, the researcher would like to see a broad-based screening program of all primiparas and those multiparas who display risk factors for developing PPD. Follow-up screening of those who originally score positive on the EPDS should then be incorporated into scheduled visits with a PHN, midwife, or physician. This form of two-stage screening has been discussed by Dennis (n.d.) as a possibility for mothers at risk of PPD.

Whether or not a hospital screen is performed, PHNs could screen women at risk in the community in order to establish the risk for PPD and implement secondary preventative measures (such as self-care strategies and family support). Dennis (2004) showed EPDS scores at 1 week postpartum were predictive of maternal mood at 4 and 8 weeks postpartum. Dennis

also noted administering the EPDS as an adjunct to routine clinical evaluation could significantly enhance the quality of care provided to new mothers. Screening using the EPDS could easily be incorporated into postpartum telephone calls or visits delivered by PHNs or midwives. Glavin and colleagues (2010) pragmatic trial of supportive counselling by PHNs of women with PPD showed that PHNs trained in identifying (screening using the EPDS at 6 weeks, 3 months, and 6 months) and providing supportive, non-directive counselling , were effective in treating postpartum depression (as measured by a statistically significant decrease in the EPDS score). The EPDS screening and counselling were incorporated into regularly scheduled follow-up appointments at the well-baby clinic, and the authors concluded that PHNs have the opportunities and skills to identify and treat PPD (Glavin, Smith, Sørum, & Ellefsen).

Screening for PPD also could be conducted during routine visits to pediatricians, by either the physicians or the nurses who have opportunities for frequent contact with new mothers (Meadows-Oliver, 2012). Obstetrician-gynecologists are in a unique position to incorporate psychological care of new mothers into their practice, given they have early and frequent contact with mothers in the early postpartum period (Leddy, Haaga, Gray, & Schulkin, 2011). In summary, it would be possible to integrate PPD screening using the EPDS into routine follow-up by PHNs, midwives, family physicians, pediatricians and obstetricians.

Letourneau and colleagues (2012) recommended a unique family-centred approach to the treatment of PPD whereby fathers and mothers are screened for PPD in an effort to improve diagnosis and treatment of an illness that impacts the entire family. A proposed decision tree shows mothers with a score of 12 or more on the EPDS entering a therapeutic process with the father, who also is screened for PPD (Letourneau et al.) A father's score of greater than 6 on the EPDS indicates a need for further follow-up (Matthey, Barnett, Kavanagh, & Howie, 2001) and

the administration of medication, psychotherapy, couple therapy, or parent/infant interaction guidance (Letourneau et al.) To date, this effectiveness of this model has not been evaluated.

Prenatal engagement of families

Nurses can engage fathers early in the transition to parenthood by requesting their presence at prenatal appointments, promoting attendance at prenatal classes, and tailoring prenatal education to their needs. For example, PHNs in Halton Region highlight the transition to parenthood in one class where expectant fathers and mothers are asked to meet separately and describe the changes that pregnancy has brought to their lives. This gives expectant fathers an opportunity to connect with each other and a chance to make their voices heard. The separate groups then come together and findings are shared before proceeding to a discussion of what to expect in the postpartum period and the impact on mothers and fathers. Many prenatal classes already highlight messages about the mood changes in pregnancy as well as following the birth of the infant; messages could be reinforced by inviting a couple that had lived through maternal PPD to speak to the class about their experiences. An additional anticipatory guidance strategy could be prenatal dissemination of a resource (paper or electronic) focusing on mental health promotion and caring for self in order to promote healthy postpartum outcomes for mother, father, and infant.

Postpartum engagement of families

Health professionals need to engage fathers early in the transition to parenthood by acknowledging their input at the bedside, and targeting teaching to them in postpartum home visits and classes. Collaboration between hospitals, midwives, and PHNs could result in a family systems-focused approach for families at risk that is inclusive of the needs of new mothers and fathers and delivers consistent messages and support. The quality and content of teaching materials need to be carefully reviewed in order to ensure an approach inclusive of fathers' needs

and desires for practical suggestions and access to electronic forms of support. For instance, an app for a cell phone might prove more useful than a pamphlet. Care providers also need to provide new fathers with flexible alternatives for delivery of information and support such as websites and chat forums, which may be easier for the fathers to access once they return to work following the baby's birth.

