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What Postpartum Depression Looks Like For Men: A Phenomenological Study

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Abstract

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BS Psychology, University of Laverne, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Postpartum depression (PPD) has been identified as a mental health condition that impacts women, men, and families. PPD has been shown to be prevalent in both women and men following the birth of a child; it has been associated with marital conflict, insecure attachment, and poor infant-child outcomes. While PPD has been studied extensively in women, paternal PPD often goes understudied, undetected, and untreated. The purpose of the present research was to explore the lived experiences of men who have experienced PPD through the lens of self-perception theory using a qualitative phenomenological study. Six men who have experienced PPD shared their lived experiences with PPD, including how they recognized they had a problem and what alerted them to get help. Data were analyzed using coding and the development of themes; the findings for this study showed that men's lived experiences with PPD included feelings of sadness, anger, fear, confusion, and being in denial. The men tended to not seek help for their experiences of PPD, and they were not previously informed about the disorder of paternal PPD. The present study provides a better understanding of PPD for fathers, information for healthcare providers who deal with expectant fathers, and significant others such as mothers of the child, and other family members and coworkers regarding how to respond to paternal PPD. Better understanding of PPD will provide fathers with more of the support they need to successfully make the journey through PPD.

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Dedication

This dissertation is dedicated first to God and then to my family who has sacrificed so much to allow me to spend the time that it took me to complete my dissertation. Your support and encouragement kept me going when I wondered if I should retreat. I extend much love and appreciation to George (my husband), Nakeda and Mustafa (my daughter and son-in-law), Jaharah (my son), Califa, Medina, and Nubia (my granddaughters) for being there for me. Also, I want to give a shout out to the many significant others who supported me along the long way to the completion of my dissertation.

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Chapter 1: Introduction

Paternal postpartum depression (PPD) is a psychological disorder that affects a significant number of new and expectant fathers, with a prevalence rate ranging from 12% to 25% (Da Costa, Zelkowitz, Dasgupta, & Sewitch 2017; Melrose, 2010). Paternal PPD is almost as common as maternal PPD (Ekin, Nuray, & Serka, 2016; Underwood, Waldie, & Peterson, 2017), although significantly less research exists on it. The purpose of this study was to gain a better understanding of what PPD looks like for men. Furthermore, the purpose was to understand their lived experiences and what alerted them to seek help.

Based on past and current literature, there is a gap in research regarding how men experience PPD. New and expectant fathers suffer paternal PPD, yet there is a lack of noteworthy insight regarding the etiology and experiences of paternal PPD. Paternal and maternal postpartum symptoms can present as anxiety and depression from early pregnancy to one year after delivery of the baby (Don & Mickelson, 2012). When depression in men during the postpartum period is addressed, it is commonly viewed as being related to the impact of maternal PPD on paternal PPD and not as a separate issue (Beestin, Hugh-Jones, & Gough, 2014).

Research on how PPD manifests for men as elaborated by men who have suffered PPD could close a gap in understanding as to how to treat the disorder. Even though there is a correlation between maternal and paternal PPD and a cumulative risk for children with two depressed parents (Paulson & Bazemore, 2010), research on father experiences

is scarce. Additionally, information gained from the study could help develop criteria for diagnosing paternal PPD.

Background of the Study

One area of interest for many researchers and clinicians is depression that occurs immediately after pregnancy, which is referred to as PPD. This area of interest stems not only from the suffering of the individual but also the impact PPD can have on an infant's development (Kumar, Oliffe, & Kelly, 2018; Paulson & Bazemore, 2010).

PPD, also known as postnatal depression, refers to clinical depression after childbirth (Paulson, 2010). It affects both men and women; however, it is more frequently noted in women (Paulson, 2010). Prevalence rates among women have ranged from 5% to 25%, but Paulson (2010) asserted that methodological differences among the studies make the actual prevalence rate unknown. Further, the prevalence of PPD in men has been estimated to be between 1.2% and 25.5% (Paulson, 2010).

PPD is a complex illness that occurs in the first few months after childbirth (Courtenay, 2008; de Bellefonds, 2018). In more advanced cases of PPD, there are marked feelings of sadness, inactivity, difficulty in thinking and concentration, and feelings of dejection (Courtenay, 2008; de Bellefonds, 2018). PPD is serious and does not get better without treatment (Paulson, 2010). PPD has a negative impact on the individual, family, and particularly infant attachment (Courtenay, 2008; de Bellefonds, 2018).

Since PPD has had a relatively short history as a recognizable disorder, it is still not clear how men experience PPD or what causes paternal PPD (Courtenay, 2008; de Bellefonds, 2018). Men have always experienced PPD, but did not recognize the disorder existed (Courtenay, 2008; de Bellefonds, 2018). Researchers, therefore, lack a history of classic symptoms to evaluate (Courtenay, 2008; de Bellefonds, 2018). When new fathers have a history of poor parenting or social skills and depressive mood disorder, and the mother is experiencing PPD, the risk for developing paternal PPD in the first year after the birth of the child is increased (Paulson, 2010).

Men experiencing PPD report barriers such as not knowing where to look for resources and not understanding the signs and symptoms of their depression well enough to justify their complaints (Courtenay, 2012). Specifically, low levels of social support, especially within the marriage, present as a barrier when men suffer PPD. These barriers pose a significant negative influence on men's likelihood to seek help (Courtenay, 2012). In addition, men who experience marital discord pertaining to a partner's depression show a higher incidence of distancing themselves from the partner and baby as well (Tach, Mincey, & Edin, 2010). The characteristics of paternal PPD may be prolonged and intensify as the father is aware of his lack of feeling proud and accomplished as an expectant or a new parent (Tach et al., 2010).

Low levels of testosterone predispose men to paternal PPD (Irwig, 2015). During their partner's pregnancy, testosterone levels drop, risking of depressive moods for the father (Irwig, 2015). For men, testosterone levels ranging from 300-1,200 nanograms per

deciliter (ng/dl) are normal (Irwig, 2015). Men with low testosterone levels are at high risk of developing depression (Irwig, 2015).

There is a shortage of self-reports from men to evaluate how postpartum depression is experienced by men. Current literature tends to evaluate paternal PPD based on maternal reports or external displays of behavior demonstrated by men as a guide to explain their lived experiences. However, this research sought to understand men's lived experiences separate from other considerations such as maternal reports or external behavioral displays of men's behavior as a guide to explain lived experiences of men.

Men experiencing PPD after the birth of their children tend to decrease their involvement with their partner and family, making it difficult to serve as a parent or a partner (Da Costa, Zelkowitz, Sewitch, Lowenstein, Cruz, Hennengan, & Khalife, 2017; Johnson & Jacob, 2000; Papp, Goeke-Morey & Cummings, 2007). Additionally, men experiencing PPD after the birth of their children tend to have increased feelings of unexplained anxiety and fear (Walters, 2013).

PPD has a higher prevalence rate in American men than other nationalities (Meighan, Davis, Thomas, & Doppleman, 1999). Courtenay (2012) suggested that American men live in a society where they believe that complaining is a sign of weakness. Also, American men are not as likely to seek help as men from other countries, which is related to their cultural upbringing (Courtenay, 2012).

Couvade syndrome is a type of paternal PPD where men unconsciously try to understand and assist in the experience of their partner's pregnancy (Brennan, Marshall-

Lucette, Ayers, & Ahmed, 2007). Men's lived experiences of couvade syndrome were similar to those experiences reported by their pregnant partners (Brennan et al., 2007). Men and their pregnant partners reported signs and symptoms such as nausea and vomiting, abdominal pain, headaches, craving certain foods, and disliking certain foods (Brennan et al., 2007).

The effects of paternal PPD are linked to an increase in the occurrence of psychopathology and behavioral problems in children (Beck, 2008). It is associated with disrupted infant attachment to both parents, as well as spouse/partner conflict. The impact of depression does not remain isolated to the one suffering but can affect the entire family system (Goodman, 2004; Kumar, Oliffe, & Kelly, 2018). To this end, a study designed to learn what PPD looks like for men would be a worthy addition to the literature.

Problem Statement

Paternal PPD is a legitimate diagnosis with a postpartum onset and is more prone to develop when maternal PPD exists as well (DSM-5, 2013). PPD in men is related to marital discord, history of mood disorders, deficits in information, and education and hormonal changes (Courtenay, 2008; Goodman, 2004; Roberts et al., 2016). Adverse family outcomes such as negative impact on family health and negative effects on child outcomes exist when a father suffers from PPD (Courtenay, 2012; Melrose 2010). While some research on PPD on men does exist, the majority of research on PPD centers on how women experience depression and the effects of maternal PPD on family structure,

child development, and social interactions of the family (Courtenay, 2012). Though paternal PPD has been recognized for years, related literature is still scarce.

Expectant new fathers find it difficult to seek help for their PPD due to their desire to be self-reliant as well as lack of knowledge regarding paternal PPD (Courtenay, 2012). PPD lacks specific criteria or a standard language as an aid to help voice what PPD looks like for men, and therefore, men may be unable to identify it within themselves (Matijasevich, Munhoz, & Barbosa, 2014). Even though there has been an increasing interest in the prevalence of paternal PPD and the way it impacts partners and infants' lives, studies of men's lived experience are uncommon, thus leaving a gap in knowledge of what the experience of PPD looks like for men.

PPD depression is a serious mental health condition affecting approximately 10% of new fathers (Paulson & Bazemore, 2010). While it is related to several adverse outcomes for the family, little is known about a father's experience of PPD. It is important to understand experiences involving PPD in men so that improvements can be made in both the recognition and treatment of it for men. Therefore, this study focused on what PPD looks like for men, how men assign meaning to it, and how it affects their tendency to seek help within it.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore fathers' experiences of PPD including their experience detecting the disorder and seeking help for paternal PPD. A phenomenological approach was used to solicit accounts of fathers who

perceived or believed that they experienced PPD as defined by Segre and Davis (2015): (a) at least 2 weeks during which there was either loss of interest or depressed mood or loss of interest or pleasure in nearly all activities, (b) at least four additional symptoms such as changes in appetite or weight, sleep, or psychomotor activity, decreased energy, feelings of worthlessness or guilt, difficulty thinking, concentrating, or making decisions, or recurrent thoughts of death or suicidal ideation plans or attempts, symptoms that were newly present or must have clearly worsened with the partner's pregnancy status, (d) symptoms that must have persisted for most of the day nearly every day for at least 2 consecutive weeks, (e) PPD episodes accompanied by clinically significant distress or impairment in terms of social, occupational, or other important areas of functioning, and (f) symptoms that must have occurred during the partner's pregnancy or within 1 year after the delivery of the child. Face-to-face or telephone interviews with six male participants were conducted, and the recordings of the interviews were transcribed (see Appendix B). Transcripts were analyzed via content analysis to identify themes and patterns that emerged. These themes were used to look for patterns across the datasets to describe the phenomenon of male PPD. These then were applied to a specific research question. The categories for analysis were used to determine dominant themes. Thematic analysis was used with a coding system that included the following phases: familiarization with data, generating initial codes, searching for themes among codes, reviewing codes, defining and naming themes, and arriving at the final findings.

Theoretical Framework of the Study

The theoretical framework for this study was Daryl Bem's self-perception theory (SPT). Bem (1972) asserted that individuals develop attitudes and opinions by observing and drawing conclusions from attitude formation. When internal cues are weak or difficult to interpret, individuals infer what they think or feel based on how they behave within a situation (Bem, 1972). Since the purpose of this qualitative phenomenological study was to understand the lived experience of PPD in men, Bem's theory of self-perception was a viable theory for this study. Bem's theory interfaces with this study in that it suggests that people develop and describe perceptions of lived experiences and what they meant to them. Six fathers were included in the study. Unassisted by their partner, the fathers verbally described their lived experiences of PPD and what they meant to them. Furthermore, what caused fathers to seek help was explored.

Unlike other attempts to assess paternal PPD, this study focused on the lived experiences of men who believe they experienced PPD. Bem's SPT interfaces with this study in that it suggests that people develop and describe perceptions of lived experiences by observing their own behavior and drawing conclusions from them.

The researcher theorized that men's narratives demonstrate a self-perception that can only be told by the men themselves regarding their lived experience. It was theorized that by providing the participants an opportunity to describe what PPD looks like for them, their narratives stand to provide the men and others a better understanding of their lived experiences as well as how to cope with them.

Compared to what is known about PPD in mothers, PPD in fathers is a relatively new area of exploration. In men, major risk factors include a history of depression, lack of social support, relationship dissatisfaction and conflict, and maternal depression. Men with partners with PPD have been found to be 2.5 times more likely to become depressed themselves (Paulson & Bazemore, 2010). While some researchers have suggested that men may be more reliant upon their partners' support than women, studies have focused on transition to parenthood and the unique challenges it poses for men. The term *gender role stress* has been used to describe the experience of emotional distress that results from not adhering to traditional masculine gender role norms. Men who experience gender role stress are more likely to experience anxiety, depression, aggressive behavior, and alcohol abuse, all symptoms that are commonly associated with paternal PPD. Strict adherence to masculine gender roles may inhibit men from seeking social support when needed (Mahalik, Good, & Englar-Carlson, 2003).

Research Questions

The purpose of this study was to explore what PPD looks like for men. The following questions guided the research:

RQ1: How do the participants describe their lived experiences of PPD?

RQ2: How do men experience and understand PPD?

Nature of the Study

The design selected for this study was a phenomenological analysis design. Interviews were conducted to obtain men's lived experiences involving PPD. The open-

ended interview method was suitable in this study in that it allowed participants to describe what PPD looks like for men. The interview material was revised work from the Gotland Scale for Male Depression (GSMD) and Edinburgh Postnatal Depression Scale (EPDS). In order to satisfy prospective sampling techniques, the researcher recruited six participants through community churches by posting recruitment flyers. The researcher used the convenience sampling technique to post flyers which contained a description of the study. The researcher did not know the participants. A qualitative phenomenological research method was used to collect descriptive data and analyze using qualitative analysis.

For this study, PPD is defined as a non-psychotic depressive episode that begins in or extends into the postpartum period. One must meet criteria for both a major depressive episode as defined by the APA (2013), "a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities" (p. 349) as well as the criteria for the postpartum-onset specifier, which means that onset of the major depressive episode must be within 4 weeks postpartum (p. 387).

Definitions

The DSM-V criteria for depression is the most frequently used tool for diagnosing depression in men. Symptoms include significant weight loss or change in appetite, insomnia or hypersomnia, fatigue or loss of energy, feelings of worthlessness, inability to concentrate, and recurrent thoughts of death (APA, 2013). While this is the standard list of symptoms used for the diagnosis of depression, the list of possible presenting

symptoms does not take into account the different ways in which men and women exhibit depression. This difference in the presentation of symptoms was first studied 30 years ago which could help explain the current gap in knowledge regarding paternal PPD.

Möller-Leimkühler et al. (2004) developed the Gotland Scale for Male Depression, (GSMD)and described symptoms thought to be exhibited by depressed men such as irritability, anger, and alcohol use. According to Möller-Leimkühler et al. (2004), depression in men often seems to be masked by atypical symptoms or depressive equivalents such as somaticizing, brooding, and aggression. Because these symptoms are not included in the current DSM-5 diagnostic criteria, many depressed males may be misdiagnosed, undiagnosed, and untreated. Understanding and recognizing the gender differences regarding depression is another consideration.

Couvade syndrome: Sympathy depression where some men try to work through the experience of their partner's pregnancy (Brennan et al., 2007).

Gender Role Distress: Psychological discomfort caused by self or others that results in feelings of lowered self-worth related to gender (O'Nell, 2008).

Maternal Postpartum depression (PPD): Symptoms in women that present as anxiety and depression from early pregnancy to 1 year after delivery of the baby (Don & Mickelson, 2012).

Paternal postpartum depression (PPD): Symptoms in men that present as anxiety and depression from early pregnancy to 1 year after delivery of the baby (Don & Mickelson, 2012).

Phenomenological analysis: A qualitative scientific approach to research in psychology and the human, health, and social sciences (Smith et al., 2009).

Postnatal/*Postpartum Depression (PPD):* Depression after birth characterized by low mood, self-esteem, concentration and energy, increased tension, agitation, pessimism and guilt, as well as disturbed sleep, weight change, and ideas of self-harm (Milgrom & McCloud, 1996).

Postpartum Psychosis: A severe form of depression occurring after childbirth. Distorted thought processes and periods of mania are common occurrences seen in postpartum psychosis. Postpartum psychosis is a rare disorder, and it usually affects only the mother 1-4 weeks after the birth of a child (Pinelli, 2009).

Prenatal Postpartum Depression: Depression before birth is characterized by low mood, self-esteem, concentration and energy, increased tension, agitation, pessimism and guilt, as well as disturbed sleep, weight change, and ideas of self-harm (Milgrom & McCloud, 1996).

Methodological Assumptions

One methodological assumption pertains to whether participants were able to provide comprehensive reports regarding what PPD looks like for men. It was assumed that participants were able to recount their experiences and had adequate memory of PPD to describe it. Secondly, it was assumed that interview responses were clearly presented, and participants were truthful in their description of their experience.

Scope, Delimitations, Limitations, and Assumptions

The scope of this study was confined to assess the experiences that were described by participants concerning PPD in fathers as well as their likelihood of detecting the disorder and seeking help for PPD. A delimitation of the study was that the researcher will interview fathers only and the study did not include mothers. A limitation of the study was a selection bias may exist related to the volunteer nature of the selection of the participants because participants were self-selecting. Self-selecting participants could be more inclined to voluntarily respond to interview questions than participants who were randomly selected for the study. An assumption of the study was the participants expressed and recalled with honesty the experiences that they were explaining

Significance of the Study

Research in this area could lead the spouse, family, and public to better understanding of depressive moods experienced by men after the birth of their infants. Also, this study will influence results regarding further developments in the field. The review of the research on paternal PPD indicated a family and a public need for studies and strategies regarding the significance of men's lived experiences related to PPD.

Data that report and describe what PPD looks like for men stand to be significant in the understanding and development of criteria for measuring paternal PPD distress. Currently, there are not enough empirical reports men who experience PPD or, criteria

for measuring PPD in new fathers, nor is there a practice or tendency to measure the number or the severity of the problem.

Current literature suggests a lack of acknowledgment, recognition, and research which constitutes barriers that negatively impact progression toward focusing on paternal PPD early enough to ward off pathology. There has been an increasing interest in the prevalence of paternal PPD and the way it impacts infants' lives. Unlike women who have been examined for a moderate range of psychological problems regarding how likely they are to suffer PPD, men are expected to not be at risk, or they will adjust (Courtenay, 2008).