The language around the care of, and supports for, new parents tends to refer exclusively to mothers. Examples would be the terminology “Maternal Child Unit” and local online support group www.bamom.ca (Bay area mothers of multiples) – although the website for the latter indicates that it is a support group for parents of twin and triplets. (“About BAMOM, 2011). While this reflects the biological reality of the mother giving birth, education for emerging and experienced health professionals should stress the family systems approach where interventions are designed to target the needs of every member of the family. For instance, nursing students need to be exposed to the family systems theory and challenged to apply its principles to clinical situations, i.e. speaking with new fathers at the bedside or during postpartum visits. Assessment tools used in the community by physicians, PHNs, and social workers need to incorporate sections asking the fathers about their transition to parenthood.

Men supporting men

The stated desire for male support has interesting implications for the education of nurses and the policies that guide them, once in the workplace. For instance, are male nursing students encouraged to practise clinical rotations in what has traditionally been called “Maternal Child Health”? The researcher had a male nursing student observe as she did her public health liaison rounds in the hospital earlier this year and was interested to see how well the new fathers at the bedside responded to his presence and questions. Recently, McMaster University's Faculty of Health Sciences celebrated the graduation of the first male midwife from a midwifery program in

Canada (Dharmarajah, 2012). One can hope that his presence will encourage expectant and new fathers to ask about, and share regarding, their transition to parenthood.

Advocating for family leave

On a policy level, nurses need to advocate for family leave time that includes the possibility of extra time off for the father when the mother has PPD. One study participant said he would have welcomed the opportunity to take time off work without penalty in order to care for his family. This suggestion points towards the need for legislation governing a form of “family leave” as it is unlikely individual businesses would want to assume the cost associated with such a leave.

Considerations for future research

This study contributes to the current body of knowledge regarding families experiencing PPD by highlighting the experiences of the new fathers – their heightened involvement with their infants and coping strategies for adjusting to their partners’ shifting moods – and describing their experience of available and desired for supports.

Future research is required to address the needs of expectant families and families immediately post-birth as well as several weeks following the birth. With expectant families, research could address knowledge gaps regarding the appropriateness of targeted screening for expectant fathers as well as mothers, and the effectiveness of prenatal messaging in encouraging parents experiencing PPD to access supports following the infant’s birth. Research for the immediate post-birth time frame could evaluate the effect of consistent, concise, and timely screening for mental health risks for both partners and links to community follow-up via office/clinic visits or public health home visits. Research on postpartum support needs of new families, and in particular new fathers, could focus on the design and evaluation of electronic peer support forums, websites, and face-to-face groups. Recent research has shown a positive

response to peer support delivered via telephone to new mothers with PPD (Dennis, 2010); a pilot of the effectiveness of a similar program delivered to men supporting their partners might also be considered.

Future research could also focus on some aspects of the impact of PPD on the transition to fatherhood not addressed by this study. For instance, are partners of women with PPD more fatigued than other new fathers given their heightened involvement with their infants and attempts to ensure adequate sleep for the mothers? Does this impact their transition to parenthood? Given the relatively homogenous nature of the study sample with respect to race, would expanding recruitment to include a more ethnically diverse population change the findings?

CONCLUSION

The transition to parenthood is a complex process for new fathers regardless of the emotional health of their partners. This study considered the transition to parenthood for first-time fathers whose partners had PPD. These fathers' experiences of parenthood were particularly impacted by challenges in the couple relationship, increased involvement with their infants, and the limited availability of supports for their families and themselves. When a family systems approach to working with postpartum families is applied, it is apparent that strategies to support the woman suffering from PPD must include her partner in order to improve outcomes for all family members. Approaches to working with families experiencing PPD need to include prenatal education about mood disorders, consideration of the fathers' questions and needs prior to, during, and following the birth of their infants, and postpartum support for fathers delivered in a mode they are likely to access, whether that be by telephone, in person, or via the Internet. While the study findings provide direction for the practice of nurses and other health professionals, future research is needed to address the effectiveness of having PPD support delivered to fathers by a male health care provider, the design and evaluation of a media campaign on PPD targeting the information and support needs of partners, the delivery of support to partners using the internet (website, blogs, and chat forum), and establishment of best practice approaches to engaging fathers at every step of the transition to parenthood.

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APPENDICES

Appendix A: Database Search Strategies

The following search terms were used to search CINAHL:

1. Depression TX All Text plus published date Jan 1990 to June 2012
2. Postnatal Depression TX All Text plus published date Jan 1990 to June 2012
3. Postpartum Depression TX All Text plus published date Jan 1990 to June 2012
4. Transition to Parenthood TX ALL Text plus published date Jan 1990 to June 2012
5. Fathers TX ALL Text plus published date Jan 1990 to June 2012
6. Search Mode Boolean/Phrase
7. 1 plus 4 plus 5
8. 2 plus 4 plus 5
9. 3 plus 4 plus 5

The following search terms were used to search Pubmed:

Date – Publication 1990/01/01 to 2012/06/30 and

1. (postpartum depression[Title/Abstract]) AND fathers[Title/Abstract]
2. (postpartum depression[Title/Abstract]) AND fathers[Title/Abstract] AND mothers [Title/Abstract]
3. (postpartum depression[Title/Abstract]) AND mothers [Title/Abstract]
4. (paternal depression[Title/Abstract]) AND fathers[Title/Abstract]
5. (first-time fathers[Title/Abstract])
6. (first-time fathers[Title/Abstract]) AND postpartum depression [Title/Abstract]
7. (first-time fathers[Title/Abstract]) AND paternal support[Title/Abstract]
8. (paternal depression[Title/Abstract] AND family support[Title/Abstract]
9. (paternal depression[Title/Abstract] AND paternal support[Title/Abstract]
10. (postpartum depression[Title/Abstract] AND mothers [Title/Abstract]
11. (postpartum depression[Title/Abstract] AND mothers [Title/Abstract] AND family support [Title/Abstract]
12. postnatal depression[Title/Abstract]) AND fathers[Title/Abstract]
13. postnatal depression[Title/Abstract]) AND family support [Title/Abstract]
14. postnatal depression[Title/Abstract]) AND paternal support[Title/Abstract]
15. transition to parenthood[Title/Abstract]) AND postpartum depression [Title/Abstract]
16. transition to parenthood[Title/Abstract]) AND postpartum depression [Title/Abstract] AND fathers[Title/Abstract]
17. transition to parenthood[Title/Abstract]) AND postpartum depression [Title/Abstract] AND paternal support

The following search terms were used to search OVID:

Embase 1988 to 2012 Week 26 AND Ovid MEDLINE(R) 1988 to 1995 AND PsychINFO 1987 to June Week 4 2012 AND

1. postpartum depression AND fathers
2. postnatal depression AND fathers

3. postpartum depression AND fathers AND family support
4. postpartum depression AND fathers AND paternal support
5. first-time fathers AND postpartum depression AND family support
6. first-time fathers AND transition to parenthood
7. first-time fathers AND transition to parenthood and family support
8. first-time fathers AND transition to parenthood and paternal support

Appendix B: Study Recruitment Flyer

Have you recently become a father for the first time?



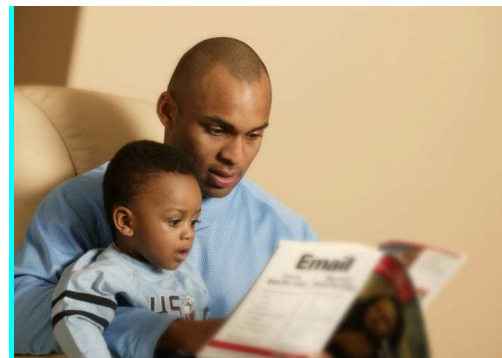
Does your partner have postpartum depression ?

If so, I would like to talk to you. I am a graduate student from McMaster University. I want to know more about your experience as a father whose partner has postpartum depression.

Your experience is valuable, and will help health professionals design resources that will help the whole family. Please contact me, Janet Siverns, at:

sivemjb@mcmaster.ca, or
905-966-3364

Receive a \$20.00 Tim Hortons gift card if you take part in this study and complete an interview.



Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression Study

Appendix C: Recruitment Flyer with Tear-off Contact

Have you recently become a father for the first time?



Does your partner have postpartum depression ?

If so, I would like to talk to you. I am a graduate student from McMaster University. I want to know more about your experience as a father whose partner has postpartum depression.

Your experience is valuable, and will help health professionals design resources that will help the whole family. Please contact me, Janet Siverns, at: sivernjb@mcmaster.ca, or 905-966-3364

Receive a \$20.00 Tim Hortons gift card if you take part in this study and complete an interview.

Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression Study



First-time Fathers Study
sivernjb@mcmaster.ca
905-966-3364

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905-966-3364

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905-966-3364

First-time Fathers Study
sivernjb@mcmaster.ca
905-966-3364

Appendix D: Screening Telephone Tool Script



Transitions to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression

TELEPHONE SCREENING TOOLSCRIPT

Hello, my name is Janet Siverns and I am a graduate student recruiting first-time fathers for my study, *The Transition to Parenthood for First-time Fathers whose Partners have Postpartum Depression*. Thank you for calling for information about my study. I am doing this study to find out about ways to support fathers whose partners have postpartum depression.

How did you find out about this study?

Are you interested in learning more about the study?

If **no**: *"Thank you for your interest."*

If **yes**: *"Before I arrange a time to obtain your informed consent and do the interview, I need to ask you a few questions to see if you qualify to participate. This will only take only a few minutes."*

1. Partner of a Woman who has Postpartum Depression

"Does your partner have postpartum depression?"

- Yes: (go to Question #2)
- No: *"I am sorry, but I need to speak with fathers whose partners have postpartum depression. Thank you very much for your interest."*

2. Child is Less than 12 months of Age

"Is your child less than 12 months old?"

- Yes (go to Question #3)
- No: *"I am sorry, but I need to speak with fathers whose child or children are less than 12 months old. Thank you very much for your interest."*

3. Father is Age 20 years of age or older

"Are you 20 years of age or older?"

- Yes (go to Question #4)
- No: *"I am sorry, but I need to speak with father whose age is at least 20 years. Thank you very much for your interest."*

4. Ensuring Variation in Demographics for the Study Sample

“I need to ask you a few further questions as I hope to have fathers of varying backgrounds represented in my study. This should only take a few minutes.”

1. What is your age? Years

2. What is your highest level of formal education?
 - Elementary school or less
 - Some high school
 - Completed high school
 - Some community college or technical school
 - Completed community college or technical school
 - Some university
 - Completed bachelor's degree
 - Graduate degree

3. Has your partner required treatment for her postpartum depression in addition to the support group, such as medication, counselling, or hospitalization?
 - Yes _____
 - No _____

4. Have you had to take time off work in order to support your partner and manage your household?
 - Yes _____
 - No _____

5. Have other family members been involved in supporting your partner and managing your household?
 - Yes _____
 - No _____

Conclusion for Eligible Participant

Thank you very much for taking the time to go through these few questions with me. Based on what you have said, you are eligible to participate in my study. Please provide me with your email address so that I can send you an interview confirmation reminder before your interview takes place.

Email Address: _____

Please bring to the interview 4-6 photographs showing your day-to-day life as a father whose partner has postpartum depression. In order to protect your privacy, I will use Paint.net software to obscure your face or the faces of friends and family members in the photograph. I will send you an example by email so that you can see what an altered photograph with a face obscured looks like.

Appendix E: Email Confirmation of Interview

EMAIL CONFIRMATION OF INTERVIEW TO STUDY PARTICIPANTS

Dear (Name of Participant),

Thank you for agreeing to take part in an interview for my study, ***Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression***. As I mentioned when we talked on the phone, I would like you to bring about four to six photographs with you to the interview, showing your day-to-day life being a father with a partner who has postpartum depression. If these are digital photographs, please bring them on your camera, cell phone, or a memory stick so that I can transfer them to my laptop and we can review them together. If you have a print copy of a photograph, I will take a picture of it with my camera and you will be able to keep your original copy.

In order to protect your privacy, I will use Paint.net software to obscure your face or the faces of friends and family members in the photograph. Here is an example:



The interview will take about 1 1/4 to 1 1/2 hours. You will also be asked to complete a questionnaire with some background information. Your privacy is assured.