Adverse infant-child outcomes are less well researched in terms of PPD. PPD in the postpartum period negatively impacts the quality of parenting, exacerbates the adverse impact of maternal PPD irrespective of child's gender, and acts independently as a risk factor for boys (Ramchandani et al., 2008; Wilson and Durbin, 2010).

Courtney (2008) found that paternal depression at 10 months postpartum negatively impacted father involvement in Early Head Start programming. The Early Head Start programming researchers noted that those fathers most in need were the least likely to access services, suggesting that proactive attention to men's mental health needs would positively influence paternal involvement and infant-child development. Understanding the processes through which fathers meet the challenge of parenthood is particularly important to the development of father-inclusive studies designed to support families at risk. Despite the known risks and consequences, paternal PPD remains largely

underdiagnosed and undertreated (Courtney, 2008). Also, there was little research regarding healthcare providers' knowledge of recommendations that suggested fathers too should be screened for PPD, especially when their partners are depressed. Implications for positive social change include a better understanding of paternal PPD for fathers, information for healthcare providers who deal with expectant fathers and significant others such as mothers of the child and other family members and coworkers regarding how to respond to paternal PPD, Better understanding of PPD will provide fathers with more of the support they need to successfully make the journey though PPD.

Summary

In this chapter, a general introduction to PPD and what it looks like for men was presented. Also, Chapter 1 included a definition for PPD, its impact on new and expectant fathers, partners, children, and the theoretical framework for the study. Chapter 2 presents literature pertaining to the body of knowledge supporting the study. Specifically, what PPD looks like for men will be discussed. Prevention and intervention practices were included in the literature review as an adjunct to better understand men's lived experiences.

Methods and rationale for the study are detailed in Chapter 3. In Chapters 4 and 5, data are synthesized and clinical implications are analyzed. In summary, given the risk for PPD, fathers' narratives were transcribed close to verbatim as described by participants. This research aimed to contribute to a growing literature interested in

gaining a better understanding of father-sensitive and father-inclusive learning pertaining to what PPD looks like for men.

Chapter 2: Literature Review

Introduction

This phenomenological research will focus on exploring what PPD looks like for men and their lived experience related to PPD. This chapter will include an introduction, the research search strategy, theoretical framework, and informative literature about PPD in men and women. Each section of Chapter 2 is designed to review research on the phenomenon of lived experiences of PPD for men in relation to the research questions.

Literature Search Strategy

This literature review was conducted using Medline, CINAHL, PsycARTICLES, and PsycINFO, and relevant articles in the study were retrieved by use of search words and phrases related to *father* and *postpartum depression*. To ensure that the materials used in this literature review were up to date, I set search dates from 2013 to 2018. The articles were then limited to those written in English and focusing on fathers and PPD. Some articles published prior to 2013 were classic since they had a certain bearing on the background and history of PPD research. In this chapter, the researcher presents information concerning the impact of PPD on fathers' lived experiences.

Theoretical Framework

The theoretical framework for this study is Bem's SPT. Bem (1965) asserted that individuals develop attitudes and opinions by observing and drawing conclusions in attitude formation. When internal cues are weak or difficult to interpret, individuals infer what they think or feel based on how they behave within a situation (Bem, 1965).

Recruitment organizations used the compliance technique called foot-in-the-door technique (FITD) to get potential recruiters to agree to non-threatening activity; then gradually increasing the level of the threat of activity. Guadagon et al. examined how the use of the FITD technique works. The compliance technique drove the recruiters' internal thoughts and their behavior.

Critcher and Glilovich (2010) used the theory of self-perception to test a connection between self-perception and mindwandering. The researchers looked at how randomly recruited participants used unobservable (mindwandering) behavior to make inferences related to their attitudes and preferences (Critcher & Glilovich, 2010). The mental of process of mindwandering to positive, concurrent, and many events as opposed to one or past events, mindwandering led to boredom and perceived dissatisfaction with a task (Critcher & Glilovich, 2010).

Goldstein and Cialdini (2007) hypothesized that individuals sometimes infer their own attributes and attitudes by amalgamating with others. Their study involved participants who could observe the action of an actor they strongly identified with. As the experiment progressed, participants reported feeling a sense of almost as if they had become an extension of the actor. The participants' sense of self, as well as their own behavior, changed as they further observed the actor (Goldstein & Cialdini, 2007). This study demonstrated how an individual's self-concept relates to a close relationship between individuals.

A group of volunteer participants completed a questionnaire designed to recall either past pro-ecological behaviors or past anti-ecological behaviors (Chaiken & Baldwin, 1981). The participants were identified as having environmentalist or conservationist attitudes toward ecological behavior. Environmentalists were asked questions such as "Do you always recycle?" or conservationists were asked, "Do you ever recycle?" Later, participants' attitudes toward ecological behavior were re-measured. Those who identified with the strong environmentalist attitudes were unchanged. Those with weak environmentalist attitudes were affected in that they changed their attitudes (Chaiken & Baldwin, 1981). At the conclusion of the study, the pro-ecology condition participants reported themselves considerably more pro-ecology than the anti-ecology condition participants (Chaiken & Baldwin, 1981). Results from this study supported the self-perception theory in that it demonstrated that emotions do follow behaviors.

Since the purpose of this qualitative phenomenological study was to understand the lived experience of PPD in men, Bem's SPT allowed the men to verbalize what PPD looked like according to their own experiences. Six men who self-reported that they experienced PPD were included in the study. Unassisted by their partners, fathers verbally described their lived experiences of PPD and what it meant to them. Furthermore, what caused the fathers to seek help was explored.

Unlike other attempts to assess paternal PPD, this study was focused on the lived experiences of men who believe they experienced PPD. Bem's SPT interfaces with this

study in that it suggests that people develop and describe perceptions of lived experiences by observing their own behavior and drawing conclusions from it. The researcher theorized that men's narratives would demonstrate self-perceptions that can only be told by the men themselves regarding their lived experiences. It was theorized that by providing the participants an opportunity to describe what PPD looks like for them, their narratives stand to provide the men and others a better understanding of fathers' lived experiences and how they coped with those experiences.

Compared to knowledge of PPD in mothers, PPD in men is a relatively new area of exploration. There are potential difficulties in terms of negotiating multiple roles at once (e.g., provider, guide, household help, and nurturer), and the challenges of meeting the expectations of an emerging new father ideal, a sociocultural expectation to be more emotionally involved and available than in previous generations (Dalton & Nokes, 2011). The term *gender role stress* has been used to describe the experience of emotional distress that results from not adhering to traditional masculine gender role norms. Men who experience gender role stress are more likely to experience anxiety, depression, aggressive behavior, and alcohol abuse, all symptoms that are commonly associated with paternal PPD (Dalton & Nokes, 2011). Strict adherence to masculine gender roles may inhibit men from seeking social support when needed (Mahalik, Good, & Englar-Carlson, 2003). The SPT relates to this study in that it operates on the theory that individuals perceive their world through their lived experiences. This theoretical framework relates to

this study in that it maintains that each person could perceives a phenomenon of what PPD looks like differently.

Defining PPD

Depression is one of the most common mental health disorders among individuals (McLeod, 2015). A history of clinical depression, spousal disconnect, poor parenting skills and a lack of social support may predispose an individual to depression (McLeod, 2015). PPD is a form of depression that some new mothers and fathers experience after the birth of their child (Paulson & Bazemore, 2010). PPD is a mood disorder, tends to have a gradual onset, and may persist for a year or longer (Paulson & Bazemore).

New fathers are currently more likely to discuss the disorder of PPD (Moller-Leimkuhler, 2002). Not enough research has been done to develop treatment models to effect change for the disorder, and there is a failure for healthcare providers and fathers to recognize or view paternal PPD as a legitimate disorder. Ultimately, there is a lack in terms of recognition of symptoms of paternal PPD when it comes to understanding and managing sometimes stereotypical thinking about fathers and their emotions as a new parent. Additionally, a gap in knowledge on how PPD relates to child attachment or a father's perception of the disorder (Paulson & Bazemore, 2010). PPD has been defined as a disorder that impacts both individual and familial relationships (Paulson & Bazemore, 2010). There have been few qualitative research studies especially regarding the experiences and support needs of fathers who experience PPD. There is a gap in the literature that specifically addresses men and prenatal and postnatal mental health.

PPD has been associated with marital conflict, insecure attachment, and poor infant-child outcome (Paulson & Bazemore, 2010). Despite these risks, paternal PPD often goes understudied, undetected and untreated. Preliminary research suggested a correlation between maternal and paternal PPD and a cumulative risk for children with two depressed parents (Courtenay, 2008; Paulson, 2010). Overall, this literature review revealed that the question of what PPD looks like for men lacks empirical study.

During the first year, PPD affects 1.2% to 25.5% of new fathers, and when maternal PPD co-exists, 24% to 50% of new father's experience PPD (Paulson, 2010). Typically, theories of the disorder explained what new fathers' symptoms looked like but did not ask fathers to describe their own lived experience for PPD leaving fathers and their families without adequate knowledge to deal with the disorder (Paulson & Bazemore, 2010).

Depression related to pregnancy is defined as a non-psychotic depressive episode that begins in or extends into the postpartum period. One must meet criteria for both a major depressive episode as described by the (American Psychiatric Association), and as defined by the Diagnostic and Statistical Manual, 4th edition, text revision (DSM-IVTR), "a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities" (p. 349), and the criteria for the postpartum-onset specifier, which states that onset of the major depressive episode must be within four weeks postpartum" (p.387).

The (APA, 2013) criteria for depression is the most frequently used tool for diagnosing depression in men. The symptoms include significant weight loss or change in appetite, insomnia or hypersomnia, fatigue or loss of energy, feelings of worthlessness, inability to concentrate, and recurrent thoughts of death (APA, 2013). While this is the standard list of symptoms used for the diagnosis of depression, the list of possible presenting symptoms does not take into account the different ways in which men and women exhibit depression. This difference in the presentation of symptoms was first studied 30 years ago (Moller-Leimkuhler, Bottlender, Straub & Rutz, 2004).

Möller-Leimkühler et al. (2004) developed the Gotland Scale for Male Depression and described symptoms thought to be exhibited by depressed men such as irritability, anger, and alcohol use. According to Möller-Leimkühler et al. (2004) depression in men often seems to be masked by these atypical symptoms or depressive equivalents such as somatizing, brooding and aggression. Because these symptoms are not included in the current DSM-5 diagnostic criteria, many depressed males may be misdiagnosed, undiagnosed and untreated. Understanding and recognizing the gender differences in regard to depression is the next consideration.

When depression occurs before or during pregnancy, it is also referred to as prenatal or postnatal depression and is a clinical disorder which can affect both women and men (Courtenay, 2008). According to wide application, PPD requires treatment to get better (Courtenay). Additionally, infant/childcare intervention may be indicated to help manage PPD (Courtenay).

Postnatal Depression in Fathers

Despite the fact that postnatal depression had generally been associated with mothers in the past, recent studies indicated that there were several cases of the condition affecting fathers, especially after the child was born. The process of transiting to fatherhood tended to be a complicated process for men that began during the prenatal stage and extended to the postnatal period involving plenty of changes in priorities. In other studies, the transition to fatherhood was viewed as a gradual process that involved mastering of the role of parenthood, processes and behaviors related to caring for a child. Paternal PPD symptoms and the quality of the spousal relationship were predictive of fathers without experiences in parenting (Brizendine, 2011). The development of PPD was ascribed to the uniqueness of dealing with the complicated and evolving roles of fathers in a family set up along with the redefining relationships of mother, child, and father as they tried to complement each other in the family structure (Roberts, Bushnell, Collins, & Purdue, 2006). The father tended to experience a conflict of priorities as home life and work life competed for attention especially at the onset of the prenatal period. Different fathers demonstrated a varying degree of success in meeting work demands and the need to have an emotional attachment with their babies (Kokkinaki, 2016).

In men, major risk factors for PPD are thought to include a history of depression, lack of social support, relationship dissatisfaction and conflict, and maternal depression. (Paul & Bazemore, 2010). Of note, men with partners with PPD have been found to be two and one-half times more likely to become depressed themselves (Paulson &

Bazemore, 2010). While some researchers have suggested that men may be more reliant upon their partner's support than women, others have focused on transition to parenthood and the unique challenges it poses for men. One study including over 200 first-time fathers, identified uncovered /unmet expectations and dissatisfaction (Paulson, 2010).

Studies on PPD in women suggested that men are also as much at risk for many of the emotional problems experienced by women during the postpartum period, yet criteria for the disorder and treatment plans are geared toward providing care and education for women. Men's emotional health can be seriously compromised during their partner's pregnancy and during the first year after the infant's birth, rendering new fathers unable to give optimal emotional support to partner and infant (Rabin, 2010).

PPD has been defined as a disorder that impacts both individual and familial relationships (Letourneau, Tryphonopoulos, Duffett, Stewart, Benzies, Dennis, & Joschko 2012). There have been few qualitative research studies especially on the experiences and support needs of fathers having PPD (Letourneau et al., 2012). Paulson, (2010) also established that there is a gap in the literature regarding paternal postpartum mental health conditions.

Men are almost as likely to experience PPD as women, especially when men feel left out or not needed (Ekin et al., 2016). When PPD presents, common behaviors include lack of sleep, excessive stress related to becoming a parent, and relationship problems with spouse, in-laws, or stepfamily (Ekin et al., 2016). Other aggravating problems seen in paternal PPD include economic problems or limited resources, lack of a support

system, and poor social/parenting skills, all which leads to a feeling of not being valued as a partner or a parent (Ekin et al., 2016).

For the past half a century, studies focused on the environmental and biological aspects connected with maternal PPD along with the destructive impact of the disorder on the development of an infant (Ballard, & Davies, 2012). Nevertheless, fathers were also subjected to numerous life changes during the postnatal period, some of which related to the experiences of mothers during the same period. Therefore, fathers were required to adapt to a variety of demanding new tasks and roles especially during the early months of the postpartum period. The adjustment to these changes was dependent upon the quality and level of cooperation between mothers and fathers (Hill, 2012). Postpartum experience indeed presented several challenges to both men and women in terms of their mental health. The details and effects of paternal PPD had in the past been rarely researched, but the disorder began attracting the attention of researchers recently. Studies indicated that paternal PPD had a great impact on the ability of the father to offer support for both the mother and the infant particularly during the year after delivery (Dalton & Holton, 2013).

Postnatal depression in men was associated with cases where the female spouse had suffered the disorder. A study conducted using 200 postnatal couples in England indicated that 9% of fathers and 27% of women were found to have developed the disorder by the second postnatal month (James, 2012). During the six months after the childbirth, 5.7% of fathers and 25.7% of mothers had developed postnatal depression

(Ballard & Davies 2012). From that analysis, it was evident that fathers were more likely to develop the disorder during the second to sixth month after the child was born. An integrated review by Goodman of 20 research works ranging from 1990 to 2002 indicated that 24% to 50% of men with spouses' already suffering postnatal depression had increased chances of developing the disorder (Dalton & Holton, 2014). Therefore, the existence of maternal postnatal depression was found to be a critical indicator for projecting the onset of PPD.

Kumar and Lovestone (as cited by Kim & Swain, 2016) divided men into three categories to have a better understating of PPD. The first category consisted of men with spouses who already had developed postpartum depression while the second category included men with spouses who had a prolonged history of the disorder. The third group of men was the control group consisting of men who had no symptoms of postnatal depression. One half of the men with spouses with symptoms and a history of PPD had a high chance of developing the disorder (Cox, 2015). In a study conducted on a US population of men indicated alcohol abuse was positively correlated with PPD. PPD was found to be a major health concern in the US as evidenced by a 14% rate of the disorder in the country which exceeded the international rate of 8.2%. A majority of the past studies had shown that the risk factors, prevalence and the impact of PPD had been explored only minimally causing a poor understanding of the disorder (Milgrom, Martin, & Negri, 2015).

From the above-mentioned research studies, it was evident that paternal PPD was strongly associated with cases where the female partner had already developed postnatal depression. Moreover, the presence of postnatal depression in the female partners acted as a significant predictor of the development of the disorder in a male partner. PPD also affected the psychological stability of a man (Milgrom et al., 2015). The development of PPD could be an impediment to male partners in the role they play in providing emotional support to their spouses experiencing postnatal depression.

This researcher set out to examine the existing understandings on the topic as well as provide an overview of future directions for research in the topic. This was helpful in not only improving the medical insights but also in enhancing the mental health of fathers. Moreover, the review was important in assisting the affected families by ensuring that both the infants and partners had an improved quality of life.

Diagnoses of Paternal PPD

There existed no single criteria for diagnosing paternal PPD (Cox, 2015). For that reason, paternal PPD had several definitions. From the past studies, paternal PPD had relied on measures initially developed for assessing maternal PPD (Cox, 2015)' Maternal PPD referred to a major depression occurrence that began within the first month following childbirth. This depression occurrence was often characterized by hypersomnia, weight gain or loss, sad moods, energy loss, fatigue psychomotor retardation or agitation, recurring suicidal thoughts, decreased cognitive ability, loss of concentration, marked loss of interest in virtually all activities, and feelings of guilt or

worthlessness (Milgrom & Gemmill, 2015). According to the diagnostic and statistical manual of mental disorders 4th edition (DSM-IV), at least five of the aforementioned symptoms could be manifested especially during the first 2 weeks of the postpartum period and that one of the signs was supposed to be depression or noticeable reduction in the loss of interest in virtually all activities (Edoka, Petrou, & Ramchandani, 2011).

Nevertheless, the criteria for diagnosing were for maternal PPD. Validating a similar diagnostic criterion for paternal PPD was as crucial as the distinction in the risk factors for fathers and mothers (Ballard & Davis 2015). For instance, some past studies proposed that paternal PPD tended to develop in a slow and gradual manner over the course of the first year following a delivery. In that regard, the criterion for the diagnosis of paternal PPD based on the occurrence of the disorder within the first four weeks might not have been applicable (McDonald, Wall, Forbes, Kingston, Kehler, & Vekved (2012). The Edinburgh postnatal depression scale (EPDS), had commonly been applied in the past analyses of maternal PPD. The tool was initially developed to assess PPD in mothers though it has in the recent past been applied in the assessment of paternal PPD. The EPDS scale contains 10 self-assessing elements, eight of which addressed the depression signs such as self-blame and sadness while the remaining two addressed the signs of anxiety such as feelings of panic or worry. The responses were recorded from zero and increased in accordance with the rising severity of the signs up to a maximum of thirty. The scale was often used to measure the symptoms of PPD between one six and twelve weeks after child delivery. However, the scale has been used in assessing the symptoms

of PPD for up to one year after childbirth. A range of nine to thirteen points within the EPDS scale indicated the minimum scores for assessing depressive symptoms. The scale has a wide applicability and validity for assessing maternal and paternal PPD in the United States and in other countries across the world. Other tools used in measuring PPD included Center for Epidemiologic Studies Depression (CES-D), General Health Questionnaire (GHQ), and Beck Depression Inventory (BDI) (Pope, 2014).