I look forward to meeting with you on (day, date) at (time) at (location). Please contact me at 905-966-3364 if you have any questions or will be unable to make your interview.

Regards,

Janet Siverns, MSc Student
McMaster University School of Nursing
Hamilton, Ontario

Appendix F: Interview Guide



Transitions to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression

INTERVIEW GUIDE

1. What has it been like for you to become a father?
 - What's the same as it was when you and your partner were a couple?
 - What's different from when you and your partner were (just) a couple?
2. Tell me about these photographs that you brought with you today.
3. What has been the best thing for you about becoming a father?
4. What has been the most difficult thing for you about becoming a father?
5. How has (your partner's) postpartum depression affected your role as a father?
6. If you have struggled in your role as a father as a result of your partner's postpartum depression: Tell me about any support you have had in dealing with postpartum depression in your family
 - Support from your *partner*? (*emotional* support such as listening, encouragement; *practical* support such as demonstrating aspects of baby care she wants help with)
 - Support from *health professionals* such as doctors, midwives, public health nurses? (answers to questions, listening, encouragement, ability to make appointments or referrals, willingness to prescribe medication or recommend treatment)
 - Support from other *family members*? (listening, encouragement; help with baby care, groceries, meals, errands, costs, transportation to appointments, keeping your partner company when you are at work)
 - Support from *co-workers or friends*? (*emotional or practical*)
7. If you have not struggled in your role as a father: Why do you think you have been able to cope well with becoming a father when you have also had to deal with a partner who has postpartum depression?
8. Is there anything else that you would like to share with me about your experience of becoming a father?

Appendix G: Background Demographic Questionnaire

Study ID:

Transition to Parenthood for First-Time Fathers Whose Partners Have Postpartum Depression Study

Background Questionnaire

Thank you for agreeing to participate in this study of the transition to parenthood.

Remember, all information you provide will be kept confidential.

1. What is your age? years
2. How old is your child? months

You have been chosen to participate in this study because (1) you are a first-time father, and (2) your partner has postpartum depression. The next few questions relate to your partner.

3. Has your partner been diagnosed with postpartum depression by a physician?
- Yes
 - No
 - Not sure
4. Some women with postpartum depression receive treatment. Is your partner taking part in any of the following?
(Check ALL that apply)
- Counseling
 - Medication
 - Support Group
 - Light therapy
 - Hospitalization
 - Other (please describe)
 - _____
 - Not sure if my partner is receiving treatment

The next set of questions asks about you and your family and will allow us to describe as a group the fathers who participated in our study. Please remember that your answers will be kept confidential and will only be used to describe, as a whole, the men who participated in this study.

5. What language do you speak *most often* at home?
(Check ONE)
- | | |
|---------------------------------|------------------------------------------|
| <input type="radio"/> English | <input type="radio"/> Persian (Farsi) |
| <input type="radio"/> French | <input type="radio"/> Polish |
| <input type="radio"/> Arabic | <input type="radio"/> Portuguese |
| <input type="radio"/> Chinese | <input type="radio"/> Punjabi |
| <input type="radio"/> Cree | <input type="radio"/> Spanish |
| <input type="radio"/> German | <input type="radio"/> Tagalog (Filipino) |
| <input type="radio"/> Greek | <input type="radio"/> Ukrainian |
| <input type="radio"/> Hungarian | <input type="radio"/> Vietnamese |
| <input type="radio"/> Italian | <input type="radio"/> Korean |
| <input type="radio"/> Other | |
- Describe: _____

6. Which of the following best describes your racial background?
(Check ONE)

- Aboriginal (Inuit, Métis, First Nations)
- Arab/West Asian (e.g., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- Black (e.g., African, Haitian, Jamaican, Somali)
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
- South East Asian (e.g., Cambodian, Indonesian)
- White (Caucasian)
- Other

Describe: _____

7. The ancestors of Canadians come from many ethnic and cultural groups. Which ethnic or cultural group do you *most* identify with as reflecting your heritage?

(Check ONE)

- | | |
|---------------------------------|-------------------------------------|
| <input type="radio"/> Canadian | <input type="radio"/> Jewish |
| <input type="radio"/> French | <input type="radio"/> Polish |
| <input type="radio"/> English | <input type="radio"/> Portuguese |
| <input type="radio"/> German | <input type="radio"/> South Asian |
| <input type="radio"/> Scottish | <input type="radio"/> Black |
| <input type="radio"/> Irish | <input type="radio"/> First Nations |
| <input type="radio"/> Italian | <input type="radio"/> Métis |
| <input type="radio"/> Ukrainian | <input type="radio"/> Inuit/Eskimo |
| <input type="radio"/> Chinese | <input type="radio"/> Other |

Describe: _____

8. Were you born in Canada?
(Check ONE)

- Yes (go to question 11)
- No (go to next question)

9. What is your country of origin? _____

10. How long have you lived in Canada? years

11. What is your marital status?
(Check ONE)
- Married
 - Separated
 - Common-Law
 - Living with a partner
 - Single (never married)
12. What is your *best estimate* of the total income, before taxes and deductions, of *all* household members from all sources in the past 12 months? (check ONE)
- No income
 - Under \$10 000
 - \$10 000 - \$19 999
 - \$20 000 - \$29 999
 - \$30 000 - \$39 999
 - \$40 000 - \$49 999
 - \$50 000 - \$59 999
 - \$60 000 - \$79 999
 - Over \$80 000
13. What is your *highest* level of education? (check ONE)
- Elementary school or less
 - Some high school
 - Completed high school
 - Some community college or technical school
 - Completed community college or technical school
 - Some university
 - Completed bachelor's degree
 - Graduate degree

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Please provide your contact information so that I may (1) contact you to ensure I have accurately recorded your comments in the interview, and (2) share with you a copy of the study results once the study has been completed.

Name: _____

Address: _____

Email address: _____

Telephone number: _____

Thank you for taking the time to fill in this questionnaire.

Appendix H: Participant Information Form



PARTICIPANT INFORMATION SHEET

Title of Study: Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression

Principal Investigator: Janet Siverns, MSc student

Faculty Supervisor: Dr. Wendy Sword, RN PhD, McMaster University

Funding: RNFOO (Registered Nurses' Foundation of Ontario)

You are being invited to participate in a study conducted by Janet Siverns, a graduate student in the School of Nursing at McMaster University. In order to decide whether or not you want to be a part of this study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the study and who to contact if you would like to take part.

WHY IS THIS RESEARCH BEING DONE?

This study is being done because we know little about the experiences of new fathers whose partners have postpartum depression. This information will help guide the development of services and supports for partners of women with postpartum depression.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to learn more about the experiences and needs of new fathers whose partners have postpartum depression. Also, this study will explore access to, expectations and experiences of, health services and supports by these same fathers.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you agree to take part in this study, I will ask you to do the following things:

- Share with me four to six photographs showing your life as a father whose partner has postpartum depression
- Talk with me in a face-to-face interview for 1 ¼ to 1 ½ hours about your experiences of being a new father when your partner has postpartum depression
- Complete a brief background questionnaire before the interview
- Complete a second brief interview so that the researcher can check that she has accurately recorded my comments

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

There are no known risks to you if you take part in this study. You may become uncomfortable when you are describing your experiences as a new father. You will be given information about postpartum depression resources in your area.

HOW MANY PEOPLE WILL BE IN THIS STUDY?

Fifteen to twenty fathers will be interviewed.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

I cannot promise any personal benefits to you from your participation in this study. However, your participation may help other fathers in the future. The findings will provide important information to people who care for fathers and families where the mother has postpartum depression.

IF I DO NOT WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

It is important for you to know that you can choose not to take part in this study. If you decide not to participate, this decision will in no way affect the care or services you receive.

WHAT INFORMATION WILL BE KEPT PRIVATE?

Your participation in the study will be kept confidential. Your information will not be shared with anyone. All personal information such as your name, address, and telephone number will be removed from the data and will be replaced with a study number. A list linking the number with your name will be kept in a secure place, separate from your file. When the results of the study are published or presented at conferences, your name will never be used. Your identity will be anonymous and there will be no way that you can be identified.