Some studies in the past employed structured or unstructured interviews including structured clinical interviews for depression severe combined immunodeficiency disease (SCID) and affective disorders and schizophrenia (SADS). The studies that relied on these tools often used small groups of people sampled from limited populations (Byrne, Pennix, Sallis, Viktorin, Chapman, & Henders, (2014). Even though the outcomes obtained from these studies might have been generalized to the rest of the population, both the quantitative and qualitative self –assessment measures were in support of the view that maternal PPD might be a thoughtful diagnostic tool for paternal PPD (Dalton & Holton, 2013).

Most of the recent studies done on paternal PPD were based on cut-off scores generated from self-report assessments for depression symptoms in mothers (Silverman, Reichenberg, Savitz, Cnattingius, Lichtenstein, & Hultman, 2017). It was important that the cut-off scores for paternal PPD be validated using the various assessment tools. Only a few studies had examined the validity of the EPDS for fathers in the past. The findings from these studies indicated that the cut-off scores for identifying depressed fathers were

in the range of 5-6, which was a bit lower compared to that of women (Pilkington, Whelan, & Milne, 2015). Lower cut-off scores tended to diagnose trivial cases of maternal PPD, there could be underestimations of the importance given to PPD in men. Without a doubt, fathers expressed their feelings less often than mothers, therefore were likely to score lower points in the EPDS scale than women, even though they could be experiencing similar depression levels (Moura, Canavarro, & Figueiredo-Braga, 2016). Developing the measures and cut-off scores to determine the PPD in men was quite essential for an accurate diagnosis and effective interventions and treatment for the disorder.

PPD in men tended to develop in a gradual manner compared to the case in women. Past studies suggested that the depression rate in women over the prenatal period used to decrease immediately after child delivery but went up within the first postpartum year. For example, a study involving first-time fathers showed that the 4.8% of fathers were depressed within the initial six weeks following childbirth and this eventually increased to about 23.8% by the end of the first year (Roberts, Bushnell, Collings, & Purdie, 2016). In another study on the same topic, 5.3% of first-time fathers tested positive for prenatal depression with the rate decreasing to 2.8% and eventually increasing to 4.7% by the end of the first prenatal year (McDonald, et al., 2012). Nevertheless, some recent studies have suggested that the rate of PPD in men tends to be consistent over the whole postnatal period.

Prevalence and Incidence of Paternal Postpartum Depression

In the past, PPD used to be construed as a medical condition that only affected women (Yura, Marco, Bastianins, Alessio, & Paola (2015). More recent medical studies on PPD have shown that one out of four new male parents reported that they experienced troubling depression after the birth of their firstborn (Yura et al., 2015). In the past few decades, the number of PPD cases in men has been on the increase (Alfayumi-Zeadna, Kaufman-Shriqui, Zeadna, Lauden, & Shoham-Vardi, 2015). The tools used to measure the incidents of PPD, especially following the initial year following the firstborn indicated a prevalence of between 1.2 % to 25.5% in a sampled population in a community (Cox, 2016). Moreover, past studies had indicated that maternal depression was a major contributor towards the development of PPD during the postnatal period. The high prevalence of PPD was a significant indicator of how the condition continued to affect several families across the world. In a study conducted in England in the eighth week after childbirth, the symptoms of PPD were found in 4% and 10% of fathers and mothers respectively (Zubaran, Schumacher, Roxo, & Foresti, 2010).

In several community samples conducted in the US, it was found out that 32% to 47% of couples had at least one partner experiencing increased symptoms of PPD during the first eight weeks after childbirth (Koutra, Vassilaki, Georgiou, Koutis, Bitsios, & Chatzi, (2014). Moreover, past studies had indicated that maternal depression was a major contributor toward the development of PPD during the postnatal period. The high prevalence of PPD was a significant indicator of how the condition continued to affect

several families across the world. In a study conducted in England in the eighth week after childbirth, the symptoms of PPD were found in 4% and 10% of fathers and mothers perceptively (Zubaran et al., 2010).

Again, most of the past studies about paternal PPD derived the research data from studies initially designed to investigate PPD in women. From these studies, it was found that depression in the female partner had a significant correlation with that of the male. In several community samples conducted in the US, it was found out that 32% to 47% of couples had at least one partner experiencing increased symptoms of PPD during the first eight weeks after childbirth (Koutra et al., 2014). Moreover (Koutra, 2014) suggested that about 60% of families had at least one spouse suffering from either prenatal or postnatal depression.

Comorbidity of Paternal Postpartum Depression

Even though a few studies in the past had focused on this field, there exists a high comorbidity of paternal PPD with several other psychiatric conditions (Hwang, Norell, Qiang, & Kequin, 2015). Obsessive-compulsive disorder (OCD) is one such psychiatric disorder that commonly co-occurs with PPD (Hwang et al., 2015). From studies conducted on the experience of fathers during the period of transiting to parenthood, it was found that about 10% of men exhibited a considerable increase in the level of anxiety (Hwang et al., 2015). In other related research studies, the rate of developing depression was found to increase by 30% to 100% for fathers had anxiety problems (Kim & Swain, 2016). The fathers tended to experience anxieties similar to those of OCD especially

during the onset of postnatal period. These elevated levels of anxieties used to develop around the delivery period. Even though both fathers and mothers had a tendency of displaying increased anxiety levels around the same period, the anxiety levels were often lower in men than in women (Roberts, Bushnell, Collings, & Purdie, 2015). For instance, after two weeks of childbirth, mothers with normal babies tended to spend up to 14 hours daily as opposed to men who could spend about one half of that time (Roberts et al 2015. The psychological content of these anxieties involved feelings of unity and reciprocity with the baby. In a study conducted on the thoughts towards an infant during the first three months, it was found that 66% of men and 73% women had feelings of perfection regarding their babies (Fanaka, 2014). These perceptions played an important role in in the development of self-efficacy mental resilience particularly during the depression period when one's priorities are reorganized. In the absence of such perceptions, there could be a problem in the development of the early affection between a child and a parent (Stewart, 2013).

The parental anxieties also involved unpleasant thoughts concerning the baby. In past studies, about 80% and 95% of fathers and mothers respectively had experienced unpleasant feelings such as the possibility of a bad thing happening to their infants during the first two months of the postnatal period (Dan, 2016). During the subsequent weeks after the childbirth, the studies showed that these figures slightly decreased to 73% and 80% for mothers and fathers respectively (Dan, 2016). Upon returning home after childbirth, most of the detected issues related to the well-being of the baby such as

crying, doubts about adequacy as the baby's parents and the feeding of the infant decreased (Dan, 2016). Such feelings were frequently reported especially among the parents of abnormal babies, those with complicated malfunctions or disorders, critically ill infants or those with critical birth disorders (Hernandez, Liverman, & Greenlick, 2015). Moreover, both fathers and mothers were experiencing worries or fantasies like accidentally harming their babies by dropping them during the moment of frustration or exhaustion (Hernandez et al., 2015).

A development of thoughts of harming an infant could place new fathers at an increased risk of developing postnatal depression or even OCD. Undoubtedly, anxiety and depression experienced during the postnatal period could be associated with OCD. Some distinctive symptoms of postnatal OCD consist of unpleasant thoughts such as injuring a baby or obsessive behavior such as constantly checking an infant. In one study about PPD in mothers, about 41% exhibited unpleasant thoughts of injuring their babies in comparison to 7% of mothers in the proper state of mind (Maxwel, 2014). Though past studies had not been able to identify a significant correlation between the severity of hostility and the symptoms of depression among men, it could be ruled out that their intrusive thoughts were not expressive and needed to be identified indirectly (Thackston & Thackston, 2015). Past studies found that approximately 45% of fathers could not help having worrying thoughts concerning the possibility of their infants being suffocated and about 25% experienced fears of intentionally harming their infants with about 3% reporting anxieties around losing their infants (Lieberman, 2015). Finally, men also

exhibited an array of mental problems and somatic symptoms during with postnatal period including restlessness, nervousness, irritability and fatigue that could possibly contribute to the risk of developing depression (Hester, Harrison, & Harrison, 2011).

In summary, findings from past studies indicated that the presence of a psychiatric disease placed fathers at an increased risk of experiencing PPD as well as other psychological disorders. Additionally, having multiple comorbid psychological ailments could consequently affect the coping skills of men during the postnatal period (Merrill, 2014).

Biological and Ecological Risk Factors of PPD

Quite little was known concerning the biological factors of PPD in men. However, an extensive body of literature relating to PPD in women exists. Maternal PPD was related to various hormonal levels including prolactin, oxytocin, and estrogen all of which play a role in mood regulation during the postnatal period (Weaver, 2014). The available body of literature on maternal PPD suggested that PPD in men could be triggered by the hormonal variations that occurred during their partners' prenatal and postpartum period. In that regard, there were various biological factors that could be attributed to PPD in men (Farooqui & Farooqui, 2011).

Firstly, PPD in men could be triggered by the variations in their testosterone levels which reduced with time especially during the pregnancy and postnatal period of their partners (Farooqui & Farooqui, 2011). In most men, the level of testosterone often declined a few months to the end of the prenatal period and remained low for subsequent

months after the delivery (Farooqui & Farooqui, 2011). Several scholars proposed that such a hormonal decline led to strong bonding with the baby and decreased aggression as well as enhanced parental concentration (McCoy & Salerno, 2010). With lower levels of testosterone, fathers developed increased sympathy and became responsive at the voice of a crying infant (McCoy & Salerno, 2010). Contemporary studies on aging men suggested that there was a positive correlation between low levels of testosterone and severe cases of depression (Roberts, Bushnell, Collings, & Purdue, 2006). Medically depressed men between 45 and 60 years of age exhibited lower levels of testosterone compared to normal men (Roberts et al., 2006). However, the authors cautioned that further research could be required to show if such relationships could be generalized to all men during the postnatal period and whether they could be a part of an extreme variation (Roberts et al., 2006) If established, then the level of testosterone could contribute to the biological knowledge about PPD in men as well as suggest the means of preventing and testing for the disorder. (Roberts).

Secondly, PPD in men could be associated with the decline in cortisol levels. (Roberts et al., 2006). Cortisol is the hormone responsible for regulating the physiological reactions to stressful occurrences. High levels of cortisol were related to high levels of stress. Nonetheless, high cortisol levels in mothers often decreased their depressive moods and increased their compassion towards their babies (Roberts et al., 2006). Therefore, the decreased levels of cortisol among some fathers could have

contributed to depressive moods and problems experienced in forming the father-baby relationship (Roberts et al., 2006).

Thirdly, PPD in men could be associated with the low levels of vasopressin, which increased in a consistent manner with the mother's oxytocin levels. Vasopressin played an important role in the formation of a father-baby attachment (Hatfield, Schweizer, Tsuji, & Gladyshev, 2016). Paternal behaviors that developed during the initial stage of the postnatal period such as protection and carrying were related to the rapid increase in the level of vasopressin receptors in the brain which enhanced the organization and planning of parenthood (Hatfield et al., 2016). Indeed, lower levels of vasopressin in fathers could be associated with the parenting problems experienced by some fathers and the subsequent development of PPD (Hatfield et al., 2016).

Moreover, PPD in men could be associated with the variations in the levels of prolactin (Gordon & Feldman, 2010. Prolactin played an important role in the initiation and maintenance of the parenting behaviors (Gordon & Feldman, 2010. The levels of prolactin had a tendency of increasing during both the prenatal and the first year of the postnatal period. Increased levels of prolactin were associated with heightened reactions towards baby stimuli particularly among the first-time fathers (Gordon & Feldman, 2010). Therefore, decreased levels of prolactin could be the reason for the frequent negative temperaments and difficulties experienced by fathers in adjusting to paternity.

Finally, PPD in men could be related to lower estrogen levels (Niceta, 2015). The levels of estrogen in men increased during the last month of the prenatal period of their

spouses which continues till the onset of the perinatal period (Sprague, 2012). The increased estrogen levels in men had a tendency to nurture improved behaviors of parenting towards their infants during the postpartum period. Men who got more involved in parenting showed increased levels of estrogen compared to those who did not. A deregulation of paternal estrogen seen in men could be associated with the intrusive behavior and hence a critical risk factor for PPD in fathers (Martinez & Rusch, 2014).

Ecological risk factors on the other hand focused on how various environmental levels such as culture, work, family and community influence the personal development of new fathers (Faroon, 2013). In the absence of role models, it became quite difficult for new fathers to adopt the roles of paternity. In recent times, there had been an increased societal expectation for men to take up the role of parenting, despite many of them reporting they lack paternity skills from their fathers (Altman & Katz, 2015). Therefore, inadequate understanding of the paternal role had the potential of causing anxiety, particularly among new fathers which resulted to an increased risk of PPD among men.

Inadequate reward systems in parenting could also trigger PPD in fathers. Men were quite sensitive to responses they got from their spouses and babies. For instance, when infants smiled at fathers, they responded by smiling back and such a move could be a quite important reward in paternity. However, due to lack of enough time with a baby and inadequate parenting, the father-baby relationship could be a bit stressful. Men also experienced isolation when a mother developed an affectionate relationship with the baby

due to how much time she spent with the baby particularly during breastfeeding (Ghetti, Checcucci, & Bornman, 2016). Fathers could develop jealousy feelings out of their spouses' dominance over the baby making them feel unimportant due to their limited time for marital intimacy. Father's feelings of jealousy could trigger an intrusive attitude towards both the mother and the baby and eventually lead to paternal PPD (Ghetti, 2016).

Postpartum stress could be further increased by the perceived gender roles of parents (Plant, 2012). For instance, the perception that men were the breadwinners could be amplified due to the new financial obligations that came with the delivery of a child making it hard for fathers to get involved in child-rearing. Therefore, failure to meet the financial obligation could considerably affect the psychological status of the fathers which placed them at a high risk of experiencing PPD. Finally, a problematic relationship between mothers and fathers could affect the paternal mood during the postnatal period. Due to the abrupt lifestyle change over the postpartum period, intimacy relationship can considerably be affected (Plant, 2010). The deterioration of the relationship between fathers and mothers, as well as with other family members such as the in-laws could negatively affect parenting which, in turn, could increase the risk of experiencing PPD (Plant, 2010).

The Impact of PPD on the Family Organization

Determining the impact of PPD on families is quite a difficult task. However, researchers have identified and linked several problems such as marital discord with the development of PPD (Watson, Preedy, & Zibadi, 2014). There were two major past

studies that attempted to analyze the impact PPD posed to the family structure. One study was conducted by Boyce, in research that involved 100 fathers and mothers during the first year of childbirth (Ballard & Davies, 2012). The study was conducted during the first two months, six months and at the year-end after the birth of the first born. The research relied on the Edinburgh postpartum depression scale (EPDS) which indicated that there was a positive correlation between postnatal depression and spousal dysfunction (Milgrom & Gemmill). In their study, several women had associated their spouses with qualities of misunderstanding and being uncaring which could have significantly contributed to the development of postpartum depression. In a related study conducted on a population of 1000 Finnish couples, the researcher administered questionnaires and EPDS to new mothers and fathers (Smart, 2015). It was found that the couples who had previously gone through depressing moments before childbirth registered increased chances of developing postpartum depression than those who had stable relationships (Smart, 2015).

In another study, meta-analysis research was conducted with an aim of determining the effect of postnatal depression on the family. An evaluation of 28 pieces of research indicated that development of depression after childbirth had a prevalence of about 15% with a 300% likelihood of recurrence in the successive pregnancies (Edoka, Petrou, & Ramchandani, 2011). The analysis also indicated that spouses who had experienced postpartum depression were twice as likely to develop the condition, especially within the initial five years after the birth of their first born. During the

postnatal depression, the affected mothers used to draw a lot of support from their spouses, a factor which had the potential to strain the intimacy in marriages resulting in marital challenges such as divorce. (Edoka et al., 2011). Another meta-analysis conducted on 43 studies illustrated that 24% to 50% of spouses had experienced some form of depression after childbirth (Pope, 2015).

The PPD in women occurred during the first few months of the postnatal period while that of men occurred later and developed more gradually especially after the onset of maternal PPD (Pope, 2015). In cases where both spouses simultaneously developed PPD, marital problems were singled out as the major contributors of the condition due to strained interactions, communications, and feelings of frustration and isolation (Pope, 2015). PPD was associated with several conditions including economic stress, aggression, substance abuse and violence towards one's partner (Knox, O'Reilly, & Smith, 2011). Other factors that contributed towards the development of PPD in both spouses included variations in the level of vasopressin and cortisol as well as stresses from the environment (Knox et al., 2011). Some of the psychosocial stresses associated with new mothers included low levels of coping with stress, low self-esteem, social isolation, feelings of incompetence and inadequate social support (Watson et al., 2014). Men, on the other hand, were affected by stresses associated with social expectation such as increased socioeconomic responsibilities since men are viewed as the breadwinners for their families (Walters, 2013).

There was also plenty of evidence that showed that both maternal and PPD negatively influenced the parent-child association and the parenting cognition (Watson, 2014). For instance, mothers experiencing postnatal depression were more likely to indulge in impulsive parenting behaviors including reduced attention to the safety of their children in homes, using corporal punishments, and less attention to monitoring the well-being of their children like skipping health visits (Watson, 2014). Such behaviors could also make the affected mother less likely to talk to or to read to their children. Fathers suffering from postpartum depression, on the other hand, were found to have little psychological control and showed little emotional support to their spouses and children which had the effect of disengaging them from the father. (Watson, 2014). Past studies on the subject further showed that maternal postnatal and paternal postnatal depression had adverse consequences on the development of a child and led to problems such as poor health, neglect or abuse, reduced socioeconomic and intellectual development, slow growth, and damaged child-mother emotional attachments, as well as behavioral problems. (Watson, 2014). From the above meta-analysis results, the impact of paternal or maternal postnatal depression had the potential to lead to long-term consequences such as mental illnesses and family problems. Therefore, family-centered interventions could significantly alleviate the worsening of the postnatal depression for both fathers and mothers. It was important that both spouses exhibiting the symptoms of postnatal depression get screened to ensure that necessary treatment of the condition was initiated as early as possible.

Coping with PPD

During the period of postnatal depression, both parents experience an array of changes including learning new skills required to care for a new born, adjusting to varying hormonal changes and sleep patterns and handling other social adversities all of which add to stress (Page & Wilhelm, 2007) Stress resulting from the birth of a child has the potential to cause a depressed father to develop skills for coping (Beutler, Brookman, Harwood, Alimohamad & Malik (2001). Coping skills are reflections of how well an individual respond to stressful conditions (Beutler et al.,). To effectively cope with postnatal depression, fathers try to regulate and manage their distress (Folkman & Moskowitz, 2000; Matud, 2004).

Men cope with partner's postpartum depression in different manners (Soliday, McCluskey, Fawcett, & O'Brien, 1999). Coping with postnatal depression involves an attempt to regulate and manage the challenges that caused the stress. (Folkman & Moskowitz, 2000). Coping styles in managing postnatal disorder depend on the individual's emotional traits, the social resources available, and the ability to master the disorder. (Beutler et al., 2001).

The two major coping styles of PPD included problem and emotion-centered coping ((Felsten,1998; Matud, 2004)). The problem-centered coping style changed, corrected, or removed the problem. Emotion-centered coping style approaches decreased or regulated emotional stress (Felsten, 1998; Matud, 2004). Researchers have also identified a third coping style-cognitive-centered coping. Cognitive-centered coping

addresses the problem, then figures out how it could be managed. (Felsten, 1998: Matud, 2004). Ultimately, psychological support was identified as one of the factors that facilitated a father's capacity to manage postnatal depression. (Felsten, 1998; Matud, 2004).

Past studies had found that men coped differently with postnatal depression compared to women. For instance, men used instrumental coping styles while women employed emotionally focused styles (Hanley, 2015). Several past studies had indicated that traditional patterns of socialization used to play a critical role in the manner spouses coped with postnatal depression. For instance, the traditional western culture used to discourage men from exposing their feelings of sadness, frustration, and grief or looking for support when overwhelmed with depression (Hanley, 2015). Traditionally, males were supposed to be more assertive, self-confidence, and autonomous when coping with depression (Hanley, 2015). Men were perceived as the breadwinners in a family set up while women were perceived as the dependent, lacked assertiveness, and were more passive in terms of emotions and behaviors and tended to seek for social support (Hanley). Moreover, the masculine roles that men assumed made them use external defense mechanisms to reduce stress such as indulging in drug and alcohol abuse. In addition, men had a tendency to develop withdrawal, anger, and irritation when undergoing through depressing moments. Other typical male behaviors of men experiencing depression included cynicism, poor performance at work, and hostility (Hanley). Since all these behavioral attributes pertained to depression, they could be quite

important in unmasking symptoms of postnatal depression and hence lead to effective detection and treatment of the disorder (Hanley, 2015).

Men also got distinguished using the roles they played in their interpersonal relations. This relation could either be categorized as cultural or societal influences (Hanley, 2015). For instance, spouses of the African-American origin were more engaged in egalitarian roles compared to the whites (Hanley, 2015). Other cultural groups such as Hispanic Americans used to assume a more masculine structure whereas the concepts of feminism and masculinity tended to be influenced by the culture of a given group of people (Hanley). Currently, some fathers had embraced a more democratic approach to the gender roles at the workplace, family and home responsibility. These gender expectation and roles had a tendency to have a profound impact on how men behaved towards their postnatal struggling partners. In dealing with the struggles of partners with postnatal depression, some men had a tendency to sacrifice their feelings. The traditional gender perspective required men to be the source of socioeconomic support for the family. In that regard, some men used to suffer silently in the hope that by composing themselves together could offer the emotional support required by their postnatal depressed spouses. The past studies consistently suggested that the men who expressed emotional support for their spouses undergoing depressing moments after childbirth tended to reveal their own share of depression. Mythological concepts about parenting had the tendency to influence the perceptions of men concerning their new roles in parenthood (Hanley). One such myth of parenthood was that mothers were supposed to

be the nurturers and father were to be the family providers. In that regard, men's work was to take precedence over the other roles in a family unit. For the new mothers, the expectation was that their spouses could ultimately make the family roles the top of their priority lists. Thus, the perception of couples concerning the change to parenting responsibilities had the tendency to create relationship conflicts (Hanley, 2015).

PPD and Satisfaction in Relationships

The birth of a new child changes the way in which a family is connected as a unit. The workload expands, concepts of responsibility and role playing affect the relationship within a family (Milgrom & Gemmill, 2015). As satisfaction in partner relationship decreased, during the postnatal period, feelings of dissatisfaction exasperated despite partner's attempt to stabilize their condition (Milgrom, & Gemmill, 2015).

Transiting to parenthood reduces the marital level of satisfaction if one partner suffered postnatal depression (Altman & Katz, 2015). Couples experienced more suffering when the male partner was the one suffering from the postnatal depression. (Altman & Katz, 2015). The past studies had consistently illustrated that the female who suffered from depression could adversely affect the life of a normal partner. Consequently, being with a depressed partner reduced the problem- solving and cognitive abilities of the stress-free partner. Moreover, the traditional gender roles could project the degree of marital contentment especially following the birth of first born and could heighten postnatal depression in mothers (Altman & Katz, 2015).

Other studies had shown that there was a positive correlation between postnatal depression and relationship satisfaction. For instance, one study found that poor marital relationships were positively correlated with the development of postnatal depression (Cox,2015). Relationship satisfaction had been found to be a good predictor of postnatal depression (Cox, 2015). Other aspects that contributed towards relationship satisfaction were the extent of social support and stress. In the majority of studies conducted in the past on PPD, it was evident that family support played an important role in the management of postnatal depression (Cox, 2015). It was also evident that a high level of within the family support especially during prenatal period led to a healthier family relationship between partners (Byrne et al., 2014).

In some studies, it was found that high-level social support led to the reduction or prevention of PPD (Cox, 2015). With regard to stress, it was established that low relationship satisfaction levels led to increased stress during both the prenatal and postnatal period. Men who exhibited low levels of satisfaction in relationships showed higher distress levels than those exhibiting low relationship satisfactions. Therefore, the quality of couple's relationship tended to deteriorate between the prenatal and postnatal period, especially for those who experienced low levels of relationship satisfaction a (Cox, 2015).

Tools of Measuring PPD

PPD had several ways of manifesting itself. For the purpose of ensuring that a patient met the threshold for PPD, the medical practitioners used the DSM-IV-TR tool to

describe and differentiate the disorder from the changes witnessed during the transition to parenthood. The DSM-IV-TR was specifically used to diagnose the critical episodes of PPD that often commenced after the first month following the childbirth.

Characteristics of PPD included weight loss or gain, losing interest in almost all activities, energy loss or fatigue, reduced concentration levels, recurrence of suicidal thoughts, psychomotor retardation or agitations, feelings of guilt or worthlessness, fear for their babies and indecisiveness (Ballard & Davies, 2012).

Intervention and Prevention for Paternal PPD

Various support strategies were used to ease the process of transition to paternity during the postnatal period. One of the most effective strategies was to encourage more support opportunities between spouses since the PPD in men was often linked to the mental health of the partner (Courtenay, 2012). A mother's reassurance, and lively communication between couples during the prenatal period could play a critical role preparing the new fathers and easing their stress. of parenthood (Letourneau, et al., 2012). The sharing of parenting roles between mothers and fathers could lower the paternal feelings of solitude from the mother-baby relationship as well as erase resentful feelings towards the baby (Letourneau et al., 2012). Being acknowledged by the other members of the family could foster a positive attitude in new fathers (Letourneau et al., 2012).

Societal support strategies such as providing paternity leave pay also assisted fathers to adjust to the changes that occurred over the postnatal period. Other countries have policies for paid maternity or paternity leave (Smart, 2015). Sweden, for example,

had in the recent past implemented policy changes aimed at encouraging fathers to embrace paternity leaves where out of 450 days allocated for parental leave, thirty days were dedicated to the fathers for paternity vacation (McCoy & Salerno, 2010). This paternal leave could be utilized at any time before the infant attained the age of 18 months. Recent research studies suggested that there were numerous benefits associated with a paternity leave. For instance, longer paternity leave was associated with a positive attitude toward paternity while a shorter one led to low child care quality and reduced work performance among first-time fathers (Sprague, 2012). Community educational programs could also assist men in understanding their role as fathers. Past studies show that enrolling both PPD mothers and fathers to an educational program was more productive than educating just one partner. Therefore, involving both PPD couples in training could be more effective in alleviating PPD in men (Sprague, 2012).

In the past, new fathers lacked supportive networks. Fathers were traditionally perceived as the sources of support for their spouses. Nevertheless, with the increased involvement of men in parenting roles, appropriate support networks from family and society would assist first-time fathers in alleviating the depression associated with the postnatal period (Sprague, 2015).

PPD is an emotional disorder (Courtney, 2012). It has been suggested that because men are taught to be self-reliant, expectant fathers find it difficult to seek help for an emotionally based disorder especially if they are not knowledgeable about the problem (Courtney, 2012). Additionally, PPD lacks a specific criteria or standard

language to help voice what paternal postpartum looks like for me to allow men to identify it within themselves (Matijasevich et al, 2014). Men suffering PPD fall into a category that places them at risk for not seeking help; thus, making them more prone to depressive moods, and thus having a negative influence on the quality of life for the entire family (Paulson, 2010).

Even though there has been an increasing interest in the prevalence of paternal PPD and the way it impacts partners' and infant's lives; interviews on men's lived experience are uncommon. Unlike women who have been interviewed for a moderate range of lived experiences, men tend to get the men will tough it out approach (Courtenay, 2010).

Men make mental notes about what being a parent looks like (Madsen, 2007). Fathers' reports of their lived experience, by way of interviews, to generate information on how paternal PPD is described, labeled, and experienced, provides more knowledge regarding what postpartum depression looks like for men in relationship to their images and fantasies about the fatherhood experience (Madsen). When a father's expectation is not actualized, depressive moods are likely to occur (Madsen). Men's narratives about their postpartum depression serve as a guide to understanding men's progression toward dealing with their depression.

Based on his literature (Odent, 2009), mid-wives and other care givers fail to make notes regarding the father's expressions related to the birthing experience. Terrence Real (1997) coined the term 'covert depression' while explaining aspects of men's lived

experience of PPD. In his summary, he advised that men attempt to escape their depression by fight or flight (Odent). It is hypothesized that new and expectant fathers who suffer PPD and are familiar with the disorder will be more likely to seek help for the disorder (Real). Contrarily and coincidentally, if the new and expectant fathers' fantasies do not match their reality related to becoming a parent, the disorder exacerbates. Men's narratives about what PPD looks like for them indicate their depression emerged from an array of angles such as their own raising, unmet fantasies about parenting, and intimacy issues. (Madsen, 2007; Real, 1997).

The purpose of this study is to explore fathers' experiences of PPD including their likelihood of detecting the disorder and seeking help for paternal PPD. A phenomenological approach was used to solicit accounts of fathers who perceived or believed that they experienced postpartum PPD as defined by (Segre & Davies, 2015). Implications for social change include educating on what PPD looks like for men which could lead to greater success in detecting and treating the disorder.

The theoretical framework for this study is Bem's (1965) self-perception theory. Unlike other attempts to assess paternal PPD, this study focused on the lived experience of men who experienced PPD. Bem's (1965) self-perception theory suggests that people develop and describe perception of lived experiences by observing their own behavior and drawing conclusions from it.

The researcher theorized that men's narratives demonstrate a self-perception that can only be told by the men themselves regarding their lived experience. By providing

the participants an opportunity to describe what PPD looks like for them, stands to provide the men and others a better understanding of their lived experience as well as how to cope with their depression.

Implications for social change include a better understanding of paternal PPD for fathers, information for health care providers, and others in how to respond to paternal PPD. Understanding men's lived experience related to PPD stands to be meaningful for early identification and treatment for PPD. Another implication for social change includes contribution to research rendering decreased number and severity for PPD.

Other Studies and Considerations

Until the Andrea Yates case in (2001), which involved (a mother accused of drowning her five children), penetrated public memory, PPD and postpartum psychosis lacked much attention. Postpartum psychosis is a severe form of depression where the parent (usually the mother) becomes out of touch with reality and is a danger to herself and her baby/child (Pinelli, 2009).

Studies on testosterone in men suggested that low levels of testosterone predispose men to paternal PPD (Irwig, 2015). During their partner's pregnancy, testosterone levels drop producing risk for depressive moods in the father (Irwig, 2015). For men, testosterone levels ranging from 300-1,200 nanograms per decileter ng/dl are normal (Irwig, 2015). Men with low testosterone levels are at a high risk for developing depression (Irwig, 2015).

Literature on paternal PPD suggested that men who suffer the disorder are not likely to seek support and resources. Considering that some people believe PPD cannot happen to men, it stands to reason that seeking help is considered counterproductive. Although legislation has been passed at the federal level that would require education for both men and women about PPD, literature on the subject remains scare (Nauert, 2010).

Additionally, with inclusion of the Melanie Blocker Stokes MOTHERS Act in the 2010 Patient Protection and Affordable Care Act it received federal level approval. The MOTHERS Act is intended to provide support services to families suffering from PPD and will also help educate mothers, fathers, and other family members about PPD.

This research, with its emphasis on men's lived experience related to PPD serves to augment future study. The average rate of PPD is 10.4% over the period of one year postpartum (Don & Mickelson, 2012), which suggests a need for broader study of what the disorder looks like for men.

Again, a significant number of men suffer postpartum depression after the birth of their baby (Paulson & Bazemore, 2010). For example, 7500 fathers suffered PPD in Massachusetts alone (Massachusetts Department of Public Health, 2009). In the mentioned Massachusetts study, the specific psychological and behavioral reactions of the men are not known. The study suggested men's lived experience remains elusive.

However, studies are beginning to look at the impact of positive and negative father-infant interaction on the child's development. As such, understanding the facets of PPD, including futuristic approaches, is becoming more pressing (Paulson & Bazemore,

2010). Consequently, paternal PPD is a growing problem where the entire family is at jeopardy when either parent suffers PPD (Paulson).

Similar research demonstrated a link between future depressive symptoms in men following the birth of their child and subsequent poor family structure (Courtenay, 2008). Poor health outcomes in children are believed to be associated with poor infant-father relationship and subsequently, child difficulties (Courtenay). As such, the effects of PPD in fathers where many negative behaviors exist, child difficulty exists (Courtenay).

Paternal depressive symptoms are predictive of interpersonal problems existing with the male-female bond and the subsequent development of depressive problems (Epiferenio et al., 2015). When maternal PPD and paternal PPD were compared, the findings showed patterns of co-occurrence for paternal depression with maternal depression. In the absence of certain gender related factors, the individual's lifestyle, mainly belief system about role assignment was rated as a major indicator of whether the individuals would receive a diagnosis of PPD, regardless of the number or severity of the depressive systems presented (Epiferenio et al., 2015).

When paternal PPD was associated with maternal PPD, the results indicated a clinical significance for the prevalence of PPD especially when their partner is depressed (Peniero, Magalhacs, Horta, da Silva, & Pinto 2006). Their population based random sample research demonstrated how from the sixth to the 12th week after having a baby when the mother was depressed, 11.9% of fathers showed depressive symptoms according to the Beck Depression Inventory (BDI).

Other studies on the subject of the likelihood of developing PPD following the birth of a baby supported the thinking that even if men became depressed after the birth of their newborn, the causes could be fairly easily attributed to familial and other causes (Peniero, et al. 2006). For these men the symptoms of PPD, their symptoms were often more severe for those who lacked a support system, practiced poor nutritional and exercise habits, or believed they lacked control over their own well-being (Peniero, et al., 2006).

Prenatal education that informs both parents regarding the likelihood that either or both partners will experience emotional difficulty during the perinatal period, stands to close a gap factors leading to PPD/unsuccessful parenting (Epiferenio, et l., 2015). Also, prenatal education is a key component in advancing toward quality health care for PPD (Epiferenio, et al., 2015). Additionally, the literature review for this study suggested that the educational approach indicated a vital and pivotal role in saving billions of dollars in health care expenses (Epiferenio et al., 2015).

Education and support systems served to help combat depression in that it enabled the individual to improve mood, and help relieve depressive symptoms (Brownridge, Taillieu, Tyler, Tiwari, Chan & Santos., 2011). As a result, aggression such as physical abuse was less likely to occur once the act of exerting control was learned through education. Once the controlled learning was strengthened, mood swing was improved, and the likelihood for divorce or other family disharmony decreased (Brownridge et al. 2011).

Research Gaps in Paternal PPD

Search engines results reflected a gap in literature regarding what PPD looks like for men (Ramchandani et al. (2008). Even though PPD is a major disorder, a lack of empirical study on paternal PPD exits (Ramchantani, 2008). The existing literature suggested associations between PPD and divorce rates, spousal abuse, incarceration, unemployment, and an array of other family problems. Studies on men's lived experience were generalizations about maternal reports and related history on men and their aggressive behaviors.

Data that reported and described what paternal PPD looks like for men were scarce. (Nauert, 2010). Data that stand to be significant in the understanding and development of criteria for measuring paternal PPD distress were lacking. There were not empirical reports on stories that were narrated by men who experienced PPD. Criteria for measuring PPD in men showed a practice or a tendency to utilize criteria designed for women. The number or the severity of the problems for men were scarcely provided in the literature search (Nauert, 2010).

Also, the literature search engines indicated a lack of acknowledgement, recognition, and research which constituted barriers that significantly impacted progression toward focusing on paternal PPD early enough to ward off pathology. There has been an increasing interest in the prevalence of paternal PPD and the way it impacts infant's lives (Courtenay, 2008). Unlike women who have been examined for a moderate

range of psychological problems in regard to how likely they are to suffer PPD, men are expected to not be at risk or to just tough it out (Courtenay, 2008).

Adverse infant-child outcome was less well researched regarding PPD than that of infant child outcome related to other populations (Wilson & Durbin, 2010). Preliminary evidence suggested that paternal depression in the postpartum period negatively impacts the quality of parenting, exacerbates the adverse impact of maternal PPD across domains irrespective of child's gender, and acts independently as a risk factor for boys (Ramchandani et al., 2008; Wilson and Durbin, 2010).

An exploratory Early Head Start study found paternal depression at ten months postpartum to significantly impact father involvement in Early Head Start programming. Of interest, access services suggested that proactive attention to men's mental health needs would positively influence paternal involvement and infant-child development. Too, understanding the processes through which fathers meet the challenge of parenthood improved infant-child development. Likewise, the development of father-inclusive education served to support families at risk. Despite the known risks and consequences, paternal PPD remains largely under-diagnosed and under-treated (Courtenay, 2012).

In current literature, there is little research regarding healthcare providers' knowledge of or practice with regard to what PPD looks like for men. Yet, repeated recommendations in the research literature suggest that fathers too should be screened for PPD, especially when their partners are depressed.

PPD is one of the least understood types of depression (Wiley, Burke, Gill, & Law 2004). During the course of my study, most of the research looked at maternal PPD and not paternal PPD. A few studies combined maternal and paternal PPD. The method of combining maternal and paternal depression in studies diminished the understanding that is unique to PPD. Postpartum screening opportunities are limited to postpartum visits and well newborn/child visits (LaRocco-Cockburn, 2003). Limited opportunities to make assessments related to the course and nature of PPD was common practice in this literature review (Bethell et al. 2004).