However, if information provided during the interview indicates that a child has experienced harm or is at risk of harm, I must report these concerns to the local branch of the Children's Aid Society. This is a requirement for all health professionals.

I will use Paint.NET to obscure features of the photographs (i.e. faces) to ensure that the photographs do not allow you or your family to be identified. You will have the chance to see the altered photographs before they are used. You may choose to leave the photographs intact if you feel that obscuring some features such as facial expressions would take away from the story told by the photographs. At no time will the location or names of persons in the photographs be revealed.

CAN PARTICIPATION IN THE STUDY END EARLY?

Yes, however any information you have provided can be used in the study. You may decide at any time that you do not want to be in the study. If you withdraw from the study, this will in no way affect services you receive. You also may refuse to answer any questions you don't want to answer and still remain in the study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

Completion of the background questionnaire and interview is entirely voluntary and you will receive a token of appreciation for taking part – a \$20.00 Tim Hortons gift card.

WILL THERE BE ANY COSTS?

Your participation in the study will not involve any additional costs to you.

IF I HAVE ANY QUESTION OR PROBLEMS WHOM CAN I CALL?

If you have any questions about the research now or later, please contact Janet Siverns at 905-966-3364, or the Faculty Supervisor, Dr. Wendy Sword, at 905-525-9140 ext 22307.

If you have any questions regarding your rights as a study participant, or about the way the study is conducted, please contact: The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them.

Appendix I: Consent to Participate in Interview



CONSENT TO PARTICIPATE IN AN INTERVIEW

I understand that Janet Siverns, a graduate student in the School of Nursing, McMaster University, is asking me to take part in an interview as part of the study ***Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression***. The purpose of this study is to (1) learn more about the experiences of new fathers whose partners have postpartum depression, and (2) learn about what these fathers expect and experience when they use health services and supports. I have received and read a copy of the Participant Information Sheet. I have had the chance to ask questions and get answers to all my questions.

I understand that:

- I will be asked questions about becoming a father and how my partner's postpartum depression may affect this
- I also will be asked about my experiences and expectations when I use health services and supports for new fathers whose partners have postpartum depression
- The interview will take 1 ¼ to 1 ½ hours
- The interview will be digitally recorded and then transcribed (written out) with all identifying information removed
- I can ask to review my digital recording
- The digital recording will be downloaded to a secure computer that is password protected and assigned a study ID number; the digital file also will be password protected
- The saved digital file and transcription will be destroyed after 5 years
- Reports of the study may include quotes from the interview
- My answers will be anonymous and my name will not appear in any study reports
- My participation in the study is entirely voluntary
- Even after I agree to take part, and the interview begins, I can refuse to answer any specific question or withdraw from the study
- If I do not want to answer a question or stop participating, this will not affect any services that I might receive
- I will be given a \$20.00 Tim Hortons gift card for my participation in the interview

If I have any questions about the study, I can contact Janet Siverns at 905-966-3364.



CONSENT TO PARTICIPATE IN AN INTERVIEW

I fully understand the nature of this study entitled *Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression* and agree to take part in the interview. I understand that I will receive a signed copy of this form.

Name of Participant

Signature of Participant

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.

Name, Role in Study

Signature

Date

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013

Appendix J: Consent to Photograph Use



CONSENT TO ALLOW FUTURE USE OF PHOTOGRAPHS

I understand that Janet Siverns, a graduate student in the School of Nursing, McMaster University, is asking me to share photographs during an interview as part of the study ***Transition to Parenthood for First-Time Fathers Whose Partners have Postpartum Depression.*** The purpose of this study is to (1) learn more about the experiences of new fathers whose partners have postpartum depression, and (2) learn about what these fathers expect and experience when they use health services and supports. I have received and read a copy of the Participant Information Sheet. I have had the chance to ask questions and get answers to all my questions.

I understand that:

- I have provided four to six photographs showing my day-to-day life as a father whose partner has postpartum depression
- These photographs may be used by the researcher in a publication or presentation in the future

I consent to the use of my photographs in future publications or presentations by the researcher.

- Yes
- Yes, with faces obscured using Paint.NET software so that I and/or my friends and family members cannot be identified
- No

Name of Participant

Signature of Participant

Date

Person obtaining consent:

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.