Measurement Instruments in the Literature Review

There are two issues discussed regarding the measurement instruments used in the articles reviewed and the conclusions drawn based on these instruments. First, the use of measurement instruments that have not been validated for assessment of postpartum depression specifically for men challenges the strength of the conclusions drawn by the authors of a relationship between maternal and paternal PPD. When assessing for postpartum depression, the EPDS has been categorized as the most valid measurement tool (Beck, 2008, part 2). Because tools other than the EPDS were used by the authors of the studies reviewed, the reader should exercise caution in the interpretation of the conclusions of a relationship between maternal and paternal PPD.

The limitation and scope of previous research afforded little opportunity for men to describe their lived experience. Research on PPD often used small sample sizes and the studies have typically used females exclusively to study PPD. Even though there has

been an increase in the research of biological influences in depression and men's health, there remain only a small number of studies on PPD in men.

Inconsistency in Prevalence Rates

Throughout the articles reviewed, there were major inconsistencies in the prevalence rates of PPD ranging from 4% to 25% and up to as high as 50% (Don & Mickelson, 2012; Roberts et al., 2006). This inconsistency raises questions about exactly how common PPD is in society today. Don and Mickelson (2012) estimated the prevalence rate of PPD to be an average of 10.4% over the first year postpartum. It is possible that limitations previously discussed regarding non-validated measuring tools and inconsistent scoring can explain why there is such a wide range of prevalence rates. Missed opportunities to interview men who suffered postpartum depression left researchers unable to adequately measure inconsistency in prevalence rates of the disorder.

Directionality of Relationship

About half of the studies included in this dissertation looked at the impact of maternal PPD on paternal PPD. Only a few considered whether there should be research into the impact of PPD on the development of maternal PPD. Even fewer studies addressed what PPD looked like for men. This indicates a bias in the literature regarding the relationship between maternal and paternal PPD. Sample sizes for the various studies were relatively small averaging10 study participants.

The literature indicated limited inclusion criteria used by the authors in selecting articles to be reviewed. The authors used articles that only met the inclusion criteria of discussing specifically a relationship between maternal and PPD. This caused the elimination of some articles. These articles did include research on maternal and paternal PPD, however the primary goal of this study is focused on men's lived experience for PPD.

A new or an expectant father's perception pertaining to PPD impacts his risk factors for developing the disorder (Melrose, 2010). A new father learns many things during the prenatal and postnatal period; one of the most important is if he has the ability to care for his child (Melrose, 2010). A new father's lack of confidence in parenting, coupled with other perils of life, lead to depression (Melrose, 2010).

Additionally, a new father's lack of recognition of the symptoms of the disorder prevents him from seeking help (Melrose, 2010). Given the scope of what men's health care looks like; men have a tendency to avoid seeking help even when help is available (Paulson, 2010). Myths about PPD perpetuate not understanding and treating the disorder (Paulson, 2010; Ramchandani, 2008). New and expectant fathers who are not familiar with the symptoms form unrealistic approaches toward dealing with the disorder (Melrose, 2010). Knowing the symptoms of paternal PPD helps demystify the disorder (Melrose, 2010).

Men's verbal history related to their lived experience was scarce. Instead, the stories reflected significant other's assessment about the men's experience. According to

the Diagnostic and Statistical Manual-IV-TR, DSMIV (APA, 2000), postpartum symptoms must be present and a diagnosis of PPD given within four weeks of the birth of the baby. However, the most recent version of the Diagnostic and Statistical Manual-V, DSM-5 (APA, 2013) changed the postpartum diagnostic criteria to include depressive symptoms that occur prenatally as well; giving men's vulnerability to the disorder a wider range.

The entire family is at jeopardy when both parents suffer PPD (Goodman, 2004). However, past studies centered on the effects and remedies for maternal PPD, but less attention addressed ways on how to remedy paternal PPD. The lack of understanding the dynamics of PPD enables men to believe that men do not get PPD (Courtenay, 2008; Paulson, 2010).

There is an increasing interest in the prevalence of paternal PPD and the way it impacts partners and infant's lives (Paulson & Bazemore, 2010). Unlike women who have been examined for a moderate range of psychosocial predictors regarding how likely they are to develop various postnatal emotional illnesses, men are often expected to not be at risk, or it is assumed that they will adjust (Paulson & Bazemore, 2010). The literature reviews demonstrated a link between future depressive systems in men following the birth of their child and subsequent poor family structure (Courtenay, 2008; Paulson & Bazemore, 2010). This suggests that studies on the effects of PPD in fathers should be expanded.

Therefore, this literature review focused on viewing material aimed at understanding men's lived experience related to paternal PPD. Specifically, this study addressed what PPD looks like for men. The participant's self-reports drove the study. Only the fathers described what PPD looked like for them. Understanding the negative effects of paternal PPD, theoretically, serves to decrease depressive moods seen in men; and stands to increase the quality of life of the family (Figueredo, & Conde, 2011). Therefore, research designed to better understand paternal PPD stands to help clarify what PPD looks like for men.

Again, what PPD looks like for men lacked empirical exploration. Furthermore, agreement of the etiology of paternal PPD lacked consensus. Consequently, the lack of knowledge related to paternal PPD, impeded the establishment of further understanding of and treatment for the disorder. Comparably, the rate of maternal PPD for first time mother's ranges from 9 to 16% according to the American Psychiatric Association. This change was discussed in more detail later in this dissertation. Because untreated PPD relates to men and their perception of the disorder, this research placed lived experience for men who suffer prenatal PPD at the center of the study.

Paternal PPD is a growing problem and is more prone to develop when maternal PPD exists as well (Don & Mickel, 2012). PPD jeopardizes the entire family when both parents suffer PPD (Don & Mickel, 2012). However, past studies addressed effects and remedies for maternal PPD on family structure, child development and social interactions of the family but less attention addressed studying effects and ways on how to remedy

paternal PPD. The effects of paternal PPD has been a psychological problem for years now yet related literature on the subject remains scarce (Nauert, 2010).

A review of current literature indicated a disproportionate amount of study for paternal PPD when compared to that for maternal PPD. Seemingly, the dominant belief system supports the thinking that it is the women who is at risk for suffering PPD and men are not at risk for suffering PPD. Other search results on paternal and maternal PPD indicated that effects of PPD mirrored negative- and seemingly generational- behaviors seen in family patterns and systems. Emotional difficulties, social problems, and an array of other behavioral problems mirrored those behaviors reported in previous generations of relatives.

In this literature review, I focused on research pertaining to what PPD looks like for men, how they coped with their depression as well as how likely men are to seek help. Also, the literature review was focused on possible effects of PPD in men on their partner and their children. The few studies that assessed the mental health status of new fathers proposed that minimizing the negative effects of the depressive mood in both parents stood to increase the quality of the life of the entire family. Therefore, what PPD looks like for men need further study. This chapter has presented and discussed relevant literature as it relates to the proposed study. Chapter 3 provided an overview of the methodology that was used to evaluate the research questions. The specific methods, instrumentation, population, and data analysis were presented.

Summary

This literature review examined current trends as well as how understudied the subject of paternal PD and its relationship to partner mental health and infant attachment remains. We know that anywhere from 4% to 25% of fathers are at risk for PPD during the first two months after childbirth. When maternal PPD exists as well as paternal PPD, there is even greater risk for the development of other postpartum psychiatric problems. Additionally, researchers depended mostly on diagnostic criteria designed for women. The subject of paternal PPD and its relationship to infant attachment has not received accurate diagnostic study. According to the current literature, some researchers suspect that hormonal changes such as testosterone, cortisol, vasopressin, and other biological risk factors for the development of paternal PPD exists, and research for the disorder remains scarce. Therefore, there is a need for further study to help minimize or prevent paternal PPD and to inform what PPD looks like for men.

Chapter 3: Research Methodology

Introduction

The purpose of this qualitative phenomenological study was to explore the experiences of fathers' PPD including their likelihood of detecting the disorder and seeking help for PPD. The following research questions were used.

RQ1: How do men who have experienced PPD describe their lived experiences?

RQ2: How do men who have experienced PPD describe how they identified, coped with, or treated their PPD?

PPD is a psychological disorder that affects a scientifically significant number of new and expectant fathers with a prevalence rate ranging from 12% to 25.5% (Melrose, 2010). Despite its seriousness and prevalence, little is known about lived experiences of this phenomenon for men. This chapter provided the research design and rationale, the role of the researcher, methodology, recruitment of participants, procedures of recruitment, instrumentation, data collection, data analysis, issues of trustworthiness, and ethical procedures and confidentiality.

Unlike other attempts to assess paternal PPD, this study's focus was on the lived experiences of fathers. In this study, fathers were invited to verbalize their lived experiences. Again, the research design was a phenomenological design that described what PPD looks like for men. Narrative interviews were conducted with six fathers who experienced at least one episode of PPD following the birth of their infant. The researcher used face-to-face and telephonic interviews to conduct research.

In order to satisfy prospective sampling techniques, the researcher accessed fathers through non-denominational churches where recruitment flyers were posted on a bulletin board at community churches. The researcher visited church locations and obtained permission to recruit participants by posting flyers to initiate the recruitment process. A pre-interview questionnaire (see Appendix C) defined the requirements for participant qualification once the participant was recruited for the study. The researcher was careful to secure a private setting (away from the churches) for each interview. If privacy was compromised for some reason, the researcher reassessed and readjusted the environment so that privacy requirements were met. Face-to-face interviews were held at designated coffee shops and community centers where closed doors were used to protect participants' privacy. Telephonic interviews were conducted by the researcher via a telephone number and at a specific time and place chosen by the participant.

Research Questions

The purpose of this study was to explore what postpartum depression looks like for men. The following research questions guided the research:

RQ1: How do the participants describe their experiences of PPD?

RQ2: How do men experience and understand PPD?

The theoretical framework for this study was Bem's SPT. The central phenomenon for this study was that individuals self-perceive their own experience and that experience is the most reliable story of an event for the experience (Bem, 1965). The

purpose of this qualitative phenomenological study was to understand lived experiences of PPD for men.

The qualitative method was suitable for this study in that it allowed participants to describe their lived experiences and thus limited researcher bias. Phenomenology research was a suitable design in that it involved looking at individual experiences of people by way of the perception of the participant. This phenomenological research allowed fathers to give their own detailed experiences of what PPD looked like for them. The results emerged from the data whereas in quantitative research, fathers could not verbalize the essence of their lived experiences of paternal PPDs Quantitative research designs look at cause and effect which would not have been a suitable research design for this study since it would not allow fathers to articulate their lived experiences.

Role of Researcher

The researcher did not know the participants. The researcher got written permission from participants who agreed to participate in the study (see Appendix E). The researcher interacted with the participants during face-to-face interviews and one telephone interview. Other roles of the researcher included: maintaining flow of effective verbal and listening communication with participants, limiting interviewer's assumptions during the interview process, maintaining the research process by avoiding a rushed approach, and resisting the behavior of imposing meaning from one participant to the next participant. The researcher followed rather than led the flow of the interview, remembering to ask for clarification and be reflective during the interview process.

Participants

All participants were at least 21 years old and demonstrated fluency in speaking English. All participants completed a pre-interview questionnaire (see Appendix C) confirming that they met requirements to participate in the study. The eligibility requirements included the following:

Participants experienced at least 2 weeks during which there was either loss of interest or depressed mood or loss of interest or pleasure in nearly all activities

Participants must also have experienced at least four additional symptoms that include: changes in appetite or weight, sleep or psychomotor activity, decreased energy, feelings of worthlessness or guilt, difficulty thinking, concentrating, or making decisions, or recurrent thoughts of death or suicidal ideation plans or attempts.

Participants' symptoms must either have been newly present or must have clearly worsened with the partners pregnancy status.

Participants' symptoms must have persisted for most of the day nearly every day for at least 2 consecutive weeks

Participants' PPD

Participant's' symptoms must have occurred during partner's pregnancy or within one year after the delivery of the child.

Participants who self-reported or demonstrated inability to speak English or did not meet the criteria for PPD were not included in the study. Participants' interviews did not

include partner involvement in the study. Fathers verbalized their own stories unassisted by their partners.

In qualitative research, small sample sizes of 1 to 25 is used to explore and gain an understanding or insight into a problem, as compared to quantitative research, which requires larger sample sizes to generate numerical data to formulate patterns are recommended (Creswell, 2007). Six fathers who self-reported that they believe they experienced PPD (as evidenced by their responses on their pre-interview questionnaire) during their partners' pregnancy up to 1 year after childbirth were recruited for the study. The researcher continued recruitment of participants until six participants were interview and saturation of themes were met.

Procedures for Recruitment

Once IRB requirements were met, the researcher got permission from churches to post a recruitment flyer (see Appendix C) at churches to invite potential participants to participant in the study. Once the potential participant agreed to participant in the study, the researcher reviewed the pre-interview questionnaire (see Appendix D) with participant to clarify any questions the participant may have. The interviews were held at private settings/by telephonic interviews. Researcher used closed doors/made reservations for private space to ensure participant privacy. The locations for interviews were at designated coffee shops, community centers or public libraries. The telephonic interviews were conducted by researcher and participant via telephone numbers provided

by the participant. I collected detailed contact information from each participant (in order to achieve ease in contacting participants).

Instrumentation

The instrument for the study were 12 open-ended interview questions used to solicit participant's story pertaining to their perceived experience of postpartum depression. A copy of the interview questions was included (see Appendix B).
The design of the questions was a narrative interview conducted with six fathers who experienced at least one episode of postpartum depression following the birth of his child. All interview questions focused on what postpartum depression looked like for men and how they assigned meaning to it. Again, the interviews were self-reports of fathers' lived experience regarding PPD. The researcher avoided escorting or conducting the interview in a manner that influenced or distorted the participant's experience or views (Thomas and Magilvy 2011). The researcher allowed participant to verbalize his own story without transferring meaning from one interview to the next (Seidman, 2006).

Participation and Data Collection

Once the participants agreed to participate in the study, the researcher asked each participant to review the consent and ask questions that were needed to clarify requirements for the study. In order to achieve a qualitative study, the researcher used face-to-face/telephonic interviews to conduct research and led the interview giving participant opportunity to verbalize his own story. The researcher tape-recorded all participant verbal responses and took hand written notes as the interviews were being

conducted. The researcher used a folder to write notes to compliment the audio-taped verbal responses. The researcher kept folder and notes private and secure with other data. Once the responses were recorded, the researcher transcribed verbatim and coded the data before analysis begun.

Data collection included one-on-one and one telephonic interview to conduct the research. Both one- on- one- and telephonic interviews, (Harvey & McGrath, 1988; Kirsh & Bandt, 2002) are valid means for collecting qualitative data. More so than in-person interviews, telephonic interviews allow researcher a broader access to a larger population of participants. Also, participants are more likely to remain in the study if the process is convenient (Harvey). Attempts were made to conduct face-to-face interviews; however, telephone interviews were allowed if necessary. Data collection was a onetime interview event conducted by the researcher. Duration of data collection event was 25-40 minutes for each participant.

Pre-interview questionnaire and individual interviews guided the data collection. A pre-interview questionnaire was used to determine if potential participants met the criteria to participate in the study. Participants completed face-to-face/telephonic individual interviews which consisted of twelve open-ended questions regarding what PPD looked like for the participant. The setting was semi-structured to allow participant ease in providing his own stories while getting to know and trust the researcher.

At the end of the study, each participant was thanked (verbally) for their participation in the study then offered an opportunity to talk about any issues related to

any problems or concerns that might have occurred during the study. A copy of the twelve interview questions were included in Appendix B. No incentive or follow-up offers were included in the study.

Data Analysis Plan

A phenomenological analysis approach was used for data analysis. The data consisted of interview transcripts. All interviews were audio-taped and transcribed verbatim (Patton,1990). Once all interview statements had been read and assigned a code number, the researcher categorized the transcripts in the order the interview questions were asked. Each participant was asked the same questions in the same order. To add rigor to the data, the researcher optioned to add new codes or to collapse codes if necessary (Patton, 1990). Data was analyzed using the concept of themes and patterns. A code number was assigned to all interview statements and probed responses. The researcher was the only coder.

Data were analyzed using phenomenological analysis (Smith et al., 2009). Narrative interviews were conducted by the researcher. Men's verbal accounts of their lived experience with PPD were solicited by way of interview questions. All data were obtained from interview questions that were designed to allow fathers to tell their own stories in their own voice (Manderson, Bennett, & Andajani-Sutjahho, (2006). The study was presented as an opportunity to have men tell what PPD looked like for them. Also, the study was presented as an opportunity for the researcher to gain knowledge for a PhD study in health psychology. The fathers were reminded that the interview was about their

lived experience and that they could speak as openly as they desired about their experience.

Issues of Trustworthiness

Researcher used a convenient sampling technique by posting flyers which contained a description of the study. A pre-interview questionnaire was utilized to ensure all participants met the criteria to participate in the study. The participants read and signed an informed consent that the study was a requirement for a Walden University graduate student to complete a doctorial study. The study was described as a study intended to have men who experienced PPD verbally report what their experience looked like. All information about the study is confidential and will not be used for any other purpose other than this study. All participation is voluntary, and the participant can terminate participation without any consequences.

The researcher did not know the participants. The researcher got written permission from participants who agreed to participate in the study (see Appendix E). All letters of permission are included in the study's appendix. The participants interacted solely with researcher during face -to -face interviews/telephonic interviews.

To satisfy issues of trustworthiness in this phenomenological qualitative study, researcher addressed issues of credibility, dependability and confirmability, all crucial in the development of a quality research (Creswell, 2007; Creswell, 2017). In quality study, credibility is important to help maintain accuracy in documentation of the study (Creswell). To satisfy credibility researcher sought to report a true picture of what PPD

looked like for the participants. In order to establish the credibility, researcher asked participant to check the data for accuracy. The use of audiotaping inherited an issue of dependability. To satisfy problems inherent to dependability, researcher reviewed each taped interview until quality of information was established before attempting to transcribe reports. To establish confirmability, researcher aimed to maintain that findings emerged from the data and not the researcher's own inclination. Researcher addressed her own inclination or predisposition by eliminating any desire to include researchers' own inclinations.

Ethical Procedures and Confidentiality

The researcher adhered to all Walden University's policies and procedures during the study. Attempts to protect participant's safety and confidentiality were upheld by researcher at all times. All papers, tapes, and telephone recordings were protected by keeping all participant records and files kept/locked under a protective environment at all times. Participant's records were not shared. Five years after the study is completed, researcher will destroy all participant records by burning the records.

Summary

Research has not adequately analyzed what postpartum depression looks like for men. PPD has been identified as a mental health condition that impacts women, men, and families (Paulson, 2010). Despite these risks, paternal PPD often goes understudied,

undetected and untreated (Paulson). Considering that fathers play a significant role in family dynamics (Lamb & Lewis, 2010) further research stands to enable fathers to better understand their support needs (Lamb & Lewis). In chapters four and five, the data were synthesized, and its clinical implications were analyzed.

Chapter 4: Results and Findings

Introduction

The purpose of this qualitative phenomenological study was to explore fathers' experiences of PPD including their experience detecting the disorder and seeking help for paternal PPD. A phenomenological approach was used to solicit accounts of fathers who perceived that they experienced PPD. A convenience sampling method was used by placing flyers on bulletin boards at churches to recruit participants. Chapter 4 is a presentation of the results and the findings of the study in relation to the research questions.

The following research questions guided the study.

RQ1: How do the participants describe their experiences of PPD?

RQ2: How do men experience and understand PPD?

Setting of the Study

For this study, a location of the participant's choosing was permitted. The setting was semi structured. The researcher-maintained participants' privacy and protection at all times per Walden's Institutional Review Board (IRB). The participant and researcher agreed upon times and location to conduct the individual interviews. The researcher met with them at a community center and an outdoor setting behind a local coffee shop. One participant was interviewed by telephone.

Demographics

The participants of the study were six fathers who self-reported that they perceived or believed they experienced PPD during their partners' pregnancy or after the birth of the child. The fathers ranged in age from 28 to 38. Of the fathers, two were first time fathers, three were second time fathers, and one was a third-time father. Two were African American, two were White American, one was Native American, and one was Mexican American. Their occupations were IT tech, landscaper, cook, teacher, unemployed, and dental technician. The demographics of the six participants are listed in Table 1. The pre-interview questionnaire was used to see if they met the criteria for the study.

Participant Portraits

P1 was a 34-year old African American computer technician and father of one child who self-reported that he experienced depression after the birth of his child. His experiences included unexplained sadness, sleep disturbance, poor eating habits, and weight loss. Also, he reported that his relationship with his wife became considerably less affectionate.

P2 was a 38-year-old American White landscaper. He is the father of one child. He reported that he felt very down for most days. He stated that his down feelings existed every day for most of the day. He shared that it was his wife's verbalization of her PPD that clued him in that possibly he was experiencing the same disorder.

P3 was a 29-year-old Native American who was employed as a cook. He is the father of two children. He stated that among his PPD experiences, sadness, shame, and confusion were the main symptoms that plagued him the most.

P4 was a 33-year-old White American and father of three children who was employed as an early childhood educator. He explained that he did not know what was causing him to experience feelings and behaviors such as prolonged sadness, unexplained crying, and heavy drinking. He stated that he also experienced episodes of being unable to relax or to calm down even when his environment was calm.

P5 was a 30-year-old African American and father of two children who was currently unemployed though he worked as a warehouse manager for 9 years. He explained that he was basically in denial about his experience with PPD. He lived among individuals who either did not understand PPD or stigmatized both men and women who fell prey to the depressive moods that are seen with those who suffer depression.

P6 was a 28-year-old father of two and Mexican American dental technician who reported that he suspected his problem had something to do with becoming a parent again, but he did not know how far it was going to push him, which caused him to feel scared and out of control. He said that when he could not warm up to his wife or newborn, he then realized that he was going through something.

Table 1

Basic Demographics of the Study Participants

	Age	Occupation	Ethnicity	Number of Children

Participant 1	34	IT Tech	African American	1
Participant 2	38	Landscaper	American White	1
Participant 3	29	Cook	Native American	2
Participant 4	33	Teacher	American White	3
Participant 5	30	Unemployed	African America	2
Participant 6	28	Dental Tech	Mexican American	2

Note: This was an all-male population (fathers).

There were six participants in the study who were interviewed individually. The participants agreed on the time and location of the interviews, which were conducted either at a community center or at an outdoor setting behind a local coffee shop. Five of the interviews were conducted face-to-face, and one of the interviews was conducted by telephone. Interviews were recorded on audiotape and sent to the transcriber after having been given an identifier to protect confidentiality. The transcripts were returned to the researcher where they were then analyzed to provide the data obtained through the individual interviews.

Data Analysis

The Process

An open coding system was used to analyze participants' narrative responses to ascertain or establish the themes. To establish the themes, a line-by-line, phrase-by-phrase, and word-by-word method was used. The recorded text was coded and categorized, and reoccurring themes were identified. To add clarity to the research, the few transcripts that were not clear regarding interpretations drawn from the transcriptions were clarified between researcher and participant by reviewing responses during the interview process as needed.

The first step of phenomenological analysis, referred to as the epoche, is the process wherein the researcher sets aside bias and predispositions to acquire the meanings that the participants of the study want to convey to the researcher (Moustakas, 1994). The second step, the process of reduction, is the stage where the researcher assigns codes to every response that each participant shared and communicated (Moustakas, 1994). Words, ideas, phrases, and statements directly related to the phenomenon of what PPD looked like for the participants were identified as a way for coding. The third step, which is the imaginative variation, is the process where themes are formed based on the codes from the interview transcripts. Participants' perceptions and experiences were grouped to create a theme. Grouped themes were done per research question as seen in Table 2. The final step of Moustakas' method of phenomenological analysis is the synthesis of meanings and essences which is the "intuitive integration of the fundamental textural and structural descriptions into a unified statement of the essences of the experiences of the phenomenon as a whole" (Moustakas, 1994, p. 100).

Data Results

The following research questions guided the study.

RQ1: How do the participants describe their experiences of postpartum depression?

RQ2: How do men experience and understand postpartum depression?

Codes and Themes

Twelve interview responses were coded. Codes were grouped in clusters of similar responses to develop themes. Responses from the six participants were counted to show number of interview question responses.

Table 2

Interview Questions, Codes and # of Responses

Interview Question	Codes	# of responses
1	**Intensity of postpartum depression**	
	My depression was mild	1
	My depression was moderate	1
	My depression was severe	3
	I was in denial of my depression	1
2	**Symptoms of postpartum depression**	
	I was confused	2
	I was anxious	1
	I was overwhelmed	2
	I was in detached	1
3	**Recognition of postpartum depression**	
	I did not know I was experiencing depression	2
	I knew immediately that I was experiencing depression	3
	I knew later that I was experiencing depression	1
4	**Evidence of postpartum depression**	
	I noticed my behavior and feelings had changed	5
	Others noticed my behavior and feelings had changed	1
5	**Reasons for seeking help or not seeking help**	
	No, I did not seek help because I thought I could fix it.	2
	No, I did not seek help because I hoped it would go away.	1
	No, I did not seek help because I talked to other people.	3
6	**Dealing with Symptoms of postpartum depression**	
	I acknowledged symptoms and got help	3
	I acknowledged symptoms and isolated myself	2
	I dealt with symptoms by denying them	1
7	**How postpartum depression symptoms manifested**	

	I have a specific example that led to uncertainty of self	4
	I have a specific example that confirms alcohol use	1
	I have a specific example that confirms denial	1
8	**Impact of manifestation on relationships**	
	The relationship with my partner was close	1
	The relationship with my partner was distant/lacked support	3
	The relationship with my partner was detached	2
	The relationship with others was okay and they were supportive	1
	The relationship with others was distant/lacked support	1
	The relationship with my child was distant	4
9	**Seeking professional help or not for postpartum depression**	
	I sought professional help to take care of depression	2
	I did not seek professional help to take care of depression	4
10	**How others can influence postpartum depression positively**	
	Other people showing empathy with words was helpful	3
	Other people showing kindness with actions was helpful	3
11	**How others can influence postpartum depression negatively**	
	Other people using discouraging words was unhelpful	3
	Other people mocking/minimizing my feelings was unhelpful	3
12	**Explaining postpartum depression to other fathers**	
	Postpartum depression is unexplained loneliness/sadness	2
	Postpartum depression is a roller coaster of emotions	2
	Postpartum depression means you get help and information	2

Emerging Themes

Codes were grouped in clusters of similar responses to develop themes see Table 2.

Table 3

Themes

Themes	Codes Associated
Acknowledging and recognizing symptoms of postpartum depression	My depression was mild My depression was moderate My depression was severe I was in denial of my depression I was confused I was anxious I was overwhelmed

	I was detached I did not know I was experiencing depression I knew immediately that I was experiencing depression I knew later that I was experiencing depression
Identifying changes in personal behavior and response from self and others due to changes in behavior.	I noticed my behavior and feelings had changed Others noticed my behavior and feelings had changed No, I did not seek help because I thought I could fix it. No, I did not seek help because I hoped it would go away. No, I did not seek help because I talked to other people I acknowledged symptoms and got help I acknowledged symptoms and isolated myself I dealt with symptoms by denying them
Impact of behavioral changes on relationships and decision to seek professional help	I have a specific example that led to uncertainty of self I have a specific example that confirms alcohol use I have a specific example that confirms denial The relationship with my partner was close The relationship with my partner was distant/lacked support The relationship with my partner was detached The relationship with others was okay and they were supportive The relationship with others was distant/lacked support The relationship with my child was distant I sought professional help to take care of depression I did not seek professional help to take care of depression
How other people influence postpartum depression and explaining it to other fathers	Other people showing empathy with words was helpful Other people showing kindness with actions was helpful Other people using discouraging words was unhelpful Other people mocking/minimizing my feelings was unhelpful Postpartum depression is unexplained loneliness/sadness Postpartum depression is a roller coaster of emotions Postpartum depression means you get help and information

Four main themes were determined from the data analysis, as shown in Table 2 and 3. These themes were:

1) Acknowledging, and recognizing symptom of postpartum depression varied

2) Identifying changes in personal behaviors and response from self and others

3) Impact of behavioral changes on relationships and decision to seek professional help,

4) How other people influenced postpartum depression and explaining it to other fathers.

Theme 1. Acknowledging, and recognizing symptoms of postpartum depression varied. Participants were asked to describe what postpartum depression was like for them including thoughts, feelings and when they knew they were experiencing depression. The responses helped to capture the ability of the respondent to describe the intensity of the postpartum depression, the ability to recognize it and symptoms that they could associate with this experience. Based on the responses, the intensity ranged from mild to severe. The feelings described were anxiety, confusion, and denial of the depression's existence. Participants explained that they either didn't know what was happening to them, knew immediately what was happening to them, or knew later that it was some form of depression. Their views are outlined as follows.

Participant # 1 reported:

> I felt unhappy, sad because raising a kid is a new experience that changed my whole life. I was not myself and I can't explain that well. I couldn't relax, enjoy myself like I usually do. Usually at night I used to watch television, but I can't do that now with a kid.

Participant # 2 reported:

> It felt like it was doom, a feeling of doom. I felt scared, ashamed and confused. This feeling was on and off. It came from nowhere and it would visit for a while and then it would go away and come back. I did not know what I had. I'm still not

> 100 percent sure what I had. Just sure that it got me down and sometimes so down until I questioned my being. I would be down for no real reason.

Participant # 3 reported:

> I was confused. I was anxious a lot. I cried sometimes and that's not me. I didn't know where this was coming from at the time.

Participant # 4 reported:

> At first, I avoided the signs. Since my wife is Korean, she would say Koreans don't get depressed, and that they don't do mental illness like Americans. At first, it was all about of denial. I lived in an overwhelmed state, and I was not in an environment where people got help, especially men, for a problem that was seemingly more of a woman problem. I first experienced a little of postpartum depression with my first child, not so much with the second one. This previous experience kind of alerted me this time with my third one.

Participant # 5 reported:

> I lost interest in almost everything. I couldn't eat. I couldn't sleep, and I gave up while putting my responsibilities on hold. By the time the baby was a few months old, I cut off visits with the baby or my partner. In other words, I became an absentee father. The mere fact that I did not get better alerted me that something was wrong and that I was in trouble. I had something on my shoulders that I couldn't deal handle.

Participant # 6 reported:

> I could not rise above the problem. It rained down on me. I was caught up in the problem. Even without being provoked, I got mad, agitated, and hateful. I had a high level of fear and shame. I knew it had to do with expecting a baby, but the lack of control was way past me! It was confusing, and crazy. Since I didn't know what was happening to me and I didn't know how far it was going to push me, I didn't know what to do with it and I didn't know how deep it was going to get.

Theme 2. Identifying changes in personal behavior and response from self and others. Participants were asked to share events that took place that caused them to believe that they experienced postpartum depression, what caused them to seek or not seek help and to describe that process, as well as how they dealt with or were dealing with the symptoms they described. Based on the responses, the interviews helped to capture the evidence of postpartum depression, reasons why respondents decided to seek help or not, and the process of dealing with the symptoms. Respondents explained that they noticed their behavior and feelings about life had changed, and that other people also noticed. All participants shared that they did not seek help for reasons ranging from denial to they thought they could fix it.

Participant # 1 reported:

> I noticed my behavior had changed and other people did as well. I couldn't sleep, so I felt sleep deprived. People noticed that while I am usually well groomed, I had let myself go and I too noticed my hygiene was not a priority. I lost my appetite. My partner noticed that I tossed and turned in bed. I did not seek help

because I thought the problem would go away or I could fix it myself. That is why I didn't ask a psychiatrist about what's going on with me, about being sad and sleep deprived. I got a little help from my wife. We changed our schedule a little bit, so that helped. Also, my job has a small daycare, so I could go and see my child during my break. I think it makes things a little better that the kid is older and I'm getting help with everything.

Participant # 2 reported:

I noticed change in my behavior and feelings. My wife was checked out for postpartum depression and then a light came on and I told her I too had the same symptoms and problems. I decided not to seek help because I did not know what to say and who I should say it to. I basically just went in the closet with my little sad secret. I kind of withdrew from people and others. I moped around, moved slower than usual. I was kind of a mess, I was in denial about it or trying to sleep all the time, trying to turn it off.

Participant # 3 reported:

Others noticed change in my behavior and feelings. I first realized when other people noticed or complained that my behavior changed. I was out of control. The drinking was too much! I talked to people about it. I understood that there was a problem with me, and I had to figure out what's going on with me. I felt I had to stop the problem.

Participant # 4 reported:

I noticed change in my behavior and feelings**.** One time when I was to lead a Parents Teachers Association (PTA) meeting, a lot of other people were present, and a few had brought their kids. When I saw all the chaos with the kids, I really didn't feel comfortable with the idea of getting a third child. Then I thought, I'm a man, I'm a teacher, and I can't handle a PTA meeting, something I've done a lot? That was one of the things that alerted me I had some depression. I didn't seek help, and I think it was because of my wife's belief system. As I said earlier, she thinks that mental illness and depression is kind of an American invention and with that said I guess I questioned that a little bit myself, so I didn't seek help. I knew I had problems then, and I didn't do anything about it, but I still have questions and concerns if you will. I think I'm okay now, but I don't think we're going to have another baby.

Participant # 5 reported:

I noticed change in my behavior and feelings. I experienced weight loss, and excessive sleeping. I couldn't seem to ever quite wake up and be clearheaded. I was sad, and moody. I was in a sad mood for most of the day. I did not seek help, but I got a lot of advice from others, unsolicited advice. I didn't know if it was all about depression or if I was going through the feelings because I was not working. Now, I'm dealing with it okay because I've read about it. I even took a course online and surveys. I just sought some information, some education on my own but at that time, when it first happened, I dealt with it poorly.

Participant # 6 reported:

> I noticed change in my behavior and feelings. I could not warm up to my lady and my newborn. I loved them both very much, but I couldn't control my emotions. I was even having a hard time saying I love you or let's do something together. It was like nothing you've ever seen. I did not know what direction to take, so I took no action. I fought it on my own. Now, I'm back to my old. Laughing, joking, loving man, but then, I felt I was experiencing somebody else's personality. I was jumpy and usually, I'm a pretty brave man. I'll stand up to whatever is in the way, but then, I was kind of wimpy, so I dealt with it in a wimpy way. Now, I think I'm okay.

Theme 3. Impact of behavioral changes on relationships and decision to seek professional help. Participants were asked to describe a specific bad experience. The responses ranged from an example that caused uncertainty and self-doubt to one that led to denial. They were asked how it affected their involvement with their partner, child or a significant other, and what it was like for them taking care of depression including whether they sought specific professional help. All participants were able to recall specific bad experiences and shared how these experiences affected their partners, child or children, and other people. The impact on relationships ranged from detached to a stronger bond with partner. Also, only one third sought professional help, the other two thirds did not seek any professional help.

Participant # 1 reported:

> My wife and colleagues noticed usually when we go out to eat, I would barely touch my food, or my drink and they noticed my hygiene was bad. I was distant with my wife Usually when I wake up, I'll say, morning, beautiful but after the baby was born, I stopped saying that, so she wondered what was going on. Usually, I am good with kids but with my own kid, it felt like, I'm off. The energy is off. My friends, and colleagues, noticed I was sleep deprived and my work was different. I handled the first part of depression poorly because I thought some of the advice from family and friends was mean and condescending. They didn't see the whole picture. They just used the way they raised their kids as an example when talking to me. My wife saw the big picture and realized we were both new to this parenting thing. Eventually, we compromised because we realized we've got to do this together.

Participant # 2 reported:

> I was thinking I was probably going crazy, and I might lose my family. I was weird, and I was going to have to live like that as a dad and a husband. I didn't know where to put this feeling. The relationship with my wife was the easiest one. We just kind of carried the burden together. We had a nursery, but I didn't go in there that much, something about that nursery seemed distant. I could change the baby, touch the baby. I wasn't afraid of the baby because I could change the baby, but I wasn’t as excited about the baby as much as I thought I would be taking pictures and laughing. I did not seek help. I think if this had gone on a longer

time, I would have been forced to get some help. I was healthy so, I didn't know what to report. As I said, I didn't know what exactly what was going on. It was kind of like it was over before I picked up, before the light went off in my head.

Participant # 3 reported:

I was drinking heavily and crying. I couldn't relax or calm down and that is not like me! My wife and I would disagree on almost everything around the house during this time. I got annoyed with my kids easily over small things. As far as other people were concerned, I would shout, and I had a hot temper! I did speak to others about what I was experiencing, and it helped a little.

Participant # 4 reported:

I was in denial. One time when my wife said that Koreans don't get mental issues, I kind of went off the handle a little bit. I let her know that anyone can have problems and that I was one of those people that whatever causes it, that it happened to me. It didn't make me feel manly at all, so I worked harder at pretending that I felt better than I really felt during this period. I have to consider my wife's thinking too and her culture, and since she thinks that Americans sort of fantasize about depression and have self-pity, those feelings did not make me feel supported. My relationship with my kids was different, from the first baby when I didn't talk a lot, I didn't think a lot, to the last baby, everything was different. I don't know why it didn't happen with the second one. The first two children were born close to each other. I did not seek help. I feel that I should have, and I felt

then that I should have gotten help even if I didn't tell my wife about it. I missed out on an opportunity to reach out for help. That's what I did. I gave it my all and didn't seek any help.

Participant # 5 reported:

I became overwhelmed with where this was taking me and if I just needed to start all over again or maybe I wasn't cut out to be a dad. My partner and I didn't talk a lot about what we're going on. She seemed distant herself. We didn't talk about it. Her conversations were more with her family, who didn't think a lot about me, and we didn't help each other a lot. I didn't get to see a lot of the baby after the first few months. I fed the baby and loved the baby, but that connection that I had expected, that love, that automatic connection that people have with their baby, I didn't get to experience it. I believe I got robbed of that. Her mother took over and I feel like I wasn't really the father or wasn't kin to the baby or something. When it came to other people, nobody really knew what was happening. I was an only child, so I didn't really know how to ask for help. My buddies just called it something, that can be a crazy time in life and to be glad that it doesn't last forever. You can get over it. I did not seek help because I felt that was the best thing to do, was to shut up about it and work through it. Now, I feel like I should have asked for help.

Participant # 6 reported:

> A surge of bad energy would come over me. What I mean by bad energy is that out of nowhere, it seemed to just come down on me and it was like the rain. I couldn't stop it. I couldn't start it. The only difference was, there was no forecast. I should have been happy, singing, but instead I was moping around feeling terrible. I didn't feel close to my wife or anyone, a little bit during pregnancy but most of it was after the baby was born. I lost compassion. I didn't feel close to my family. People didn't seem to feel close to me either, so feelings came and went. I felt bad vibes back from people. So, I wasn't close to people anymore. I did not seek help, I was on my own, but I refused to sink. It was a tug war. I refused to sink into these feelings. I would exercise. I would play music. During this time, I seemed to have been bleached out or something.

Theme 4. How other people influenced postpartum depression and explaining it to other fathers. Participants were asked what kind of behaviors from others seemed to be the most beneficial to them during their postpartum depression, what kind of behaviors from others seemed to be the least beneficial, during pregnancy and after the delivery of the baby, and how would theyaag explain postpartum depression to another father. All participants shared that acts of kindness, words of encouragement and empathy were helpful. Unhelpful behavior from others included mockery and other people minimizing their feelings or experiences. Overall, participants would explain postpartum depression to other fathers as unexplained loneliness or sadness, a roller coaster of emotions and encourage them to get help.

Participant # 1 reported:

> I work in a place that is family friendly. They offered a psychologist with a background in both computers and psychology, so I talked to the psychologist about things. The bad part of it all was people telling me, "Man up." Or telling me that I work too much and I better, since I have a kid, and my sex life with my wife was going to be different sexually, in a negative way. It's like a roller coaster of emotions. I would be sad one day, might not want to eat, and sleepless. It's not easy and there's no right way or wrong way to raise a kid.

Participant # 2 reported:

> My wife and I had our life pretty much organized. We lived in a nice quiet house and supported each other, we didn't fight and that supported our life together. What didn't help me were thousands of people asking the same question. Are you okay? Are you and your wife getting along? Are you two fighting? Are you pregnant? Are you fine to be pregnant? Also, demeaning statements didn't help. My emotions were a roller coaster**.** I really don't know to this day where it came from, pretty much, even when it stopped. I knew when it got better but don't know when it stopped. I would explain to other fathers, they need to watch out for it and know that it is something that happens during pregnancy and after a baby is born. It is not pretty. It can take you over if you let it.

Participant # 3 reported:

> I appreciated it when people told me that some people go through this experience. Some people drink more, they cry, they act out, so it was comforting to know I am not the only one. I didn't find it helpful when people would tell me that I was being dramatic and selfish about being depressed asking me to stop being a drama queen. I would explain to another father that it's a sad feeling, a lonely feeling and it's a long-term problem that will last two weeks or a month because it varies for every person.

Participant # 4 reported:

> No one really knew what I was feeling or experiencing so nobody said that much. I know that was not wise, but I kept that to myself, so no one really reached out to me except at some points I thought my wife was reaching out to me and trying to be nice to me. It was not helpful for my wife to say, "there's no such thing as postpartum depression." People would tease and say that, "Okay, number three. Number three will challenge you. They say two is a couple but three's a crowd, also first two were girls and third one was a boy. That made me think, if I can't manage two little cute girls, this boy's going to push me over the edge. I would say to other fathers, to get some information ahead of time, learn the truth, and if it happens to them, they would know what to do, and if it doesn't happen to them then good for them.

Participant # 5 reported:

> It was helpful that some people understood what I was going through, didn't point fingers or ask too many questions or try to make me feel like I wasn't doing my job. Some of them kept visiting me and talking and being my buddy. We would go out. What was not helpful, was the lack of support from my so-called in-laws. They felt that I was a spoiled brat that I came from an environment where I've never had to struggle. When I would visit them, they would say I was a weakling. I would explain to other fathers that it's a sad feeling that lasts too long. If you're not careful, you will get into a slope that you're not able to do what you usually do. You don't feel like going to the gym. You don't feel like eating. Even though you sleep in bed a lot, you're really not sleeping. You are just hiding out. It was a tiring. You tend to forget dates or appointments or whatever, and life just is not meaningful.

Participant # 6 reported:

> What was helpful to me was having people at my job give words of kindness and wisdom. They gave me a baby shower and it had pictures of babies and clothes and gifts specifically for a baby. These acts of kindness helped me to understand that a new life was coming to me. What was not helpful were mocking statements like "get a vasectomy," making me feel like I couldn't handle this new baby, being a husband. They would say that I was acting like a teenage girl, and that was negative. I would explain to another father the need to get help and not fight

through it alone, because it is much, much, bigger than you! Go for help. Take your lady with you. That's what I would say to another father.

Study Results

Two themes emerged to answer RQ. The fathers described their experience of PPD:

Participant # 1 reported:

I felt unhappy, sad because raising a kid is a new experience that changed my whole life. I was not myself and I can't explain that well. I couldn't relax, enjoy myself like I usually do. Usually at night I used to watch television, but I can't do that now with a kid.

Participant # 2 reported:

It felt like it was doom, a feeling of doom. I felt scared, ashamed and confused. This feeling was on and off. It came from nowhere and it would visit for a while and then it would go away and come back. I did not know what I had. I'm still not 100 percent sure what I had. Just sure that it got me down and sometimes so down until I questioned my being. I would be down for no real reason.

Participant # 3 reported:

I was confused. I was anxious a lot. I cried sometimes and that's not me. I didn't know where this was coming from at the time.

Participant # 4 reported:

At first, I avoided the signs. Since my wife is Korean, she would say Koreans don't get depressed, and that they don't do mental illness like Americans. At first, it was all about of denial. I lived in an overwhelmed state, and I was not in an environment

where people got help, especially men, for a problem that was seemingly more of a woman problem. I first experienced a little of postpartum depression with my first child, not so much with the second one. This previous experience kind of alerted me this time with my third one.

Participant # 5 reported:

I lost interest in almost everything. I couldn't eat. I couldn't sleep, and I gave up while putting my responsibilities on hold. By the time the baby was a few months old, I cut off visits with the baby or my partner. In other words, I became an absentee father. The mere fact that I did not get better alerted me that something was wrong and that I was in trouble. I had something on my shoulders that I couldn't deal handle.

Participant # 6 reported:

I could not rise above the problem. It rained down on me. I was caught up in the problem. Even without being provoked, I got mad, agitated, and hateful. I had a high level of fear and shame. I knew it had to do with expecting a baby, but the lack of control was way past me! It was confusing, and crazy. Since I didn't know what was happening to me and I didn't know how far it was going to push me, I didn't know what to do with it and I didn't know how deep it was going to get.

(For Theme 2) the fathers described their experience of postpartum depression as stated below:

Participant # 1 reported:

I noticed my behavior had changed and other people did as well. I couldn't sleep, so I felt sleep deprived. People noticed that while I am usually well groomed, I had let myself go and I too noticed my hygiene was not a priority. I lost my appetite. My partner noticed that I tossed and turned in bed. I did not seek help because I thought the problem would go away or I could fix it myself. That is why I didn't ask a psychiatrist about what's going on with me, about being sad and sleep deprived. I got a little help from my wife. We changed our schedule a little bit, so that helped. Also, my job has a small daycare, so I could go and see my child during my break. I think it makes things a little better that the kid is older and I'm getting help with everything.

Participant # 2 reported:

I noticed change in my behavior and feelings. My wife was checked out for postpartum depression and then a light came on and I told her I too had the same symptoms and problems. I decided not to seek help because I did not know what to say and who I should say it to. I basically just went in the closet with my little sad secret. I kind of withdrew from people and others. I moped around, moved slower than usual. I was kind of a mess, I was in denial about it or trying to sleep all the time, trying to turn it off.

Participant # 3 reported:

Others noticed change in my behavior and feelings. I first realized when other people noticed or complained that my behavior changed. I was out of control. The

drinking was too much! I talked to people about it. I understood that there was a problem with me, and I had to figure out what's going on with me. I felt I had to stop the problem.

Participant # 4 reported:

I noticed change in my behavior and feelings**.** One time when I was to lead a Parents Teachers Association (PTA) meeting, a lot of other people were present, and a few had brought their kids. When I saw all the chaos with the kids, I really didn't feel comfortable with the idea of getting a third child. Then I thought, I'm a man, I'm a teacher, and I can't handle a PTA meeting, something I've done a lot? That was one of the things that alerted me I had some depression. I didn't seek help, and I think it was because of my wife's belief system. As I said earlier, she thinks that mental illness and depression is kind of an American invention and with that said I guess I questioned that a little bit myself, so I didn't seek help. I knew I had problems then, and I didn't do anything about it, but I still have questions and concerns if you will. I think I'm okay now, but I don't think we're going to have another baby.

Participant # 5 reported:

I noticed change in my behavior and feelings. I experienced weight loss, and excessive sleeping. I couldn't seem to ever quite wake up and be clearheaded. I was sad, and moody. I was in a sad mood for most of the day. I did not seek help, but I got a lot of advice from others, unsolicited advice. I didn't know if it was all about depression or if I was going through the feelings because I was not working. Now, I'm dealing with it okay because I've read about it. I even took a course online and surveys. I just sought some information, some education on my own but at that time, when it first happened, I dealt with it poorly.

Participant # 6 reported:

I noticed change in my behavior and feelings. I could not warm up to my lady and my newborn. I loved them both very much, but I couldn't control my emotions. I was even having a hard time saying I love you or let's do something together. It was like nothing you've ever seen. I did not know what direction to take, so I took no action. I fought it on my own. Now, I'm back to my old. Laughing, joking, loving man, but then, I felt I was experiencing somebody else's personality. I was jumpy and usually, I'm a brave man. I'll stand up to whatever is in the way, but then, I was kind of wimpy, so I dealt with it in a wimpy way. Now, I think I'm okay.

RQ2:

Two themes emerged to answer RQ2. (for theme 3) the fathers described how they experience and understand postpartum depression.

Participant # 1 reported:

My wife and colleagues noticed usually when we go out to eat, I would barely touch my food, or my drink and they noticed my hygiene was bad. I was distant with my wife Usually when I wake up, I'll say, morning, beautiful but after the baby was born, I stopped saying that, so she wondered what was going on. Usually, I am good with kids but with my own kid, it felt like, I'm off. The energy is off. My friends, and colleagues, noticed I was sleep deprived and my work was different. I handled the first part of depression poorly because I thought some of the advice from family and friends was mean and condescending. They didn't see the whole picture. They just used the way they raised their kids as an example when talking to me. My wife saw the big picture and realized we were both new to this parenting thing. Eventually, we compromised because we realized we've got to do this together.

Participant # 2 reported:

I was thinking I was probably going crazy, and I might lose my family. I was weird, and I was going to have to live like that as a dad and a husband. I didn't know where to put this feeling. The relationship with my wife was the easiest one. We just kind of carried the burden together. We had a nursery, but I didn't go in there that much, something about that nursery seemed distant. I could change the baby, touch the baby. I wasn't afraid of the baby because I could change the baby, but I wasn’t as excited about the baby as much as I thought I would be taking pictures and laughing. I did not seek help. I think if this had gone on a longer time, I would have been forced to get some help.

I was healthy so, I didn't know what to report. As I said, I didn't know what exactly what was going on. It was kind of like it was over before I picked up, before the light went off in my head.

Participant # 3 reported:

I was drinking heavily and crying. I couldn't relax or calm down and that is not like me! My wife and I would disagree on almost everything around the house during this time. I got annoyed with my kids easily over small things. As far as other people were concerned, I would shout, and I had a hot temper! I did speak to others about what I was experiencing, and it helped a little.

Participant # 4 reported:

I was in denial. One time when my wife said that Koreans don't get mental issues, I kind of went off the handle a little bit. I let her know that anyone can have problems and that I was one of those people that whatever causes it, that it happened to me. It didn't make me feel manly at all, so I worked harder at pretending that I felt better than I really felt during this period. I have to consider my wife's thinking too and her culture, and since she thinks that Americans sort of fantasize about depression and have self-pity, those feelings did not make me feel supported. My relationship with my kids was different, from the first baby when I didn't talk a lot, I didn't think a lot, to the last baby, everything was different. I don't know why it didn't happen with the second one. The first two children were born close to each other. I did not seek help. I feel that I should have, and I felt then that I should have gotten help even if I didn't tell my wife about it. I missed

out on an opportunity to reach out for help. That's what I did. I gave it my all and didn't seek any help.

Participant # 5 reported:

I became overwhelmed with where this was taking me and if I just needed to start all over again or maybe I wasn't cut out to be a dad. My partner and I didn't talk a lot about what were going on. She seemed distant herself. We didn't talk about it. Her conversations were more with her family, who didn't think a lot about me, and we didn't help each other a lot. I didn't get to see a lot of the baby after the first few months. I fed the baby and loved the baby, but that connection that I had expected, that love, that automatic connection that people have with their baby, I didn't get to experience it. I believe I got robbed of that. Her mother took over and I feel like I wasn't really the father or wasn't kin to the baby or something. When it came to other people, nobody really knew what was happening. I was an only child, so I didn't really know how to ask for help. My buddies just called it something, that can be a crazy time in life and to be glad that it doesn't last forever. You can get over it. I did not seek help because I felt that was the best thing to do, was to shut up about it and work through it. Now, I feel like I should have asked for help.

Participant # 6 reported:

A surge of bad energy would come over me. What I mean by bad energy is that out of nowhere, it seemed to just come down on me and it was like the rain. I couldn't stop it. I couldn't start it. The only difference was, there was no forecast. I should have

been happy, singing, but instead I was moping around feeling terrible. I didn't feel close to my wife or anyone, a little bit during pregnancy but most of it was after the baby was born. I lost compassion. I didn't feel close to my family. People didn't seem to feel close to me either, so feelings came and went. I felt bad vibes back from people. So, I wasn't close to people anymore. I did not seek help, I was on my own, but I refused to sink. It was a tug war. I refused to sink into these feelings. I would exercise. I would play music. During this time, I seemed to have been bleached out or something.

(For theme 4) the fathers described how they experience and understand postpartum depression.

Participant # 1 reported:

I work in a place that is family friendly. They offered a psychologist with a background in both computers and psychology, so I talked to the psychologist about things. The bad part of it all was people telling me, Man up. Or telling me that I work too much and I better, since I have a kid, and my sex life with my wife was going to be different sexually, in a negative way. It’s like a roller coaster of emotions. I would be sad one day, might not want to eat, and sleepless. It's not easy and there's no right way or wrong way to raise a kid.

Participant # 2 reported:

My wife and I had our life pretty much organized. We lived in a nice quiet house and supported each other, we didn't fight and that supported our life together. What didn't help me were thousands of people asking the same question. Are you okay? Are you and

your wife getting along? Are you two fighting? Are you pregnant? Are you fine to be pregnant? Also, demeaning statements didn't help. My emotions were a roller coaster**.** I really don't know to this day where it came from, pretty much, even when it stopped. I knew when it got better but don't know when it stopped. I would explain to other fathers, they need to watch out for it and know that it is something that happens during pregnancy and after a baby is born. It is not pretty. It can take you over if you let it.

Participant # 3 reported:

I appreciated it when people told me that some people go through this experience. Some people drink more, they cry, they act out, so it was comforting to know I am not the only one. I didn't find it helpful when people would tell me that I was being dramatic and selfish about being depressed asking me to stop being a drama queen. I would explain to another father that it's a sad feeling, a lonely feeling and it's a long-term problem that will last two weeks or a month because it varies for every person.

Participant # 4 reported:

> …… No one really knew what I was feeling or experiencing so nobody said that much. I know that was not wise, but I kept that to myself, so no one really reached out to me except at some points I thought my wife was reaching out to me and trying to be nice to me. It was not helpful for my wife to say, "there's no such thing as postpartum depression." People would tease and say that, okay, number three. Number three will challenge you. They say two is a couple but three's a crowd, also first two were girls and third one was a boy. That made me think, if I

can't manage two little cute girls, this boy's going to push me over the edge. I would say to other fathers, to get some information ahead of time, learn the truth, and if it happens to them, they would know what to do, and if it doesn't happen to them then good for them

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It was helpful that some people understood what I was going through, didn't point fingers or ask too many questions or try to make me feel like I wasn't doing my job. Some of them kept visiting me and talking and being my buddy. We would go out. What was not helpful, was the lack of support from my so-called in-laws. They felt that I was a spoiled brat that I came from an environment where I've never had to struggle. When I would visit them, they would say I was a weakling. I would explain to other fathers that it's a sad feeling that lasts too long. If you're not careful, you will get into a slope that you're not able to do what you usually do. You don't feel like going to the gym. You don't feel like eating. Even though you sleep in bed a lot, you're really not sleeping. You are just hiding out. It was a tiring. You tend to forget dates or appointments or whatever, and life just is not meaningful.

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was coming to me. What was not helpful were mocking statements like “get a vasectomy," making me feel like I couldn’t handle this new baby, being a husband. They would say that I was acting like a teenage girl, and that was negative. I would explain to another father the need to get help and not fight through it alone, because it is much, much, bigger than you! Go for help. Take your lady with you. That's what I would say to another father.

Evidence of Trustworthiness

To satisfy issues of trustworthiness in this qualitative phenomenological study, researcher addressed issues of credibility, dependability and confirmability, all crucial in the development of a quality research. The researcher utilized interview questions that would gather information from men regarding their experiences with PPD. In this study, participants were from a similar population, and all six participants self-reported that they believed they experienced PPD which increased trustworthiness in the study. In qualitative study, when findings reflect the true meaning described by participants, then trustworthiness is accomplished (Creswell, 2017).

Credibility

In quality study, credibility is important to help maintain accuracy in documentation of the study (Creswell, 2017). To satisfy credibility researcher seek to report a true picture of what PPD looked like for the participants. In order to establish the credibility, member checking was used. The participants were asked to check the data for accuracy. Credibility is a qualitative technique in which the data, interpretations, and

conclusions are shared with the participants for the purpose of allowing the participants to clarify their meanings/add additional information.

Dependability

The use of audio taping inherited an issue of dependability. To satisfy problems inherent to dependability, researcher reviewed each taped interview until quality of information was established before attempting to transcribe reports.

Confirmability

To establish confirmability, researcher aimed to maintain that findings emerged from the data and not the researcher's own inclination. Researcher addressed her own inclination or predisposition by eliminating any desire to include researchers' own inclinations.

Summary

This chapter consisted of the qualitative phenomenological analysis from the data collected from six participants who were fathers who self-reported that they believed they experienced postpartum depression. The researcher interviewed, then analyzed participants' lived experience of what postpartum depression looked like for them and how likely they were to seek help. Also, the researcher presented basic demographics of the participants for this study. The four steps of Moustakas (1994) was utilized by the researcher to assign codes to every response that each participant shared and communicated (Moustakas, 1994). Words, ideas, phrases and statements directly related to the phenomenon of what postpartum depression looked like for the participants were

identified as a way for coding, then themes were formed based on the codes from the interview transcripts. Participants perceptions and experiences were grouped to create a theme. Grouped themes were done per research question as seen in Table 2 in this study (Moustakas, 1994).

In Chapter 5, the researcher will describe interpretations of the findings, limitations of the study, recommendations for future research, implications for positive social change, and conclusions for the study. Also, a summary of the findings is summarized in Chapter 5.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore fathers' experiences of PPD including their experiences detecting the disorder and seeking help for paternal PPD. A phenomenological approach was used to solicit accounts of six fathers who perceived or believed that they experienced PPD. The design selected for this study was a phenomenological analysis design. Interviews were conducted to obtain men's lived experience of PPD. The open-ended interview method was suitable in this study since it allowed the participants to describe what PPD look like for them by describing their experiences instead of answering yes or no. The interview material was revised work from the Gotland Male Depression Scale (GMDS) and the Edinburgh Prenatal Depression Scale (EPDS.

This study was conducted to explore participants' feelings and perceptions regarding what PPD looked like for them and how likely they were to seek help for their PPD. Studies on PPD are mostly geared toward maternal PPD. This study was conducted to have fathers self-report their experiences of PPD. This study on men's experiences of PPD done separately from that of women was conducted to add understanding and validity to the sparse existing literature about PPD in men.

Despite current findings on PPD in men and women, paternal PPD often goes understudied, undetected, and untreated. When compared, there was a correlation between maternal and paternal PPD and a cumulative risk for children with two

depressed parents (Courtenay, 2008; Paulson, 2010). Overall, the literature reviews for this study indicated that the question of what PPD looks like for men lacks empirical study.

This study was supportive of Bem's SPT. Bem (1972) asserted that individuals develop attitudes and opinions by observing and drawing conclusions and developing attitude formation. When internal cues are weak or difficult to interpret, individuals infer what they think or feel based on how they behave within a situation (Bem, 1972). The participants in this study reported their thoughts and feelings based on how they drew conclusions in attitude formation. As suggested by Bem (1972), people develop and describe perceptions of lived experiences and what it meant to them, which was the essence of the responses shared by the participants.

Interpretation of the Findings

The findings in this study confirm and extend the findings reported in the literature review for this study. The following four findings were identified as a result of analyzing the participants' responses to interview questions. In order to answer these research questions, the researcher used a qualitative phenomenological method involving semi structured interviews and open-ended questions. A sample of six men who self-reported that they believed they had experienced PPD was used in the study. Four themes were developed related to acknowledging and recognizing symptoms of depression such as feelings of anxiety, confusing, and denial, deciding to seek help or did not seek help,

how other people influenced PPD, and explaining it to other fathers concerning what PPD looks like for men.

For the first theme, acknowledging and recognizing symptoms of PPD, the presence of varying symptoms of PPD was one of the indicators that something was wrong. The finding for this theme relates to the participants being able to realize something was wrong but were not able to articulate it. The participants' ability to acknowledge and recognize symptoms of PPD differed in that acknowledging to others that something was wrong was not as difficult as recognizing symptoms of depression in themselves.

Ekin et al. (2016) asserted that men are not as likely as women to be familiar with symptoms of PPD. Also, stigma related to men and depression may hinder a man's likelihood to acknowledge that he is depressed. The participants' responses to interview questions, in this study, indicated that their thoughts and feelings about PPD were based on how others responded to them during their experiences of PPD. As suggested by (Bem, 1972), the men in this study described their perceptions that family members, co-workers and significant others did not understand the lived experiences of fathers' PPD.

The conclusion from this study is that the presence of varying symptoms of paternal PPD was one of the indicators to the fathers that something was wrong. The six participants did not readily acknowledge or recognize symptoms of PPD. They were reluctant to share their experience of PPD with others. Public awareness of symptoms of PPD is based on an emerging and currently inconsistent literature.

The second theme that emerged was that symptoms such as anxiety, confusion, and denial were common for all participants. This led to the finding that all six of the participants experienced some level of a lack of understanding regarding what was happening to them such as feeling emotionally out of control. Ultimately, fathers' lack of understanding and inadequate information about PPD was problematic in that it hindered their likelihood to seek professional help. The symptoms of paternal PPD included feelings of anxiety, confusion, and denial. Also, reports of crying, shame, and fear were among fathers' reports of their symptoms of PPD.

Theme 2 related to RQ2. Underwood et al. (2017) suggested that research on fathers' feelings and how they experience PPD stands to help fathers and others to recognize and treat PPD in fathers. Perinatal parenting stress such as anxiety, confusion, and fear decrease in mothers and fathers when support needs are addressed for those who are expecting parents or new parents (Underwood, 2017). The conclusion that emerged from the finding of theme 2 was that the participants needed education to help them understand what the experience of PPD looks like. Healthcare providers, family members and other support systems were not available to assist the uninformed fathers during their experiences of PPD. The fathers figured out that something was wrong on their own or others pointed out to them that their behavior was inappropriate. In one case, the father reported being in denial.

The third theme was that seeking help was difficult since the fathers did not clearly understand what was wrong. P1 who sought help shared that he was encouraged

by his spouse and coworkers to seek help. P5 shared that he decided to participate in an online help course for professional help. P2, P3, P4 and P6 who did not seek help felt they did not know enough about the problem or what to call the experience. They lacked the words to articulate their experience of PPD to others.

(Kim & Swain, 2010) suggested that not enough research has been done on paternal PPD to develop treatment models on the subject that affect change for the disorder, and to recognize paternal PPD as a legitimate disorder, men are not likely to seek help. Ultimately, there is a lack in recognition of symptoms of paternal PPD when it comes to understanding and managing the sometimes-stereotypical thinking about fathers and their emotions as a new parent (Kim & Swain). Additionally, there is uncertainty of how PPD relates to a father's perception of the disorder (Paulson & Bazemore, 2010). Postpartum depression has been defined as a disorder that impacts both individual and familial relationships (Paulson & Bazemore), yet here has been few qualitative research studies on the experiences and support needs of fathers who experience PPD. (Letourneau, Tryphonopoulos, Duffett-Leger, Stewart, Benzies, Dennis, & Joschko 2011; Paulson & Bazemore, 2010) established that there is a gap in the literature regarding men and prenatal and postnatal mental health conditions. Paternal PPD has been associated with marital conflict, insecure attachment, and poor infant-child outcome (Paulson & Bazemore, 2010). Despite these risks, paternal PPD often goes understudied, undetected and untreated. According to this research, a lack of study on PPD left new fathers without the resources and knowledge to know that they needed to seek help. Bem's (1972) theory

of self-perception supports this study in that his theory suggests that people develop and describe perceptions of lived experience and what it meant to them at that time.

The conclusion that can be derived from the third theme and findings is that for this study there is an indication of a need for training and education for individuals who are marginalized. Treatment models need to be more available to relate to problem of fathers, family members and significant others. Overall, the findings revealed that the question of what PPD looks like for men lacks empirical study which hinders help being available for men who are experiencing the symptoms of PPD. A lack of knowledge on the subject impedes men's ability to seek the help they need.

The final theme was that all participants shared that acts of kindness, words of encouragement and empathy were helpful. The findings indicated that unhelpful behavior from others included mockery and other people minimizing their feelings or experiences. Overall, participants would explain postpartum depression to other fathers as unexplained loneliness or sadness, a roller coaster of emotions and encourage them to get help.

Theme number four related to RQ1. Men who were experiencing postpartum depressing reported feelings of being stigmatized because they felt sad or fearful during their wife's pregnancy or the period after the birth of the child. While some researchers have suggested that men may be more reliant upon their partner's support than women, others have focused on transition to parenthood and the unique challenges it poses for men. One study including over 200 first-time fathers, identified uncovered and or unmet expectations and dissatisfaction about men's sexual relationships in the postpartum

period (Paulson, 2008). Other studies have explored the potential difficulties of negotiating multiple roles at once (e.g. provider, guide, household help, and nurturer), and the challenges of meeting the expectations of an emerging "new father ideal", a socio-cultural expectation to be more emotionally involved and available than in previous generations (Dalton & Nokes, 2011). The term *gender role stress* has been used to describe the experience of emotional distress that results from not adhering to traditional masculine gender role norms. Men who experience gender role stress are more likely to experience anxiety, depression, aggressive behavior, and alcohol abuse, all symptoms that are commonly associated with paternal PPD. Strict adherence to masculine gender roles may inhibit men from seeking social support when needed (Mahalik, Good, & Englar-Carlson, 2003). Bem's (1972) theory of self-perception interfaces with this study in that it suggests that people develop and describe perceptions of lived experience by observing their own behavior and drawing conclusions from it. In this study, the men observed their own behavior and described their perceptions of what their experiences were like for them.

The conclusion for the final theme and findings is that though some individuals lacked empathy when communicating with the participants, those offering words of kindness were reported as being helpful. More education about PPD to the public will serve to inform individual that women and men may have a problem with the disorder of PPD. Support of fathers during the perinatal is period is needed from the public, medical

practitioners and families. Another conclusion is that social support was lacking when individuals were not informed regarding the experience of PPD.

Limitations of the Study

As stated earlier in the study, a limitation of the study was a selection bias may exist related to the volunteer nature of the selection of the participants because participants were self-selecting. Also, the findings of this study were limited to the small number of participants who were interviewed. Another limitation was that interviews with a larger number of fathers across the country were not utilized.

Recommendations

Further research is recommended for studies with a larger number of participants stands to provide a deeper understanding of what postpartum depression looks like for men. A study to conduct a comparison between men and women regarding postpartum depression is recommended. It is recommended that medical professionals should be trained to know and provide education on how the disorder is manifested. It is recommended that DNA studies be conducted to increase awareness and understanding of PPD from a genetic standpoint. DNA studies stand to inform if individuals are genetically predisposed to PPD. Early detection of DNA lab results that indicate that an individual is predisposed to PPD stand to allow early detection and treatment for those at risk for suffering PPD. Lastly, it is further recommended that more education be provided to fathers and society on the topic of postpartum depression, such as providing

educational resources in Lamaze classes, nurseries, prenatal visits, and community centers.

Implication for Positive Social Change

The purpose of this study was to explore what postpartum depression looks like for men. Most of the fathers in this study (five of six participants) reported not being aware of what the symptoms of PPD looked like for them. Existing research has shown that new and expectant fathers suffer PPD, yet studies on paternal PPD lack noteworthy insight regarding the etiology and experience of paternal PPD (Epifenio et al., 2015; Ramchandani et al., 2008). Based on past and current literature, there is a gap in research regarding how men experience PPD. To extend this study to include men who have experienced PPD to instruct other men about paternal PPD could encourage other men to participate in studies on what PPD looks like for men.

This research could inform and provide new knowledge that stands to guide in lower incidents for PPD in men. Since new fathers are unfamiliar with the disorder, healthcare systems could add studies that assess what fathers believe about postpartum depressing and compare it to how healthcare providers view paternal PPD. Another implication for positive social change includes informing high school teachers regarding the need to add PPD to their curriculums to inform young adults regarding PPD early enough to decrease the disorder.

Also, this study stands to encourage the initiation of health care systems that provide education and resources that address paternal PPD separate from maternal PPD.

Too, establish clear and concise criteria that defines PPD and help establish an atmosphere that demystifies PPD in both men and women were implications for positive social change. Another implication for positive social change includes allowing leave of absence for fathers who need time off to recover. Like maternal leave of absence, paternal leave of absence stands to be therapeutic for men after the birth of their child, especially if the father is experiencing postpartum depression. Additionally, information gained from this study could help develop criteria for diagnosing paternal PPD.

Implication for Future Study

Further study should be done to ascertain a system where medical personnel have been trained to address PPD and know how to integrate information to men about how to identify predictors of PPD. Examples of implication for future study might include follow-up studies on Lamaze classes and test to see if providing this makes a difference. Also, further study should be done to provide specific counselor training regarding existence of pattern of PPD and the need for professional help. Inform family and others to recognize that others may be suffering from PPD and inform families and society regarding problems fathers may have with dealing with PPD. Further study should be done through public awareness groups to inform the public, family and fathers regarding stress and communication related to PPD. A lack of father's communication and understanding about PPD was a main theme in the findings of this study.

Conclusions

What PPD looks like for men lacks empirical study, recognition, and treatment consensus. Improvements for men and women can be made in both the recognition and treatment of PPD. Early education on how men assign meaning to it, and how it affects their tendency to seek help is needed. This study indicated that people are uninformed regarding what PPD depression looks like for men. Also, several studies documented that postpartum depression is a serious mental health condition affecting approximately 10% of new fathers (Ballard & Davies, 2015; Biebel & Alikhan, 2016; Paulson & Bazemore, 2010). While this research has shown that paternal PPD exists and that it is related to several adverse outcomes for the family, there is still little known about a father's experience of PPD.

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Appendix A: Demographics Checklist

Demographics

Participant (number)

Age:

Ethnicity:

Number of children:

Occupation:

Appendix B: Interview Questions

Interview Questions

Opening Statement: We are here today to talk about your experience with postpartum depression.

1. Can you describe for me what postpartum depression was like for you? Prod: What symptoms did you experience?
2. As you were experiencing it, what were you thinking or feeling about postpartum depressing? (I will restate the question for clarification if needed).
3 Can you please describe for me how you first knew you were experiencing postpartum depression? Or tell me what alerted you that you were experiencing postpartum depression?
4 Tell me about the events that took place that caused you to believe that you experienced postpartum depression.
5 What caused you to seek or not seek help? Can you describe what that was like?
6. How have you been dealing with or dealt with the symptoms we just talked about? (I will restate the symptoms stated by the participant if necessary).
7. Tell me about a time when you felt (I will repeat the participant's report or what the participant said about a lived experienced).
8. When you experienced postpartum depression, tell me about your involvement with your partner, child or children and significant others.
9. If you saw a health care professional, or sought help from others, tell me what the experience was like for you.
10. What kind of behavior(s) from others seemed to be the most beneficial to you during your postpartum experience?
11. What kind of behavior (s) from others seemed to be the least beneficial to you during your postpartum depression experience?
12. How would you explain postpartum depression to another father?

Appendix C: Letter of Invitation to Participate in a Research Project (Flyer)

SUBJECT OF STUDY: FATHERS'S EXPERIENCES AFTER THE BIRTH OF THEIR CHILD.

I am currently involved in a study addressing father's lived experiences after the birth of their child. The study explores the lived experience of men after the birth of their child who self-reported they experienced difficulty/feelings during partner's pregnancy/after the birth of a child. The study is performed as a partial fulfillment of the requirements for my Ph.D. degree in health psychology at Walden University.

Your participation in this study will provide useful information on the topic. You qualify for participation if you are at least 21 years old and are willing to share your experiences and feelings after the birth of your child. You will be asked to be interviewed. The interview will take about 25 minutes.

Participation in this study is strictly voluntary. You may withdraw from the study at any point without penalty. All information from this study is confidential and will be used for research purposes only. Names of participants will not be connected to information in the study.

Although there are no foreseeable risks to the participant, interview questions contain detailed questions regarding father's lived experience. If you feel questions of

Appendix D: Pre-Interview Questionnaire

Please check YES or NO for the following questions:

1. You are 21 years old or older? ☐ Yes ☐ No
2. English is your primary language? ☐ Yes ☐ No

During your transition to fatherhood, did you?

3 (a) Have less energy than usual? ☐ Yes ☐ No

4 (b) Slept or ate poorly? ☐ Yes ☐ No

5 (c) Enjoyed everyday activity less than usual? ☐ Yes ☐ No

6 (d) Are you a new or an expecting father? ☐ Yes ☐ No

7 Please check YES or NO for all that apply: During your transition to fatherhood did you:

1. Experience at least 2 weeks during which there was either loss of interest or depressed mood or loss of interest or pleasure in nearly all activities?
   ☐ Yes ☐ No

2. Experience changes in appetite or weight ☐ Yes ☐ No, sleep or psychomotor activity ☐ Yes ☐ No, decreased energy ☐ Yes ☐ No, feelings of worthlessness or guilt ☐ Yes ☐ No, difficulty thinking, concentrating, or making decisions ☐ Yes ☐ No, or recurrent thoughts of death or suicidal ideation plans or attempts? ☐ Yes ☐ No

3. Experiences checked above were symptoms that either had been newly present or clearly worsened during partner's pregnancy or after the birth of the baby. ☐ Yes ☐ No

4. Experiences checked above persisted for most of the day nearly every day for at least 2 consecutive weeks. ☐ Yes ☐ No

5. Experiences checked above occurred during partner's pregnancy or within one year after the delivery of the child? ☐ Yes ☐ No

Appendix E: Letter of Cooperation from a Research Partner

FATHERS' LIVED EXPERIENCS AFTER THE BIRTH OF THEIR CHILD
Letter of Cooperation from a Research Partner

Community Research Partner:

Contact Information:

Date:

Dear Clara Barnes

Based on my review of your research proposal, I give permission for you to post an invitation Flyer to recruit fathers to participate in your research entitled Fathers Lived Experiences After the Birth of Their Child within our church's Bulletin Board. As part of this study, I authorize you to post a recruitment flyer. The recruitment and any other aspect of the study will be the sole responsibility of the researcher. Also, the interviews and data collection will not take place at the church or by church affiliates. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities will not include: Personnel, rooms, resources, and supervision that the church will provide. We reserve the right to withdraw from the partner at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in ProQuest.

I confirm that I am authorized to approve posting flyers in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Authorization Official: _____
Contact Information _____